American Hospital Association

State Medicaid Redesign Initiatives -- *April 2013 Survey Responses*
Executive Summary

The American Hospital Association State Issues Forum has begun collecting information about state Medicaid reform and redesign initiatives. The purpose of this data collection is to catalogue the various initiatives and identify those efforts that other states may want to replicate. The initial survey was sent to all state hospital associations in March 2013 as the first step towards summarizing state and local health delivery and payment initiatives ***involving hospitals and health systems*** that may serve as models for future Medicaid redesign efforts. The information will be posted on the State Issues Forum website and updated on a quarterly basis.

Nineteen state hospital associations submitted responses to the initial request for information. Because of the increased interest and participation by state hospital associations, it is anticipated that more information will be collected as the State Issues Forum continues to monitor the plethora of activities in the states. All information provided for this project was supplied by the state hospital associations and does not represent the views of the American Hospital Association. This document is currently considered a draft and should not be distributed or quoted in any format.

Below is a chart that identifies which states have initiatives in each category. Some initiatives may have features found in more than one category:

Global Budgeting – Payment (6 states)	**Accountable Care Organizations (8 states)**	**Care Coordination Approach (8 states)**	**Bundled Episode Payment (5 states)**	**Medicaid Managed Care Expansion (9 states)**
Alabama Minnesota New Jersey New York Utah Wyoming	Alabama Iowa Minnesota Nebraska New Jersey New York Ohio Utah	Georgia Idaho Illinois Minnesota Nebraska New Mexico New York Wyoming	Minnesota Nebraska New Mexico New York Wyoming	Georgia Illinois Kansas Minnesota Nebraska New Jersey New York Ohio West Virginia
Shared Savings-Shared Risk (5 states)	**Pay for Performance – Value-based Purchasing (9 states)**	**Medical Homes Initiative (12 states)**	**Dually Eligible Demonstration (10 states)**	**Long Term Care/Home and Community-based Care (10 states)**
Alabama Illinois Minnesota New York Utah	Alabama Illinois Minnesota Nebraska New York Ohio Utah Washington Wisconsin	Alabama Idaho Illinois Iowa Minnesota Nebraska New York Ohio Washington West Virginia Wisconsin Wyoming	Alabama Illinois Minnesota Nebraska New Mexico New York Ohio Washington Wisconsin Wyoming	Alabama Illinois Maryland Minnesota Nebraska New Jersey New Mexico New York Ohio Wyoming
State Innovation Multi-payer Model (SIM) (7 states)	**Comprehensive Primary Care Initiative (3 states)**	**Incentives for Prevention of Chronic Diseases (3 states)**	**Basic Health Option (1 state)**	**Other (6 states)**
Idaho Illinois Iowa Maryland Minnesota Ohio Washington	Alabama Nebraska Ohio	Nebraska New York Wyoming	Minnesota	Alabama Minnesota New Mexico New York North Dakota Washington

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(All information was provided by the Alabama Hospital Association)

ALABAMA	
Redesign Categories	• **Global budgeting/Payment** • **Accountable Care Organization** • **Shared Savings/Shared Risk** • **Pay for Performance/Value-based Purchasing** • **Medical Homes Initiative** • **Dually Eligible Demonstration Capitated Model** • **Long-Term Care/Home and Community-Based Care** • **Comprehensive Primary Care Initiative** • **Other**
Brief Description of Initiative	Total transformation - moving to a community/provider-led regional care management approach. The concept is a modified version of the Oregon Community Care Organization (CCO) model. Legislation was introduced one week ago to create Regional Care Organizations (RCOs). The bill as introduced is a work in progress and it is anticipate multiple changes before it is enacted.
How established	The strategy was originally developed by the Alabama Hospital Association, then endorsed by multiple stakeholders including the Governor, Medicaid Commissioner, providers, citizen advocacy organizations, and the business community. The state is in the process of completing and submitting 1115 waiver.
Status of Initiative	• Work in progress – 1115 waiver should be submitted by mid-summer 2013 • Legislation that was introduced will be enacted by mid-May • Education and organization in progress with all providers.
Timeline	Timeline for all RCOs to be up and running (risk-bearing entities) has been set for SFY17, which is October 1, 2016. We anticipate some regions will be fully operational by SFY15.
Evaluation status	N/A
Dedicated state resources	Medicaid Commissioner and staff. No other funding.
Stakeholder involvement	Heavy engagement of all stakeholders, including business, primarily coordinated by the Alabama Hospital Association, in partnership with the Medicaid Commissioner.
Hospital or association challenges	• Education • Organizational structures & governance of the RCOs • Legislative faction that prefers Commercial Managed Care • Current hospital assessment program • Changing reimbursement from fee-for-service model to capitated rate • Global budget cap for Medicaid appropriation
Local, regional, or statewide	Regional with statewide components.
Open to all or restricted to selected hospitals	Open to all hospitals
Goals/anticipated impact on hospitals/other providers	Goals: • Coordination of care resulting in lower emergency room utilization for primary care • Increased patient compliance • Greater ability to target disease prevention strategies • Increased number of physicians willing to accept Medicaid patients. Motivation: the only alternative is commercial managed care
Association's experience to date	Since September 2012, the Association has built a tremendous coalition, and is still working to strengthen and build member unity in the process.

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(All information was provided by the Georgia Hospital Association)

GEORGIA	
Redesign Categories	**Care Coordination Approach**
Brief Description of Initiative	Use of Medical Coordination to manage the Aged, Blind and Disabled (ABD) population. The Department of Community Health (DCH) is implementing a Medical Coordination Program through which eligible ABD Medicaid members will receive services that range from basic to more intensive medical coordination services.
How established	Not yet established
Status of Initiative	Planning phase with CMMI grant date beginning 4/1/13
Timeline	Request for Proposals in later 2013
Evaluation status	N/A
Dedicated state resources	The Medicaid agency's proposed FY 2014 budget assumes that savings/cost avoidance of $7.8 million will be achieved.
Stakeholder involvement	The Georgia Hospital Association is a member of a stakeholders' advisory group the state has utilized to vet various proposals related to Medicaid redesign. Other provider associations are members of the advisory group as well.
Hospital or association challenges	Currently, there is a lack of information about how this will be implemented
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Impacts all hospitals
Goals/anticipated impact on hospitals/other providers	A care coordination vendor will be working with the provider community to manage the care of the targeted population, in particular addressing emergency room visits and inpatient hospitalization for the chronically ill (especially patients in skilled nursing home settings).
Association's experience to date	N/A

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(All information was provided by the Idaho Hospital Association)

IDAHO	
Redesign Categories	• **Care Coordination Approach** • **Medical Homes Initiative;** • **CMMI State Innovation Multi-payer Model Design Project**
Brief Description of Initiative	Three years ago the Governor's office formed a multi-payer collaborative to implement medical homes in Idaho. This collaborative has representation from physicians, hospitals, Medicaid and insurance companies. In 2011 the state legislature required the state's Medicaid program to implement managed care for the state's Medicaid population. A workgroup was formed by the Medicaid program to leverage the work of the medical home collaborative and form integrated coordinated Community Care Networks (CCNs). The CMMI State Innovation Multi-payer grant provided the opportunity to expand the Medicaid initiative to include Medicare and commercial payers, which aligns it better with the multi-payer medical home collaborative's work. The organizational structure of the CCNs is not specifically designed and may include regional networks or ACOs.
How established	Still in design phase
Status of Initiative	Planning phase with CMMI grant date beginning 4/1/13
Timeline	4/1/13-9/30/13
Evaluation status	The underlying development of the plan and the RFP for a consultant to guide the process was based loosely on the Community Care of North Carolina model but will have more complex payment and attribution of patients to primary care medical homes and CCNs.
Dedicated state resources	Yes, in the form of project management and executive staff for the oversight and public policy development.
Stakeholder involvement	Just as with the medical home collaborative, the Idaho Hospital Association is on the workgroup/public policy team and will provide oversight for the project and contractor, along with the other state provider associations, and the State's Department of Health and Welfare.
Hospital or association challenges	Legislators that want to take the easy way out and implement managed care through managed care organizations (MCO)s. It is hard to communicate the need for a redesign of the healthcare delivery system and not just how you pay for it and pass risk off to a different entity. These are complex issues to communicate to citizen legislators. There is an overriding need for the development of a sustainable healthcare delivery system that holds patients, providers and payers accountable. This is a large undertaking that takes time in a world of immediate need for budget certainty and measurable results. It will also be very hard to get insurance companies to relinquish patient management functions and turn it over to health systems that are just beginning to implement care management information systems. As long as the insurance companies get to account for their care management activities as provider payment and patient health improvement in their medical loss ratios, there is no incentive to transfer and pay for these activities and give up the data and control.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Open to all hospitals
Goals/anticipated impact on hospitals/other providers	Better primary and coordinated care should result in better disease management and fewer admissions/re-admissions and emergency room visits. A rebalancing of provider payments will need to take place to fund better coordinated care. We should see better payments to our hospital-based primary care physicians, but we are concerned about the loss of revenue to cover fixed costs which will only decrease over time as patient admission patterns stabilize over time.

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(All information was provided by the Idaho Hospital Association)

Association's experience to date	Very good in general. Other providers do not understand the needs of hospitals as they do not provide the level of capitalization that we provide to the state's healthcare infrastructure. There is a strong desire among all providers to keep MCOs out of our Medicaid program and that strong common interest has kept the group well-aligned. As commercial payers enter the project, it will be a challenge.

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How established	Still in design phase
Status of Initiative	Planning phase with CMMI grant date beginning 4/1/13
Timeline	4/1/13-9/30/13
Evaluation status	The underlying development of the plan and the RFP for a consultant to guide the process was based loosely on the Community Care of North Carolina model but will have more complex payment and attribution of patients to primary care medical homes and CCNs.
Dedicated state resources	Yes, in the form of project management and executive staff for the oversight and public policy development.
Stakeholder involvement	Just as with the medical home collaborative, the Idaho Hospital Association is on the workgroup/public policy team and will provide oversight for the project and contractor, along with the other state provider associations, and the State's Department of Health and Welfare.
Hospital or association challenges	Legislators that want to take the easy way out and implement managed care through managed care organizations (MCO)s. It is hard to communicate the need for a redesign of the healthcare delivery system and not just how you pay for it and pass risk off to a different entity. These are complex issues to communicate to citizen legislators. There is an overriding need for the development of a sustainable healthcare delivery system that holds patients, providers and payers accountable. This is a large undertaking that takes time in a world of immediate need for budget certainty and measurable results. It will also be very hard to get insurance companies to relinquish patient management functions and turn it over to health systems that are just beginning to implement care management information systems. As long as the insurance companies get to account for their care management activities as provider payment and patient health improvement in their medical loss ratios, there is no incentive to transfer and pay for these activities and give up the data and control.
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GEORGIA	
Redesign Categories	**Medicaid Managed Care Expansion**
Brief Description of Initiative	Managed Care for Foster Care Children – the state will assign foster care children to a managed care organization (MCO) for statewide care coordination and management.
How established	Not yet established (the state will need either a 1915(b) waiver or 1115 waiver to assign children to a single MCO).
Status of Initiative	Development phase: Identifying the MCO to make assignments to (one of three current MCOs); the status of CMS approval unknown.
Timeline	Implementation by January 1, 2014
Evaluation status	N/A
Dedicated state resources	Yes, state is using an existing MCO infrastructure (currently MCOs serve the low-income Medicaid population)
Stakeholder involvement	GHA has not been involved in the planning or implementation of this initiative. Other provider groups more directly involved in the provision of care to foster care children (particularly mental health services) have been consulted in an advisory capacity.
Hospital or association challenges	Any increase in Medicaid members assigned to capitated managed care typically results in a negative impact on cash flow and payments to hospitals.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Impacts all hospitals
Goals/anticipated impact on hospitals/other providers	A negative impact to cash flow and payment.
Association's experience to date	N/A

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ILLINOIS	
Redesign Categories	**CMMI State Innovation Multi-payer Model Design Project**
Brief Description of Initiative	On February 21, 2013, the Center for Medicare and Medicaid Innovation announced a State Innovations Model (SIM) program design award to Illinois to develop a comprehensive State Health Care Innovation Plan to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation, with the aim of improving health system performance for residents. One of 16 states granted design awards, the Illinois project will be broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).
How established	The program is a CMMI initiative for which Illinois applied and was awarded.
Status of Initiative	In the development phase, the initiative will build on delivery and payment system reforms already underway in the state, including changes implemented under Illinois' Care Coordination Innovations Project, and the Medicare-Medicaid Alignment Initiative, as well as innovations being spearheaded by private insurers. The planning activities will include the development and integration of three models: • a Provider-Driven Model; • a Plan-Provider Partnership Model; and, • a Plan-Provider-Payer Model. These models will feature robust coordination among health plans, providers, and payers with the goal of enhancing care management and ultimately expanding the payer base.
Timeline	Design Phase: During 6-month planning period that began in February 2013, Illinois has $2 million planning grant to design the SIM Plan. At conclusion of 6-month planning process, the state intends to use the SIM Plan to apply to CMS for $20-60 million over 3 years to fully implement and test 3 models.
Evaluation status	No further details known at this time.

ILLINOIS	
Redesign Categories	**Long Term Care/Home and Community-based Care**
Brief Description of Initiative	The state of Illinois is encouraging the incorporation of home- and community-based services to replace institutional care, where appropriate. Seniors and Persons with Disabilities (SPDs) in the Medicaid Program will be enrolled with a managed care entity for the "medical service package," which includes medical and behavioral health services. In addition, those who need long-term care will also be enrolled with the same managed care entity for the "long-term supports and services" (LTSS) service package. This package may include care in a nursing facility or in the home, with assistance from the "home- and community-based waiver" providers. Some of the SPD population includes people who are on both Medicare and Medicaid ("dual eligibles"). The federal government will partner with Illinois Medicaid to provide better coordination of services under the unique demonstration called the "Medicare-Medicaid Alignment Initiative" (MMAI). Medicare will continue to pay for the "medical service package" and Illinois Medicaid will continue to pay for the "LTSS" service package, for those who need it, with a coordinated rate setting process that accounts for savings expected from enhanced care coordination by a managed care entity and better care. (See separate summary of the MMAI).

ILLINOIS	
Redesign Categories	**Medicaid Managed Care Expansion**
Brief Description of Initiative	Legislation (SB 26) passed the Illinois legislature to expand Medicaid coverage in accordance with the Affordable Care Act, and awaits Governor's signature (6/3/13)
Status of Initiative	Legislation to expand Medicaid coverage is currently pending in Illinois.

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ILLINOIS	
Redesign Categories	**Dually Eligible Demonstration Capitated Model**
Brief Description of Initiative	In 2011 the Illinois legislature enacted a requirement that 50% of Medicaid recipients be enrolled in coordinated care by January 1, 2015. Since that time, Illinois has established several innovative programs under the umbrella of "Care Coordination", including applying for the CMS Medicare-Medicaid Financial Alignment Demonstration. Illinois refers to the dually eligible demonstration as the Medicare-Medicaid Alignment Initiative (MMAI). The Centers for Medicare & Medicaid Services (CMS) and the State of Illinois have entered into a Memorandum of Understanding (MOU) to establish a Federal-State partnership that will implement the MMAI to better serve individuals eligible for both Medicare and Medicaid (dual eligibles). Demonstration Plans will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-Covered Services under a capitated model of financing.
How established	The Centers for Medicare and Medicaid Services (CMS) approved the state's application to partner with the federal government and health plans in a 3-way contract with the various health plans. The health plans were selected jointly by CMS and the state.
Status of Initiative	Development phase, with expected roll-out in October 2013.
Timeline	October 1, 2013 to December 31, 2016, subject to conditions described in the MOU.
Evaluation status	The project has not yet begun. CMS will fund an external evaluation in accordance with Section 1115 A(b)(4) of the Social Security Act, and utilize principles of rapid-cycle evaluation and feedback. In addition, the Department expects to contract with the University of Illinois – Chicago (UIC) to conduct an independent evaluation of the demonstration.
Dedicated state resources	The Illinois Department of Healthcare and Family Services (Medicaid agency) is enhancing its quality monitoring staff with the development of a dedicated bureau for managed care quality.
Stakeholder involvement	The Illinois Department of Healthcare and Family Services (Department) has established a Care Coordination Subcommittee of the state's Medicaid Advisory Committee. This subcommittee provides a forum for stakeholders to learn about the various state initiatives, including the MMAI, and to provide input. The Illinois Hospital Association regularly attends the Care Coordination subgroup meetings. In addition, the Department posts pertinent documents on its website for public viewing.
Hospital or association challenges	The dually eligible population is among the most expensive group to care for, with many members requiring extensive health care services for co-morbidities, as well as intensive care coordination. The challenge will be to maintain or improve quality of care, without increasing spending for this population. Providers are not involved in the 3-way contract among the CMS, the state and the Plans. There is concern about how providers will fare under this arrangement: • How will the health insurance plans contract with providers, including hospitals? • Will reimbursement be adequate to engage and retain an adequate network of providers? • What are the projected savings?
Local, regional, or statewide	The MMAI will serve six counties in two regions: the greater Chicago area and fifteen counties in central Illinois
Open to all or restricted to selected hospitals	Open to all hospitals/systems that wish to contract with one of the selected Plans.
Goals/anticipated impact on hospitals/other providers	It remains to be seen if large numbers of dually eligible individuals will participate in the program, what reimbursement to hospitals and other providers will be and whether the level of collaboration necessary with community-based providers will develop.

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Association's experience to date	Too early to determine any impact on membership.
ILLINOIS	
Redesign Categories	**Shared Savings/Shared Risk**
Brief Description of Initiative	Under the state's Care Coordination Innovations Project, CCEs may suggest payment options, including a shared savings model. In addition, SB 26, which awaits the Governor's signature includes a new opportunity for provider-based Accountable Care Entities (ACEs) to begin with a shared savings model, then progress to shared risk, and finally, full risk over a four-year period.
How established	This is a state-initiated innovation as described under "Care Coordination Approach"
ILLINOIS	
Redesign Categories	**Care Coordination Approach**
Brief Description of Initiative	In 2011 the Illinois legislature enacted a requirement that 50% of Medicaid recipients be enrolled in coordinated care by January 1, 2015. Since that time, Illinois has established several innovative programs under the umbrella of "Care Coordination." In Illinois, "care coordination" will be provided by three types of "managed care entities": • Traditional insurance-based Health Maintenance Organizations (HMOs) accepting full-risk capitated payments; • Managed Care Community Networks (MCCNs), which are provider-organized entities accepting full-risk capitated payments; and, • Care Coordination Entities (CCE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis. The Care Coordination program is an umbrella over several initiatives. *For purposes of this survey, we will consider each component separately, beginning with the Care Coordination Innovations Project.*
How established	The Care Coordination Innovations Project is a state-initiated innovation. The Care Coordination Innovations Project works to form alternative models of delivering care to Medicaid clients through provider-organized networks, initially organized around the needs of the most complex clients who are Seniors and Persons with Disabilities. These provider-based networks will be organized as CCEs and MCCNs.
Status of Initiative	The Care Coordination Innovations Project is in the implementation phase. The state has approved five CCEs and MCCN.
Timeline	The CCEs and MCCN are expected to begin operating in spring and summer 2013.
Evaluation status	These entities have not yet begun operating, so evaluation is not yet applicable.
Dedicated state resources	At its sole discretion, the State may consider advancing a portion of the care coordination fees to fund start-up costs, such as investments in health information technology or startup costs for Assertive Community Treatment and Community Support Team services. Any advance payments made will be recouped from future care coordination payments on a negotiated schedule
Stakeholder involvement	The Illinois Department of Healthcare and Family Services (Department) has established a Care Coordination Subcommittee of the state's Medicaid Advisory Committee. This subcommittee provides a forum for stakeholders to learn about the various state initiatives, including the MMAI, and to provide input. The Illinois Hospital Association regularly attends the Care Coordination subgroup meetings. In addition, The Department posts pertinent documents on its website, for public viewing. With respect to development of this proposal, the state initially took comments on the concept, from all stakeholders, and then formulated the Request for Proposals (RFP).

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Hospital or association challenges	Illinois' Department of Health Care and Family Services (the Medicaid agency) has stated: "The Department invites innovative Proposals to demonstrate that Providers can provide equal or better care coordination services, produce equal or better health outcomes and render equal or better savings than traditional HMOs. In the absence of such successful models, the Department will fulfill the statutory mandate through traditional HMOs." The hospitals' challenge will be to prove these innovative entities are equal or better than traditional HMOs.
Local, regional, or statewide	Initially, there will be 4 CCEs in the Chicago area; 2 downstate. Growth will be based on capacity.
Open to all or restricted to selected hospitals	Hospitals need to apply, preferably along with the partners planning to participate in the CCE.
Goals/anticipated impact on hospitals/other providers	Participation in the CCE should ideally allow hospitals and their partners to provide an alternative to the traditional HMOs for the Medicaid population.
Association's experience to date	Hospitals are engaged participants in the initial 5 CCEs that have been chosen. Other hospitals are expressing an interest in learning more about potential participation. It is still early in the initiative, and the association will continue to adapt as the demonstration progresses, to the needs of its members.
ILLINOIS	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	As part of the requirements for the state of Illinois' Care Coordination Innovations Project, (separately summarized) Coordinated Care Entities (CCEs) and Managed Care Community Networks (MCCNs) must have a network of medical homes that are also enrolled as Primary Care Providers (PCPs) in Illinois Health Connect (IHC), the Primary Care Case Management program in Illinois, and must not exceed the PCP to Client ratio requirement that exists in IHC. A CCE is a collaboration of providers and community agencies (organizations), governed by a lead entity, that receives a care coordination payment in order to provide care coordination services for its Enrollees. The collaboration must include, at a minimum, participation from PCPs, hospitals, mental health providers, and substance abuse providers. Under this arrangement, medical services are still reimbursed via fee-for-service (with the exception of a CCE who proposes an alternative reimbursement methodology. A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department. Health Homes: If a CCE or MCCN plans to implement the Health Homes Option in Section 2703 of the ACA, the Proposal must include the services and meet the requirements defined in Section 2703. The State is not putting restrictions on which chronic conditions to manage; however, priority will be given to those CCEs or MCCNs that propose to serve the most vulnerable and expensive populations. CCEs and MCCNs will be required to track and report health home populations. (See separate summary of the Care Coordination Innovations Project under the Care Coordination Approach component of this survey.)
ILLINOIS	
Redesign Categories	**Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	As part of a more comprehensive reform of the Illinois Medicaid payment system, hospitals will receive reduced Medicaid inpatient payments when one of two situations occurs: • The hospital's annual rate of Medicaid inpatient readmissions exceeds a percentage threshold set by the state, or • During his or her inpatient stay at the hospital, a Medicaid patient acquires an additional medical condition that was not present at the time of admission to the hospital. These represent the initial implementation of "Value-Based" reimbursement payment adjustments to be incorporated into the Illinois Medicaid program.

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How established	In the summer of 2012, the Saving Medicaid and Resources Together (SMART) Act was passed by the Illinois General Assembly and signed into law by the governor. The Readmissions and Hospital-Acquired Conditions (HAC) payment reduction provisions were included as specific provisions in the Act.
Status of Initiative	Specific rules implementing those provisions of the SMART Act are currently being developed by the Illinois Department of Health and Family Services (HFS), in consultation with IHA and its member hospitals.
Timeline	Both the HAC and the Readmissions payment reductions are effective for inpatient admissions occurring on or after July 1, 2013. By law, the Readmissions payment reduction must achieve a minimum dollar savings of $40 million over the two year period, 2013-2014.
Evaluation status	N/A
Dedicated state resources	Illinois HFS has not allocated any additional funding or staff to implement these provisions.
Stakeholder involvement	There has been a significant level of stakeholder participation in the development of these policies. Illinois Hospital Association (IHA) staff has been active contributors to the drafting of the SMART Act legislation, as well as the development of the rules implementing those provisions. IHA has throughout this process solicited questions, comments and recommendations from its hospital members, as well through regularly-scheduled meetings and webinars, and is working to change aspects of the program that negatively affect hospitals and Medicaid funding.
Hospital or association challenges	There are two significant challenges: • The most obvious challenge is the reduced Medicaid funding that Illinois hospitals will receive for providing certain inpatient services to Medicaid beneficiaries. Whereas the federal Medicare program has already begun adjusting payments for both Readmissions and HACs, this will be the Illinois Medicaid program's initial implementation of VBP adjustments. The federal Medicare program is initially limiting its Readmission payment adjustments to only three diagnoses (Heart Attack, AMI and Pneumonia) and certain HACs. HFS is seeking to expand its application of these payment adjustment methodologies beyond the Medicare categories, creating a problem of consistency between the entitlement programs. • In certain instances, neither the presence of a HAC nor the occurrence of a readmission is the fault of the hospital. IHA has presented examples of situations where the hospital should be "held harmless" from payment reduction.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Both initiatives affect only Medicaid admissions at all Illinois acute care hospitals.
Goals/anticipated impact on hospitals/other providers	By law, the state is required to achieve a $40 million savings over two years as a result of the implementation of the Readmissions program; no specific aggregate savings amount was legislated for the HAC program. Hospitals' whose Medicaid inpatient claims include the presence of a HAC will experience a Medicaid inpatient payment reduction of $900 per discharge. However, the larger impact will be seen in the effect this policy will have on improving patients' quality of care, as Illinois hospitals continue to focus on providing the right care, at the right time, in the right setting. Reducing readmissions and hospital-acquired conditions are significant steps in achieving these goals—the "Triple Aim."
Association's experience to date	N/A

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Iowa	
Redesign Categories	**Medical Homes**
Brief Description of Initiative	Medical Homes Initiative: Legislation passed to plan for primary care medical home in 2008. After several years for the planning process, the state was able to take advantage of the 8 quarter enhanced FMAP rate for Health Homes for chronic conditions in the ACA effective July 1, 2012. Iowa plans to begin regional roll out of health homes for members with serious mental illness effective July 1, 2013.
How established	Program was established through a State Plan Amendment (SPA) and section 2703 of the Affordable Care Act.
Status of Initiative	Completed and underway. However, participation by medical providers has been less than the state had hoped which has led to a different strategy for the mental health medical homes.
Timeline	Underway
Evaluation status	Ongoing
Dedicated state resources	Yes, the state has dedicated both staff and a commitment to continue funding after the 8 quarters of federal funding expires.
Stakeholder involvement	N/A
Hospital or association challenges	Some practices find the certification requirements for health homes too expensive and unmanageable. Many practices that have taken members under the health home arrangements underestimated the scope of social service coordination necessary for the population.
Local, regional, or statewide	Statewide but enrollment has been very slow since the inception of the program.
Open to all or restricted to selected hospitals	Open to any practice/hospital that meets minimum certification requirements.
Goals/anticipated impact on hospitals/other providers	For those providers that were already pursuing the health home model, the Medicaid health home model provides some additional reimbursement for care coordination. However, many providers have not fully developed or embraced the model so the up-front costs can be prohibitive and the per member/per month (PMPM) fees can be too small for some of the more challenging patients.
Association's experience to date	IHA has kept members apprised of the initiative and the opportunities, especially for dually eligible population. Again, membership engagement on this topic has been varied.
IOWA	
Redesign Categories	• **CMMI State Innovation Multi-payer Model Design Project** • **ACOs**
Brief Description of Initiative	State Innovation Model (SIM) Testing Grant for Accountable Care Organizations (ACOs)
How established	Strategy has been established through CMMI design grant which became effective 4/1/13.
Status of Initiative	Initiative is in planning phase. Contractors for data support and technical assistance have been selected. Workgroup and Advisory Councils currently being shaped.

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Timeline	4/1/13-9/30-13
Evaluation status	Underway
Dedicated state resources	Staff has been allocated to support project and work with contractors.
Stakeholder involvement	Iowa Medicaid plans to have broad stakeholder involvement both at the association and individual provider level. This will occur through public workgroup and advisory meetings as well as webinars, listening sessions and individual presentations.
Hospital or association challenges	Challenges for hospitals will be whether they have the interest, and are willing to manage the Medicaid waiver and long-term services which are generally outside of the traditional acute care model. These are the areas where the bulk of the Medicaid budget is spent, but the provider network for these services today generally reside in different silos than hospitals and those leading the ACO movement. From an Association perspective, a challenge will be balancing the interests of members pursuing ACOs aggressively and those who do not embrace the concept.
Local, regional, or statewide	Yet to be determined through design process.
Open to all or restricted to selected hospitals	To be determined
Goals/anticipated impact on hospitals/other providers	To be determined
Association's experience to date	Medicaid wants IHA at the table and has stated the agency's intention to collaborate. Member unity has yet to be determined based on the parameters of member choice and whether providers must have a contractual relationship with an ACO in order to provide services to the Medicaid population.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Kansas Hospital Association)

KANSAS	
Redesign Categories	**Medicaid Managed Care Expansion**
Brief Description of Initiative	In 2011, the State Medicaid Administration announced its plan to reform Medicaid and published a request for proposal (RFP) to implement KanCare, a whole-person, integrated managed care health program for more than 360,000 consumers.
How established	1115 Waiver
Status of Initiative	KanCare was implemented on January 1, 2013
Timeline	The RFP went out in November 2011. The waiver application was submitted to CMS in April 2012. Final approval of the waiver was received in December 2012 and the plan was implemented in January 1, 2013.
Evaluation status	Ongoing
Dedicated state resources	The state has indicated that KanCare will save $1 Billion over 5 years. No additional state staffing was added to date.
Stakeholder involvement	KHA participated in numerous public and stakeholder meetings prior to implementation and continues to work with the providers, the managed care plans (MCOs) and the Department of Health and Environment to administer the program and to address issues as they arise. KHA has convened an advisory group of our members to assist all Kansas hospitals with the transition issues. This group identifies, organizes and explains the issues in a face-to-face setting with the MCOs and the State to encourage collaboration to work through implementation concerns.
Hospital or association challenges	The transition to KanCare was a major system redesign of the Medicaid program in Kansas. All Medicaid beneficiaries, with the exception of only a few limited benefit categories, have been transitioned from fee-for-service to managed care. There have been issues with contracting, credentialing, prior-authorization, billing, timely claims payment, correct claims payment and lack of education for the providers and the consumers prior to the implementation.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	KanCare impacts all hospitals that accept Medicaid. Out-of-network providers are paid at 90% of the Medicaid FFS rates.
Goals/anticipated impact on hospitals/other providers	The most significant impact to date has been the administrative burden placed on the providers to educate Medicaid beneficiaries as well as to monitor changes for the three new MCOs in billing, prior-authorization and payment. As more time evolves, we will have a better understanding of the financial impact upon the providers.
Association's experience to date	KHA is a strong partner with the State and the MCOs to implement the KanCare program. Early on, our KHA Board outlined some KanCare principles that we shared with the State with our "buy in" on the transformation. We have a very strong relationship with our State Medicaid Division, and provide a significant amount of staff resources to educate and communicate with our members.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Maryland Hospital Association)

MARYLAND	
Redesign Categories	**Long-Term Care/Home and Community-Based Care**
Brief Description of Initiative	State Balancing Incentives Payment (BIP) Program: Long-Term Care and Community Support Services under Medicaid intends on building capacity to efficiently and effectively provide services to all Maryland Medicaid participants in the community. The Department is pursuing this initiative through the federal "State Balancing Incentive Payment Program" made possible through the Affordable Care Act.
How established	Section 10202 of the Affordable Care Act, establishes the BIP Program. The program offers a targeted increase in the FMAP for non-institutional long term services and supports to States that undertake structural reforms to increase access to non-institutional long term services and supports.
Status of Initiative	Development phase – Stakeholders meet regularly with the department and CMS is provided with quarterly reports on initiative status.
Timeline	Stakeholder meetings continue through the spring of 2013. Full implementation is expected to be phased in over the next year.
Evaluation status	Maryland's BIP application was approved in the spring of 2012. CMS is updated quarterly on program progress.
Dedicated state resources	The state has established three new positions including a Balancing Incentive Program Coordinator, a Maryland Access Point (MAP) Specialist and a Money Follows the Person Policy Analyst. The state is currently seeking applicants to fill these roles.
Stakeholder involvement	N/A
Hospital or association challenges	No challenges
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The initiative is limited to long term care providers.
Goals/anticipated impact on hospitals/other providers	The impact on SNFs and other long term care facilities could be significant if the initiative successfully transitions a large population from institutional settings into community based care settings.
Association's experience to date	We are monitoring this effort but not directly involved.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Maryland Hospital Association)

MARYLAND	
Redesign Categories	**CMMI State Innovation Multi-payer Model Design Project**
Brief Description of Initiative	State Innovation Models (SIM) Award – Community Integrated Medical Home (CIMH) – Maryland received a Model Design award in the amount of $2.37 million. The funding will be used over a six-month period beginning in April 2013 to develop a "Community Integrated Medical Home" (CIMH) model.
How established	The SIM grant solicitation was released by the CMS Center for Medicare & Medicaid Innovation. The purpose of the program is to develop, implement, and test new health care payment and service delivery models at the state level.
Status of Initiative	Development phase – Two parallel stakeholder engagement processes will be implemented beginning in April 2013. One involves payers and providers; the other involves local health improvement coalitions. At the end of the six-month development period there will be an all-stakeholder summit to review recommendations from both processes.
Timeline	The Model Design project began April 1, 2013 and is expected to last six-months.
Evaluation status	The model design will form the basis for a Model Testing application that will be submitted to CMMI after the six-month design process is complete.
Dedicated state resources	The Maryland Department of Health and Mental Hygiene, Health Systems & Infrastructure Administration is the lead on the project. They have hired consultants to assist with the stakeholder engagement process and provide content expertise.
Stakeholder involvement	N/A
Hospital or association challenges	No challenges have been identified thus far. However, that may change as the planning process begins.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The engagement process described above will be open to those hospital representatives asked to participate in the process. However, MHA staff will keep all hospital members informed of developments as the program progresses.
Goals/anticipated impact on hospitals/other providers	MHA is hopeful that the establishment of a CIMH program will improve population health outcomes by reducing unnecessary hospital readmissions, improving transitions of care and better alignment of healthcare provider services.
Association's experience to date	To date, the experience has been positive. The state is reaching out to hospitals to participate and actively seeking member input.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Minnesota Hospital Association)

MINNESOTA	
Redesign Categories	**Global Budget/Payment**
Brief Description of Initiative	In 2010, the legislature authorized the MN Department of Human Services (DHS) to conduct a global budget/payment model project in Hennepin County, Minnesota's most populated county, which includes the City of Minneapolis. The project, referred to as HennepinHealth, provides a risk-adjusted, capitated payment to Hennepin County for all health care and social services for childless Hennepin County residents below 75% of the federal poverty limit.
How established	The program was authorized in state legislation enacted in 2010. The state then sought and obtained federal approval through a Managed Care Organization/Accountable Care Organization demonstration project.
Status of Initiative	The state applied for and received the first CMS approval for a project of this kind in 2011. The program began in January 2012 and is in its second year of operation.
Timeline	Enabling legislation was enacted in 2010. Federal approval through the MCO/ACO demonstration project was received in 2011, and the project began in 2012.
Evaluation status	Through the project, Hennepin County's public hospital and affiliated clinics, county-controlled health plan and social service departments coordinate and deliver total-cost-of-care services for approximately 7,000 adults. Many of the enrollees are homeless. Some defining characteristics of this population include: • ~ 68% Minority status • ~ 45% Some level of chemical dependency • ~ 42% Mental health needs • ~ 30% Chronic pain management • ~ 32% Unstable housing situation • ~ 30% More than one chronic disease (diabetes and/or heart disease are most common)
Dedicated state resources	The state pays the per-capita global payment to the county. In addition, state staff oversee the program in terms of eligibility determinations, expenditure oversight, CMS reporting obligations, etc. However, the state does not have staff dedicated to the implementation, leadership or day-to-day operations of the program.
Stakeholder involvement	MHA passively supported the enabling legislation in 2010 because it did not have broad member impact. MHA was not involved in or consulted by the state or HennepinHealth during the planning or implementation phases of the project. Early after the program began, MHA's board of directors hosted a presentation by HennepinHealth to better understand the initiative, the organization's approach and its relationship with other health care initiatives (e.g., competitive bidding for Medicaid managed care) occurring simultaneously in the same market.
Hospital or association challenges	For the hospital involved in the initiative, the challenges have centered on: (a) redesigning care and outreach services for this population, (b) calculating and tracking costs and appropriating savings across county departments, (c) clearing data privacy laws and restrictions to allow sharing of patient data across medical and social service units within the county, (d) getting the program scaled up to a population level that generates sufficient savings and predictability and (e) revamping patient outreach and communications approaches to accommodate the mobile and low-income population enrolled in the program. For other hospitals in the community, the initiative presents a challenge when patients enrolled in HennepinHealth receive services at non-HennepinHealth locations. Hennepin County's health plan manages the transaction process for billing and claims, but it is unclear how reimbursement rates are negotiated, if at all. In addition, other hospitals regard the initiative as incapable of replication because Hennepin County is unique in terms of its large population, large trauma/teaching hospital service line capacity, its wholly owned health plan and its authority over the county's social service departments. Accordingly, other hospitals point to elements of that equation missing from their situation and may tend to dismiss the project. For the association, the initiative presents challenges because of the hospital member's role in the county's governance structure. The initiative goes beyond hospital or even health care broadly defined to include social services. Also, because of the health plan's significant role in billing and claims processing, actuarial analysis, etc., information to the Association is less forthcoming.

Local, regional, or statewide	This particular effort is limited to one county, although it is the state's most populated county. A similar initiative driven by a joint powers organization formed by twelve rural counties is in the planning stages, but would operate under a different legislative provision (see discussion of Health Care Delivery Systems under the shared savings/shared risk summary page).
Open to all or restricted to selected hospitals	The program is statutorily limited to Hennepin County Medical Center. Another hospital located in adjacent Ramsey County is eligible to create a similar program under the statute, but has not sought to do so with the state.
Goals/anticipated impact on hospitals/other providers	The participating hospital, Hennepin County Medical Center, expects that the project will allow it to reduce its uncompensated care and emergency room costs by better engaging patients to keep them enrolled in coverage and better managing their health care and social service needs, especially with respect to chronic conditions. Other hospitals and providers serving Medicaid enrollees in Hennepin County anticipate that their Medicaid patient mix will be nominally affected as eligible enrollees are automatically assigned to the HennepinHealth program. However, there is not expected to be a measurable impact on net revenues or uncompensated care for other providers. Looking ahead, some providers exploring other Medicaid ACO initiatives, such as the Health Care Delivery System (HCDS) demonstration project, that would serve the Hennepin County area have expressed concern that HennepinHealth's narrowly defined population might unduly segment the total Medicaid population, making it more difficult to reach a critical mass of Medicaid patients for total-cost-of-care or risk sharing payment methods, and could unnecessarily add to the complexity and administrative costs of the Medicaid program overall. In response to some of these concerns, HennepinHealth has expressed a willingness to expand the program so that the population served aligns with an all-Medicaid ACO design, such as the HCDS demonstration projects.
Association's experience to date	MHA has adopted a policy position supporting and encouraging state experimentation with payment reform that seeks to test different models, allows for tailoring of reforms for different providers or communities, and does not jeopardize federal funding for state public programs. Because the HennepinHealth project aligns with this general policy position, MHA has been supportive of its development. Shortly after the program began operations, MHA brought HennepinHealth's leaders to our Board of Directors to present their funding and care models in the first weeks of the program's operation.
MINNESOTA	
Redesign Categories	**Shared Savings/Shared Risk**
Brief Description of Initiative	In 2010, the Legislature provided authority to the state Department of Human Services (DHS) to develop Health Care Delivery System (HCDS) demonstration projects in state public programs to test payment models with shared savings/shared risk features (see Minn. Stat. sec. 256B.0755).
How established	The HCDS demonstration projects are state-initiated with subsequent approval by CMS through a state plan amendment in 2012.
Status of Initiative	The first cohort of HCDS demonstration projects began operating in 2013. DHS has also released another request for proposals (RFP) in anticipation of a second cohort of demonstration projects scheduled to begin in 2014.
Timeline	Enabling legislation was enacted in 2010, DHS released a RFP from providers in 2011, CMS provided approval of the payment methodology in 2012, and DHS signed contracts with six organizations to begin demonstration projects in 2013. DHS released a new RFP from providers in 2013 with the intention of executing contracts and beginning operations for the second cohort of HCDS demonstrations in 2014.
Evaluation status	The first cohort of six HCDS demonstration projects began in January 2013. Accordingly, no data are yet available regarding cost or quality performance, patient satisfaction scores or shared savings or shared risk outcomes.
Dedicated state resources	The state has assigned some existing staff to the HCDS demonstration project. In addition, the state applied for and received a State Innovation Model grant of $45 million with the expectation that a significant portion of the grant funds will be used to obtain technology and analytic capacity necessary for the state to effectively manage/oversee the projects.

Stakeholder involvement	MHA worked with DHS to draft the initial enabling legislation in 2010. MHA approached DHS in 2011 with the suggestion that the new Commissioner use this statutory authority to develop a voluntary demonstration project to experiment with payment reform instead of imposing mandatory, across-the-board payment changes to all providers. MHA also provided the department with a proposed draft of the RFP. After the department released its first RFP, MHA helped convene and encouraged members to participate in potential contractor meetings DHS held to explain the demonstration projects and respond to provider questions. Based on MHA's analysis of the projects terms and conditions and feedback from members, MHA submitted a comment letter outlining multiple problems with the state's intended approach and offering several suggestions for improving the process. As a result, the department revised the RFP and project design in late 2011. MHA encouraged members to consider submitting proposals, even if they did not adhere precisely to the state's conditions, monitored and participated in potential contractor sessions and stayed in contact with state staff for updates on the project's timeline as it went through multiple delays. MHA wrote several articles in its member newsletter regarding the demonstration projects during each phase of their development and, again, encouraged members to consider participating in the most recent request for proposals for the second cohort of HCDS demonstrations.
Hospital or association challenges	For participating health systems, the most significant challenges include: (1) the patient attribution methodology that does not allow for any form of assignment or enrollment or restrictions on provider choice for enrollees; (2) receiving timely and useful utilization data from the state and managed care organizations with respect to the likely patient population; (3) planning for and managing downside risk with a low-income and mobile population and already below-cost reimbursement rates. For the Association, the most significant challenges have been getting the information necessary to fully understand and evaluate the demonstration projects because of the elongated contract negotiation period during which time neither the state nor the potential contracting providers were allowed to discuss details of the program. In addition, because each participating member considers its approach to this ACO-like program to be proprietary, they have not been forthcoming about issues, challenges or opportunities for the Association to address.
MINNESOTA	
Redesign Categories	**Care Coordination Approach**
Brief Description of Initiative	See summaries of Minnesota's Global Budgeting/Payment Program concerning HennepinHealth, Shared Savings/Shared Risk program concerning Health Care Delivery System demonstration projects and medical homes initiative concerning the Health Care Homes program.
MINNESOTA	
Redesign Categories	**Accountable Care Organization**
Brief Description of Initiative	See summaries of Minnesota's Global Budgeting/Payment Program concerning HennepinHealth, Shared Savings/Shared Risk program concerning Health Care Delivery System demonstration projects
MINNESOTA	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	In 2008, the legislature enacted a new medical home initiative, referred to in Minnesota as Health Care Homes, to create multi-payer medical home certification criteria and payment methodologies (see Minn. Stat. sec. 256B.0751, sec. 256B.0752). In October 2011, CMS began participating in Minnesota's Health Care Home Initiative for fee-for-service beneficiaries as one of its eight Medicare Multi-payer Advanced Primary Care Practice demonstration projects.
How established	The Health Care Homes initiative began as a state initiated innovation with legislation applying to state employees, state public program enrollees and commercial plans. It was later expanded through a CMS demonstration project to include Medicare fee-for-service beneficiaries.

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(All information was provided by the Minnesota Hospital Association)

Status of Initiative	The Health Care Homes initiative is operational and ongoing throughout Minnesota. To date, 224 clinics have become certified health care homes. This represents approximately 25 percent of all clinics in the state. Although actual health care home enrollees are much fewer, the total patient population served by clinics certified by health care homes amounts to approximately 2 million Minnesotans, or roughly 40 percent of the total population.
Timeline	Enabling legislation was enacted in 2008. Most of 2009 was consumed with state-led work groups to develop recommendations for health care home certification standards, payment methodologies and other operational issues. The program became operational with the certification of 12 clinics occurring in July 2010. The program expanded to include Medicare fee-for-service beneficiaries beginning in October 2011. The program now has 224 certified Health Care Home clinics and continues to expand as additional clinics seek and obtain certification.
Evaluation status	The most recent evaluation of the Health Care Home initiative by the Minnesota Department of Health is available at http://www.health.state.mn.us/healthreform/homes/legreport/2011HCHLegReport.pdf. Approximately 135,000 state public program beneficiaries have enrolled in a Health Care Home. This represents less than 20 percent of all beneficiaries. Anecdotal reports to the Minnesota Department of Health by two individual health systems indicated that the Health Care Home program, in combination with other health care reform and care delivery transformation efforts, reduced participating patients' per member costs by 2.6 to 5% over 12 months. Another study indicated that Health Care Home participating patients with diabetes or cardiovascular disease more frequently received care that was consistent with evidence-based guidelines than patients who did not receive care from a certified Health Care Home clinic. A private research study indicated that health care homes did not produce statistically significant differences in care quality or costs, but generated measurably higher patient satisfaction scores. This study was conducted on a limited set of health care homes and very early in the implementation. A more comprehensive study is underway. In addition, initial data on Medicare spending indicated that the projected cost savings for Medicare beneficiaries were not materializing so the Medicare payment rates for health care home providers were reduced in an effort to return the program to a net-balance or net–savings for Medicare. More comprehensive evaluation on cost, quality and patient satisfaction is still pending as the Department of Health has been collecting baseline data as well as initial comparison year data. MHA expects that an updated evaluation report will be available in May or June 2013.
Dedicated state resources	The state has dedicated funding in state public programs to pay per member/per month (PMPM) "care coordination fees" to certified health care homes for enrollees that elect to participate in the program. In addition, the state program has several dedicated staff that oversee the initiative, provide training and outreach for providers, administer a learning collaborative for participating health care homes, conduct on-site certification surveys and evaluate applications for certification.
Stakeholder involvement	MHA and other provider groups populated and actively participated in multiple work groups convened to develop health care home certification criteria and payment methodology. The Association provided multiple educational programs for members, as well as other interested stakeholders such as the state bar association, to better understand the initiative and its implications. MHA estimates that 80% of certified health care homes are owned, managed or operated by MHA members.
Hospital or association challenges	The state's certification and recertification process is unduly burdensome and administratively complex for providers. In addition, because participating providers' ability to receive the intended PMPM care coordination payment is dependent upon state public program enrollees' decision to actively sign up for the program, the estimated amount of care coordination fees actually paid by the state is approximately 70% lower than anticipated, yet the providers' costs are no less expensive.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The Health Care Home initiative is open to any provider or clinic that has capacity to provide care coordination and management services for primary and specialty care. Although the program is designed for primary care practices, it does not preclude specialists from becoming certified as a health care home.

Goals/anticipated impact on hospitals/other providers	The Health Care Home program is anticipated to reduce overall hospital admissions, readmissions, emergency room and diagnostic testing utilization through improved care coordination, prevention services and primary care. It is also intended to improve communication between primary care and hospital providers, and drive additional funding into primary care practices.
Association's experience to date	MHA's membership supported the Health Care Home initiative and has participated in it significantly. Members have not perceived it to increase competition between one another. To an extent, there appears to be general unity around the notion that the program's requirements are unduly burdensome, however the regulatory burdens do not rise to a high priority or rallying call for members.
MINNESOTA	
Redesign Categories	• **Care Coordination Approach** • **Other Medical Homes Initiative (Behavioral Health Home)**
Brief Description of Initiative	Behavioral Health Home planning. Minnesota received a federal planning grant to develop a health home for people with severe and persistent mental illnesses, also called a Behavioral Health Home (BHH) (see http://www.dhs.state.mn.us/main/dhs16_171741 and scroll down to "Behavioral health home workgroup"). The BHH builds on the work Minnesota has previously done on Health Care Homes (Medical Homes).
How established	CMS health homes planning grant
Status of Initiative	Development phase
Timeline	Under development. BHH work group met four times throughout fall and winter 2012-13 without coming to consensus on substantive recommendations. Proposed work plan shows BHH development throughout 2013. Goal for initial pilot model RFP in early 2014.
Evaluation status	N/A
Dedicated state resources	Yes, staff and funding.
Stakeholder involvement	MHA and members have participated in working groups to help design the BHH.
Hospital or association challenges	Hospitals are supportive of Behavioral Health Homes as a way to provide integrated, coordinated care for some of our most difficult to treat patients. Some hospitals already have a similar program in place. At this stage, the criteria for BHHs are unknown; hospitals wishing to participate either as a BHH or with a BHH might decide against participating if the criteria are not favorable. Payment levels and mechanisms will also be carefully watched.
Local, regional, or statewide	Under development
Open to all or restricted to selected hospitals	Under development
Goals/anticipated impact on hospitals/other providers	Hospitals and other providers hope integrating primary and mental/behavioral health care together with supportive services will mean fewer hospitalizations and better care and outcomes for individuals with severe and persistent mental illnesses.
Association's experience to date	The association's Mental and Behavioral Health Task Force is strongly in favor of the BHH initiative.

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(All information was provided by the Minnesota Hospital Association)

MINNESOTA	
Redesign Categories	• **Dually Eligible Demonstration Capitated Model** • **Care Coordination Approach**
Brief Description of Initiative	Special Needs Basic Care. Special Needs Basic Care (SNBC) plans are for people with disabilities age 18-65 (see http://www.dhs.state.mn.us/main/idhs16_139491). SNBC with Medicare is for dual-eligible enrollees and includes all Medicare services and Part D along with all Medicaid services. 100 days of nursing home care is also covered. Other services such as private duty nurse or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) are fee-for-service. SNBC Medicaid has both dually-eligible and Medicaid-only enrollees. It covers Medicaid services, drugs not covered by Part D and 100 days of nursing home care. Other services such as private duty nurse or ICF/DD are fee-for-service. Medicare Parts A and B are fee-for-service. Part D drugs are through a separate Part D plan. Both SNBC with Medicare and SNBC Medicaid started as opt-in; SNBC Medicaid was changed by legislation to opt-out, with passive enrollment.
How established	State initiated innovation, 1115 waiver, and 1915 (a) waiver
Status of Initiative	In rate negotiations with CMS for people under 65 with disabilities; proposal on hold for dually-eligible under age 65. Phase one of seniors demonstration began January 1, 2013.
Timeline	The Minnesota Senior Health Option (MSHO) began in 1995 and has been statewide since 2005. Dually-eligible seniors have been required to enroll in Prepaid Medical Assistance Program (PMAP) since 1985.
Evaluation status	Ongoing
Dedicated state resources	Yes, staff and funding.
Stakeholder involvement	Stakeholders, including providers and MHA, were invited to participate in workgroups and a Best Practices Symposium held January 28, 2013.
Hospital or association challenges	Sharing of medical records between providers is a challenge for hospitals and other providers in Minnesota. The state's data privacy laws are stricter than the national HIPAA standard, which creates difficulties for sharing clinically appropriate data with providers outside of a system. This challenge is not unique to Integrated Care System Partnerships (ICSP), and comes up repeatedly with other care coordination initiatives.
Local, regional, or statewide	Planned for statewide implementation
Open to all or restricted to selected hospitals	The initiative is open to all providers who are within managed care organizations' provider networks and who are enrolled Medicaid and Medicare providers.
Goals/anticipated impact on hospitals/other providers	Challenges with data sharing. Possibility to develop unique, integrated care systems for individuals who need more support. Participation will in large part be determined by ICSP criteria and rates.
Association's experience to date	A smaller group of members, mainly those with a disproportionate number of Medicaid patients, have expressed interest in this initiative.

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(All information was provided by the Minnesota Hospital Association)

MINNESOTA	
Redesign Categories	**Medicaid Managed Care Expansion**
Brief Description of Initiative	Medicaid Managed Care Expansion. Minnesota has had managed care for Medicaid since 1985, called the Prepaid Medical Assistance Program (PMAP) (see http://www.dhs.state.mn.us/main/dhs16_171635). PMAP now includes most of Minnesota's Medicaid enrollees as well as MinnesotaCare, the state's subsidized health care program for lower-income residents. Most recently, the state expanded managed care by the program to automatically enroll a disabled beneficiary into a PMAP plan, instead of fee-for-service coverage, unless the beneficiary proactively opted out of PMAP, as opposed to the previous rules which required the beneficiary to opt in to PMAP with fee-for-service as the default.
How established	1115 waiver and state innovation
Status of Initiative	Ongoing
Timeline	For almost 30 years, Minnesota's Medicaid Program (Medical Assistance or MA) has administered an 1115 waiver, allowing for the purchase of coverage from managed care organizations (MCOs) on a prepaid capitated basis. This purchasing project, known as the Prepaid Medical Assistance Program (PMAP), was originally limited to a few Minnesota counties. The project required that nondisabled MA recipients be enrolled with an MCO, and remain enrolled with that MCO for a 12-month period. In April 1995, the Centers for Medicare and Medicaid Services approved a statewide health reform amendment to the PMAP waiver. With subsequent extensions and the Phase 2 amendment, the waiver is effective through June 30, 2005. Generally, Phase 1 allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid Program. In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that CMS authorize a second phase of provisions that had been enacted by the Minnesota Legislature. Minnesota's Medicaid health care programs continue to operate under the waiver, which expires in 2014. The state recently received word it will be able to extend the waiver for MinnesotaCare one year, until 2015, in order to use MinnesotaCare as a basis for a Basic Health Plan. Minnesota has recently been the subject of state and federal audits regarding contracting with managed care organizations from 2002-2011.
Evaluation status	Ongoing
Dedicated state resources	Yes, funding and staff.
Stakeholder involvement	MHA, hospitals, and other provider groups continue to be actively involved at the state agency and legislature to protect coverage for poor Minnesotans and maintain adequate payments for care, as well as seeking appropriate program oversight to ensure that managed care organizations operate as efficiently as possible while making sure that enrollees receive high quality, medically necessary services.
Hospital or association challenges	The challenges are similar to those with private insurance plans, except in this case the state is involved as well. While negotiated contracts and rates are between plans and providers, the state does the initial negotiation with plans for the Medicaid and MinnesotaCare programs. The legislature also gets involved in raising or lowering PMAP capitation rates. Provider reimbursement rates are common complaints, and stakeholders have long sought greater transparency to determine whether PMAP plans use state resources for actual care delivered to enrollees, as opposed to unduly investing in administrative, marketing and reserve expenses.

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(All information was provided by the Minnesota Hospital Association)

Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The initiative is open to all providers who are within managed care organizations' provider networks and who are enrolled Medicaid and Medicare providers.
Goals/anticipated impact on hospitals/other providers	Hospitals in rural areas in particular are often faced with just one health plan in the area and have limited negotiating power.
Association's experience to date	MHA continues to be involved at the state agency and legislature to protect coverage for poor Minnesotans and maintain adequate payment for care.
MINNESOTA	
Redesign Categories	• **Long-term Care/Home and Community-based Care** • **Care Coordination Approach**
Brief Description of Initiative	Reform 2020 is an initiative to reform Minnesota's home and community-based services waiver programs (see http://www.dhs.state.mn.us/main/dhs16_169839). Minnesota currently has five 1915(c) home and community based services waivers, all of which have different benefits and are targeted to different populations. Reform 2020 seeks to streamline the five 1915(c) waivers to better meet the needs of enrollees; explore other mechanisms for service funding, such as the 1915(k) Community-First Choice option; allow for more flexible use of federal and state dollars; and provide more supportive services like supportive housing and supportive work for people with disabilities and severe mental illnesses. The initiative also includes a provision to exempt Minnesota's only remaining state hospital for people with severe mental illnesses from Medicaid's Institution for Mental Diseases (IMD) exclusion, thereby allowing the state to receive federal matching funds for care delivered in this setting.
How established	2011 state legislation directed reform initiative. A section 1115 waiver proposal was required for many provisions.
Status of Initiative	CMS approval pending
Timeline	2011 state legislation directed reform of the waiver programs. The Home and Community Based Services (HCBS) Partners Panel, a stakeholder group overseen by the Minnesota Department of Human Services (DHS), was given the task of guiding the work of developing the waiver reform. The Partners Panel and many subgroups and work groups met throughout 2011 and 2012. Through the process of refining the proposal, it was determined a section 1115 waiver proposal was required for many provisions. A draft was presented to the public in June 2012 and comments accepted. The initial proposal was submitted to CMS in August 2012. A second comment period was held after CMS raised questions on provisions of the proposal. The final 1115 waiver proposal was submitted to CMS in November 2012. DHS and CMS conducted negotiations throughout December. In January 2013, the governor included provisions in his budget proposal to implement the Reform 2020 initiative.
Evaluation status	Not yet applicable
Dedicated state resources	Staff has been dedicated to the initiative. Money is allocated in the governor's proposed budget for many of the initiatives, but has not yet been appropriated by the legislature at the time of this summary.
Stakeholder involvement	MHA staff participated in meetings of the HCBS Partners Panel as well as certain subgroups, and was particularly active in areas affecting mental health care. While the overall reform is focused on home and community based services, MHA staff recognized the important interaction between community services and hospital care. Other provider organizations representing home and community-based services were widely represented on the Partners Panel and various subgroups.

Hospital or association challenges	No specific challenges at this time.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The Medicaid waivers are open to providers who meet certain standards and are enrolled with the state to provide services.
Goals/anticipated impact on hospitals/other providers	Overall, more robust and appropriate care in the community that is included within a flexible payment mechanism is expected to prevent unnecessary hospitalizations and emergency room visits, and eventually allow for more growth of community providers.
Association's experience to date	The process has been quite collaborative and association members have been particularly supportive of the various mental health initiatives.
MINNESOTA	
Redesign Categories	**CMMI State Innovation Multi-Payer Model**
Brief Description of Initiative	Minnesota received a model testing project grant in the amount of $45 million to test payment and delivery reform programs that build off of the state's Health Care Delivery System demonstration projects (see shared savings/shared risk project), seek to create new Accountable Communities for Health and invest in health information technology and analytical capacity.
How established	CMMI initiative that offered grant opportunity, and then state development of grant proposal and future implementation.
Status of Initiative	The grant has been applied for and received. The implementation phase technically began on April 1, 2013, yet in many respects the state is still planning how it will undertake the activities called for in the grant.
Timeline	Minnesota submitted its State Innovation Model grant application in September 2012 and received notice that the grant would be funded in early 2013. The testing project officially began on April 1, 2013 and will last 42 months.
Evaluation status	None available at this time.
Dedicated state resources	The state will dedicate the $45 million in federal funding to the initiative. A significant portion of this funding will be used to hire approximately 24 staff necessary to oversee and implement the program.
Stakeholder involvement	The state invited MHA, as well as several other stakeholder groups, including representatives of long-term care providers, to participate in three planning and feedback sessions that occurred shortly before and during the grant application period. MHA provided a letter of support to accompany the state's grant application. Since the state was awarded the grant, MHA has been in touch with key state personnel to communicate our interest in participating in and supporting the roll out of several aspects of the models to be tested.
Hospital or association challenges	Because the state had an extremely short time to develop the grant application, many MHA members still struggle to understand what specific efforts the state will undertake and the potential impacts on or opportunities for providers under the testing model. In addition, some aspects of the state's budget indicate an interest in focusing resources on smaller providers, especially nursing homes and mental health care providers, rather than hospitals and health systems.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	A portion of the testing model is intended to support the Health Care Delivery System demonstration projects, which currently consist of six health systems, but a new opportunity for other interested providers to submit proposals is available. Other aspects of the testing model are more general in nature and will apply or be available to large classes, if not all, providers.

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Goals/anticipated impact on hospitals/other providers	The state anticipates that the state innovation model will "directly impact" 190,000 Medicaid beneficiaries by 2016, and will generate savings worth $90 million in the Medicaid program, $13 million for private payers and $7 million in Medicare. Hospitals and other providers expect to receive up to $7 million to support care coordination improvement (largely through HIT investments) and a portion of other investments in care practices. MHA anticipates that the six health systems participating in the Health Care Delivery demonstration projects, as well as any other providers that enter the next cohort of HCDS projects, will receive additional support including improvements in patient data sharing and analytical support.
Association's experience to date	Generally, the grant application timeframe and occurrence shortly before the November elections resulted in most MHA members having relatively little understanding of the testing model or vested interest in it. That said, members were pleased that the state's health care reform efforts were recognized as worthy of federal support and investment and they are hopeful that the funds will increase overall system capacity for data sharing, analytics and corresponding care coordination improvement.
MINNESOTA	
Redesign Categories	**Bundled Episode Payment**
Brief Description of Initiative	Baskets of Care. In 2008, Minnesota passed legislation to create a bundled payment program called baskets of care (see Minn. Stat. sec. 62U.05; and http://www.health.state.mn.us/healthreform/baskets/). The baskets of care were created for seven conditions: children's asthma, diabetes (including hypertension and hyperlipidemia), low back pain, preventative care for children, preventative care for adults and total knee replacement. The definitions and quality standards were developed by working groups for each condition, with an overarching Baskets of Care Steering Committee. To offer a basket of care, a provider needs to register it, along with its uniform price for all payers, with the state. No providers are required to offer a basket of care and no payers are obligated to pay the set fee for a basket of care. To date, no providers have registered or offered a basket of care.
How established	State-initiated innovation
Status of Initiative	Legislation was enacted in 2008. Rules regarding baskets of care were promulgated and completed in early 2010. The statute and rules remain on the books, although no providers are offering any of the baskets of care.
Timeline	Legislation passed in 2008. Baskets of Care Steering Committee convened January 2009 and met throughout 2009. Final rules were promulgated in March 2010.
Evaluation status	Based on the fact that no providers ever registered or offered any of the baskets of care, the redesign effort is considered a failure.
Dedicated state resources	Minnesota Department of Health staff within the department's Health Economics Program staffed the Baskets of Care Steering Committee and related work groups in 2009. No further staff or resources have been spent on the effort.
Stakeholder involvement	Work groups included MHA staff and members to represent hospitals and health systems, as well as representatives from other pertinent provider groups or interests.
Hospital or association challenges	The most significant challenge for hospitals and other providers with the initiative was its overly prescriptive and regulatory approach. Each basket was precisely defined as to the services included and excluded and any deviation by providers interested in offering more/less services propelled the service offering outside of the baskets of care construct. Likewise, providers were not interested in registering their intended services and prices with the state, to be followed by additional quality measurement reporting obligations. Finally, because payers were not obligated to pay the provider's set price for a basket of care, but state law prohibited the provider from offering the same basket to different payers for different prices, there was no financial incentive for providers to enter the program.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Any hospitals or provider may voluntarily offer baskets of care.

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Goals/anticipated impact on hospitals/other providers	Because the program is voluntary and no providers chose to offer baskets of care, no impacts are anticipated.
Association's experience to date	MHA members roundly criticized the program for being unduly bureaucratic and impractical, which had a measure of unifying force within the membership.
MINNESOTA	
Redesign Categories	**Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	Prior to 2010, the legislature enacted pay for performance mechanisms for Medicaid managed care organizations, however these incentives were set in a manner that were easily met by health plans and, effectively, allowed them to escape what otherwise would have been rate reductions. In 2010, the legislature mandated a 5% withhold from Medicaid managed care capitation payments pending demonstration of a compounding 5% decline in emergency room visits, admissions and readmissions within 30 days each year for five years until the total decrease is at least 25% less than the 2009 baseline for each category (see Minn. Stat. sec. 256B.69, subd. 5a (g)-(i)). In 2011, the legislature provided an additional incentive of a 1% fee-for-service rate increase in hospital payments for each 1% decline in statewide rates of readmissions within 30 days based on the previous two year's readmissions rates with a maximum incentive of 5% (see Minn. Stat. sec. 256.969, subd. 3c).
How established	State-initiated innovation enacted by the legislature.
Status of Initiative	Pay for performance incentives for Medicaid managed care organizations continue to be included in the states contracts with those organizations and, generally, focus on HEDIS measures. It is believed that most, if not all, health plans reach the incentive levels and, accordingly, receive their full capitated rate. The managed care withholds for emergency room utilization, hospital admissions and readmissions within 30 days have begun to be taken from capitation rates, but data from the relevant years has not been fully collected and analyzed to determine whether any of the managed care plans have met the annual targets so as to earn return of the withhold. The hospital rate incentive program for readmissions within 30 days does not take effect until July 1, 2013.
Timeline	Legislation creating these pay for performance standards was initially enacted in 2006; withholds for emergency room utilization rates, inpatient admissions and readmissions within 30 days were added in 2010 legislation and applied to capitation rates beginning in January 2011; and fee-for-service rate incentives based on statewide rates of readmissions within 30 days were added in 2011 legislation and will be effective beginning July 1, 2013.
Evaluation status	Evaluation of the pay for performance incentives remains incomplete pending further data collection and analysis. Initial indications of early withholds from Medicaid managed care organizations did not set thresholds high enough and, consequently, the impact was isolated to delaying state payments rather than generating any real savings or cost reductions. The next phases, those tying managed care organization withholds to particular utilization rates, appears to be leading to state savings as a result of health plans failing to meet the projected targets. However, because most health plans are believed to have passed those withholds along to hospitals through lower reimbursement rates, MHA speculates that the program amounted to little more than a direct cut to payments passed along to providers than any meaningful incentive for behavior changes or improvement efforts by health plans. Finally, the pay for performance incentives in the fee-for-service population have not yet had the data analysis to determine whether hospital rates will be affected. Because the incentive is based on statewide readmissions rates and applies or doesn't apply to all hospitals, rather than on hospital-specific performance, MHA believes that the program's incentive is too diluted to meaningfully change behavior.
Dedicated state resources	No, other than minimal staff time necessary to ensure withholds are implemented.

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Stakeholder involvement	MHA was not involved in developing any of the legislative provisions for pay for performance incentives, although we lobbied for more provider-friendly incentives. At one point, the state association of managed care plans solicited MHA's input on a proposal to impose daily all-patient emergency room reporting by hospitals to health plans via facsimile. MHA opposed the suggestion based on the administrative burden it would impose on hospitals, as well as our members' belief that managed care organizations are not well positioned to influence patient care decisions and, instead, the data flow from health plans to providers should be encouraged rather than the other way around.
Hospital or association challenges	Hospitals are challenged by the indirect nature of the incentives -- placing financial incentives on health plans to put pressure on providers to influence patients -- rather than directing incentives at patients or at least providers. Moreover, the measures used -- emergency room utilization, admissions and readmissions -- seem like poor choices for measuring and rewarding provider quality and interventions. MHA has expressed concerns that, in some respects, these incentives could create the impression that state public program enrollees should be discouraged from receiving needed/timely care, which is not in line with the patients' or providers' best interests. In addition, because the fee-for-service incentive program is tied to overall, statewide readmissions rates and all hospitals' payments will be adjusted rather than designing the incentives to tie to individual or even regional hospital performance, our members feel that they individually have little opportunity to influence the outcomes and, therefore, the impact of the incentive is diminished.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The incentives apply, directly or indirectly, to all hospitals.
Goals/anticipated impact on hospitals/other providers	MHA anticipates that hospitals are receiving lower reimbursement rates from managed care organizations than they otherwise would have received if the withholds were not in place. Although it is too early to know whether hospitals will receive increased fee-for-service rates based on readmissions performance, MHA anticipates that the net impact will be minimal because our fee-for-service population is extremely small and reimbursement rates are so far below cost that an increase of one or two percent will be relatively inconsequential.
Association's experience to date	To the extent that the effort led health plans to suggest an onerous, time consuming and seemingly ineffective reporting burden on emergency room providers, it has had a unifying effect within our membership. Members uniformly rejected the suggested reporting approach and experienced how the Association is extremely effective when members are united.
MINNESOTA	
Redesign Categories	**Other: Healthy Minnesota Contribution Program**
Brief Description of Initiative	In 2011, the legislature enacted this initiative to move adults without children making between 200% and 250% FPL off of the state's subsidized health care coverage program, called MinnesotaCare (MinnCare) and into a defined contribution program that provided enrollees with subsidies if they purchased commercial insurance on the private market (see Minn. Stat. sec. 256L.031; and http://www.dhs.state.mn.us/main/dhs16_168897). Enrollees who obtained private coverage would have a defined contribution amount paid from the state to the insurance plan. For those who are unable to purchase health plans on the private market because of underwriting, the state's defined contribution amount would be transferred to offset a portion of the premium for coverage through the state's high risk pool.
How established	State-initiated innovation and subsequent 1115 waiver amendment.
Status of Initiative	Ongoing until 2014
Timeline	Legislation passed in 2011 and the Healthy Minnesota Contribution Program (HMCP) began July 1, 2012. The program will end at the end of this year.

Evaluation status	Since its implementation, only 25-33% of the individuals seeking coverage through the program have benefited from the premium subsidies, meaning that the other 67-75% of individuals are likely joining the ranks of the uninsured. Moreover, most of the people receiving the premium subsidies are using them to offset the costs of coverage in the state's high risk pool, meaning that the private insurance market refused to enroll them in a commercial product.
Dedicated state resources	Yes, staff to oversee the program and process monthly defined contribution subsidies the financial costs of the subsidies themselves. These costs are significantly lower than the previous cost of subsidized MinnCare coverage with a much larger enrollment.
Stakeholder involvement	Hospitals, MHA and other provider groups were active at the legislature influencing the development of the HMCP. The original proposal included a much larger population of MinnCare enrollees that would have been moved to the Healthy Minnesota Contribution Program. Hospitals and other providers were able to get the eligibility limit raised to 200% to preserve MinnCare coverage for as many residents as possible. Since its enactment, MHA has monitored the program enrollment statistics and relative uptake. MHA issued a summary of the program for our members in December 2012.
Hospital or association challenges	The greatest challenges for hospitals have been the resulting increase in both uninsured and underinsured residents. Many of those who previously received comprehensive, subsidized MinnCare coverage are no longer enrolled in any coverage. Those few who have obtained commercial coverage are believed to be paying a greater portion of their income toward premiums and are likely to be covered by a high deductible plan, resulting in underinsurance given their low income levels.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Not limited to a selected group of providers.
Goals/anticipated impact on hospitals/other providers	Hospitals and the association believe that the legislation has led to an increase in uninsured and underinsured individuals and, consequently, uncompensated care.
Association's experience to date	The association was united in modifying the proposed legislation to restrict the program to the smallest number of residents as possible.
MINNESOTA	
Redesign Categories	**Basic Health Plan Option**
Brief Description of Initiative	Minnesota has legislation introduced to prepare to transition the current MinnesotaCare (MinnCare) program, which provides subsidized coverage for low-income residents who do not qualify for Medicaid, to a Basic Health Plan (BHP) if the federal rules make such a transition favorable. Pending federal rules regarding the BHP option, Minnesota has sought and received tentative approval from CMS to extend an existing waiver allowing the state to leverage federal matching funds for a portion of the MinnCare enrollees on the condition that the program's benefit set is modified to conform to the Affordable Care Act (ACA) standards.
How established	MinnCare is a state-initiated innovation that receives federal matching funds through an 1115 waiver.
Status of Initiative	CMS has tentatively agreed to continue funding 50% of the MinnCare costs for one additional year so long as Minnesota passes legislation to expand the covered benefits in accordance with ACA requirements. The governor's administration is interested in seeking another waiver that would allow for continued federal funding, either at the 50% level or at the BHP level, for current MinnCare enrollees who earn up to 275% of federal poverty limit (FPL) but cannot pursue that analysis or waiver application until BHP rules are promulgated by CMS.

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Timeline	MinnCare was created by the Minnesota Legislature in 1992. The current 1115 waiver expires on October 1, 2013, unless the state can secure the one-year extension conditionally agreed to by CMS. The governor's administration hopes that federal BHP rules will be issued in time for Minnesota to make any additional changes necessary for MinnCare to qualify as a BHP for enrollees earning up to 200% FPL and to seek another waiver to expand the BHP to residents earning up to 275% FPL before October 1, 2014.
Evaluation status	MinnCare is a longstanding, successful program that has a track record of providing affordable coverage for low-income, working families. Predictive analysis indicates that minor changes to the benefit set can be made to comply with ACA standards without significant additional costs to the state pending the program's certification as a BHP and, consequently, enhanced federal financial support.
Dedicated state resources	Currently, the state imposes a 2% tax on all health care providers' non-Medicare patient revenues and a 1% premium tax on health plans to generate approximately $300 million per year to finance the state's portion of MinnCare costs, including the state's staff needed to administer the program.
Stakeholder involvement	The state has consulted with MHA to evaluate the potential opportunities and concerns with the BHP option. MHA submitted a letter to CMS urging it to release BHP proposed rules as soon as possible and, in the meantime, to grant Minnesota the flexibility necessary, including a temporary extension of the 1115 waiver for MinnCare, to ensure that enrollees are not worse off financially or left uninsured when other provisions of the ACA go into effect. In addition, MHA encouraged Minnesota's congressional delegation to join together in a similar letter to CMS. At the same time, MHA has refrained from taking an official position in support of or in opposition to converting MinnCare to a BHP until we can analyze the federal rules and funding that will govern the new program. Although we expect that the federal funding and coverage options through MinnCare will be substantially better than coverage available to individuals through the Exchange, we believe it is important for the Association to reserve judgment until it can be made in a data-informed manner.
Hospital or association challenges	The biggest challenge for hospitals and the association is CMS's delaying promulgating BHP rules and financing.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	All providers enrolled in the Medicaid program are eligible to provide care to MinnCare enrollees.
Goals/anticipated impact on hospitals/other providers	It is impossible to predict the impact on providers without federal rules defining how the BHP subsidies to states will be calculated, how much private plans sold on the Exchange will cost and the reimbursement rate differential between private plans sold on the Exchange and managed care organizations in the MinnCare program. However, MHA tentatively estimates that the BHP options will allow MinnCare enrollees to receive coverage at much lower premium costs and without the expected deductibles of plans sold through the Exchange. Accordingly, while the reimbursement rates to providers will be less than commercial plans, the BHP option will decrease both the uninsured and under-insured populations in Minnesota and, as a result, net revenues to MHA members will be higher under the BHP option than letting this population obtain private coverage through the Exchange.
Association's experience to date	Members seem tentatively supportive of the BHP option, but with some expressing skepticism about the state and federal government's ability or willingness to adequately fund the BHP program and, ultimately, slashing provider reimbursement rates to balance the books.
MINNESOTA	
Redesign Categories	**Other: Competitive Bidding for Medicaid Managed Care Plans**
Brief Description of Initiative	Competitive bidding for Medicaid managed care plans in the Twin Cities metropolitan area. Rates have traditionally been set based on MCO rate history, not on competitive bidding. The new contracting saved Minnesota $175 million in 2012.
How established	State-initiated innovation

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Status of Initiative	Contracts signed for 2012 and 2013. State is considering expanding the competitive bidding initiative to other areas of the state.
Timeline	Department of Human Services provided notice of competitive bid process in 2011, issued request for proposals and negotiated contracts with successful bidders that went into effect in 2012.
Evaluation status	Ongoing
Dedicated state resources	Yes, staff and funding, but these were resources already dedicated to the pre-existing Medicaid managed care program.
Stakeholder involvement	Medicaid contracting is between the state Department of Human Services and the health plans. Other stakeholders were not invited to participate and historically have not had a role in the contracting process.
Hospital or association challenges	Hospitals and the association have concerns that driving to the lowest bid will mean greater and greater pressure to lower provider reimbursement rates from managed care organizations. However, MHA is pleased with efforts to include health plans in attempts to lower health care costs for the state and to inject a greater level of market dynamics into the capitation rate setting process.
Local, regional, or statewide	Currently regional
Open to all or restricted to selected hospitals	Only affects providers serving patients in the affected counties. However, some have argued that the competitive bid process resulted in changes in health plan contracting and reimbursement rates statewide as health plans adjusted their entire book of business to account for the outcomes from the bidding process in the Twin Cities. Because MHA does not collect negotiated payment rate information, we cannot confirm whether such contracting or rate changes went into effect.
Goals/anticipated impact on hospitals/other providers	There are concerns that already-low Medicaid rates will be decreased further as plans compete to offer the lowest bid. Also, there are concerns that the state's competitive bid contracts will make other reform initiatives, such as direct contracting with providers, ACO development or other patient attribution models, more difficult to implement because enrollees will be "captured" in managed care organizations contractually.
Association's experience to date	MHA and members are generally pleased health plans are being asked to share in efforts to lower the state's health care costs. However, because some MHA members also operate managed care organizations or have close affiliations with managed care organizations, there are different degrees of enthusiasm for the initiative.

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(All information was provided by the Nebraska Hospital Association)

NEBRASKA	
Redesign Categories	• **Accountable Care Organization** • **Care Coordination Approach** • **Bundled Episode Payment** • **Medicaid Managed Care Expansion** • **Pay for Performance/Value-based Purchasing** • **Medical Homes Initiative** • **Dually Eligible Demonstration** • **Long-Term Care/Home and Community-Based Care** • **Comprehensive Primary Care Initiative** • **Incentives for Prevention of Chronic Diseases**
Brief Description of Initiative	The Nebraska Unicameral approved Legislative Resolution 22 in March 2013, which authorizes the creation of a "Partnership Towards Nebraska's Health Care Systems Transformation." Goals of the Partnership are to: • Provide a comprehensive review of Nebraska's health care delivery, cost and coverage demands; • Engage partners in dialogue, roundtable discussions and public policy discourse; • Develop a framework for health care system transformation to meet public health, workforce, delivery and budgetary responsibilities; and, • Develop cooperative strategies and initiatives for the design, implementation and accountability of services to improve care, quality and value while advancing the overall health of Nebraskans.
How established	By legislation in March 2013
Status of Initiative	Under development
Timeline	Public hearings may be conducted; Legislative hearing to be held on November 1, 2013.
Evaluation status	N/A
Stakeholder involvement	NHA will participate in the partnership with policymakers, including state and local governments, public and private insurers, health care delivery organizations, employers, special societies, consumer groups, patients, consumers and all other interested parties.
Goals/anticipated impact on hospitals/other providers	NHA will convene a Task Force on Design of the Delivery Systems for June 2013 to consider all aspects of the comprehensive review of the state's health care delivery, cost and coverage demands.
NEBRASKA	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	Medical Homes Initiative created a pilot Medicaid Medical Homes project and established the Medical Home Advisory Council. The Council was directed to guide the formation of a medical home pilot project in Nebraska.
How established	Created by law signed in April 2009
Status of Initiative	New legislation was introduced in January 2013 to establish a statewide Nebraska "All-Payer Patient-Centered Medical Home Act" that is intended to promote the development of a new approach to the provision of and payment for primary care services by the major insurers in Nebraska. The bill will be carried over to 2014 for further development and refinement.

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(All information was provided by the Nebraska Hospital Association)

Timeline	New legislation was introduced in January 2013 to establish a statewide Nebraska "All-Payer Patient-Centered Medical Home Act" that is intended to promote the development of a new approach to the provision of and payment for primary care services by the major insurers in Nebraska. The bill will be carried over to 2014 for further development and refinement.
Dedicated state resources	The Affordable Care Act created a Medicaid state plan option to allow Medicaid beneficiaries with chronic conditions to designate a health home.

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NEW JERSEY	
Redesign Categories	• **Medicaid Managed Care Expansion** • **Long Term Care/Home and Community-Based Care**
Brief Description of Initiative	New Jersey is implementing managed long term supports and services through a comprehensive 1115 waiver that was approved by CMS in October 2012. This includes mandatory enrollment of aged, blind and disabled Medicaid beneficiaries in one of five options (4 Medicaid Managed Care plans and PACE),
How established	1115 comprehensive Medicaid waiver
Status of Initiative	Implementation of managed long term supports and services is being phased in at this time. In July 2011, some home and community-based services (HCBS) were carved into managed Medicaid. The remaining HCBS beneficiaries/services will be carved in as of Jan. 1, 2014. This will be followed by the full carve-in of the nursing home population (custodial care) in July 2014.
Timeline	Implementation of managed long term supports and services is being phased in at this time. In July 2011, some home and community-based services were carved into managed Medicaid. The remaining HCBS beneficiaries/services will be carved in as of Jan. 1, 2014. This will be followed by the full carve-in of the nursing home population (custodial care) in July 2014.
Evaluation status	No evaluation has been initiated at this time.
Dedicated state resources	The state is working with existing staff resources and has received a Balancing Incentive Payment grant from CMS as well as other federal grants to support the further development of options, counseling, curriculum and training.
Stakeholder involvement	Stakeholder inclusion is significant in the state's managed long term supports and services steering committee and work groups. NJHA serves on the steering committee. The health plans, consumer advocacy groups, state government departments, nursing home, home health and other provider associations are all well-represented. In general, stakeholder feedback has been utilized well in the process.
Hospital or association challenges	The biggest challenge is that insufficient funding of the services that are being carved into managed Medicaid will simply be carried forward as the health plans are made responsible for covering and paying for these services. The health plan must take its "slice" for administrative/operating costs out of the pool of available funds, which makes it highly likely that provider payments and beneficiary access to services will be slated for reductions/adjustments.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	All are involved—primarily not a hospital issue.
Goals/anticipated impact on hospitals/other providers	Impact is likely to be greatest on HCBS and nursing home providers offering long term care services in terms of issues of prompt authorization of services, appropriate and timely payment for services, and managing denials/appeals. Reductions in services authorized could result in greater use of emergency department and hospital resources.
Association's experience to date	Collaboration with our colleagues in other associations, as well as other advocacy organizations, has been good. Discussion with health plan representatives has been productive and candid, but their primary concern is their contractual relationship with the State of NJ. The plans do not know the frail, chronically ill dual-eligible and Medicaid populations very well from a service standpoint. Care management will be a significant challenge for them because it is not episodic for this population --- a departure from the typical MCO model of care management. Members are singularly focused and united in aiming to educate the State and the MCOs as to their concerns, and to develop strategies for how to survive in this new environment.

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NEW JERSEY	
Redesign Categories	• **Medicaid Managed Care Expansion** • **Long Term Care/Home and Community-Based Care**
Brief Description of Initiative	New Jersey is implementing managed behavioral health and developmental disabilities supports and services through a comprehensive 1115 waiver that was approved by CMS in Oct. 2012. This includes: • Launch of managed BH organization (MBHO/ASO) • Braided state and federal funding • Rebalance of provider rates • Transition from no-risk to risk model • Case management for clinical services • Creation of Behavioral Health Homes • Uniform screening and assessment • Increased community-based Developmental Disabilities (DD) services • Decrease institutional services • Increase of services for children with Mental Illness (MI) and I/DD • Increase of access to therapies for pervasive DD • Supports Waiver for in-home, self-directed services for adults with Intellectual Disabilities (I/DD) • Pilot for 200 slot in/out of home intensive supports for children with MI+I/DD • Pilot for 200 slot in/out of home intensive supports for children up to age 12 with pervasive DD
How established	1115 comprehensive Medicaid waiver
Status of Initiative	Awaiting post of ASO/MBHO Request for Proposals (RFP).
Timeline	Awaiting post of ASO/MBHO RFP
Evaluation status	No evaluation has been imitated at this time.
Dedicated state resources	State is working with existing staff resources and has received or applied for funding for various aspects of program development
Stakeholder involvement	Stakeholder inclusion is significant in the state's managed behavioral health supports and services steering committee and work groups. NJHA serves on the leadership steering committee. Consumer advocacy groups, state government departments, and other provider associations are all well-represented. In general, the stakeholder feedback has been utilized well in the process.
Hospital or association challenges	The biggest challenge is that there has been an insufficient expansion of services at the community level and hospital emergency departments continue to serve as the safety net for individuals in need of care.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	All are involved either through direct participation or represented by state hospital association.
Goals/anticipated impact on hospitals/other providers	Impact is likely to be greatest on hospital providers in terms of reduced rate setting, issues of prompt authorization of services, appropriate and timely payment for services, and managing denials/appeals. Reductions in services authorized could result in greater use of emergency department and hospital resources.
Association's experience to date	Collaboration with our colleagues in other associations as well as other advocacy organizations has been good. Engagement at the state level has been good.

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NEW JERSEY	
Redesign Categories	**Accountable Care Organization**
Brief Description of Initiative	Medicaid ACO Demonstration Project (P.L.2011, c.114)
How established	Legislation
Status of Initiative	Legislation was passed. State still has not promulgated regulations
Timeline	Unsure
Evaluation status	N/A
Dedicated state resources	Still yet to be determined
Stakeholder involvement	N/A
Hospital or association challenges	Currently the challenge is not knowing where the state will come out with the regulations. The legislation broadly talked about the scope of the ACO. However, the one concern during the legislative process we received from members was that it was going to be difficult to find 4 behavioral health entities to partner with (required in the legislation) while forming the ACO.
Local, regional, or statewide	The demonstration project is measured by population. There needs to be 5,000 Medicaid recipients within a defined geographic region.
Open to all or restricted to selected hospitals	The initiative is open to all hospitals however, if there is more than one hospital within a geographic region, all hospitals must participate for the ACO to receive approval.
Goals/anticipated impact on hospitals/other providers	Many of our hospitals and other providers in cities in New Jersey are moving forward with ACO type models. The impact has been reducing hospitalizations and inappropriate use of the emergency room.
Association's experience to date	So far the association's experience has been positive in terms of collaboration between hospitals and other community entities. Without the demonstration project fully up and running, it is hard to tell if this unity will remain without kinks.
NEW JERSEY	
Redesign Categories	**Global Budgeting/Payment**
Brief Description of Initiative	Delivery System Reform Incentive Payment: In October 2012, New Jersey received official approval from CMS for the state's comprehensive Medicaid waiver application that included the creation of a performance incentive pool, called the Delivery System Reform Incentive Payment (DSRIP) pool tool to be funded with a combination of state and federal funds totaling $166.6 million that previously existed as the Hospital Relief Subsidy Fund (HRSF). While the DSRIP pool will be funded with the state and federal funds previously used to support the HRSF, there is to be no ongoing linkage between the two pools. The new DSRIP pool will serve as an incentive pool that will be available to interested hospitals that submit an application to create a program associated with one of eight disease categories (behavioral health, HIV/AIDS, substance abuse, cardiac care, asthma, diabetes, obesity and pneumonia) that supports efforts to enhance access to care, the quality of care and the health of patients and families. In the first year of the waiver (SFY 2013), the HRSF payments to hospitals will be unaltered and will flow to hospitals in the amounts established under the previous HRSF methodology. This is being termed a "transition" year and is designed to allow for a graceful transition to the new DSRIP allocation formula, to begin in SFY 2014.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the New Jersey Hospital Association)

How established	The DSRIP program was established as part of New Jersey's Section 1115 Demonstration Comprehensive Waiver, approved October 2012.
Status of Initiative	Although CMS has approved New Jersey's Section 1115 Demonstration Comprehensive Waiver, the program funding, mechanics and planning protocols of the DSRIP program are still under review with CMS. The review was scheduled to be completed by February 28, 2013, as of today (April 5) it is not complete.
Timeline	CMS was originally targeted to approve the state's funding, mechanics and planning protocols by February 28, 2013, with hospital applications due on May 1, 2013. However, that federal approval has not yet occurred. Therefore, a definitive application deadline for the DSRIP program has not been determined.
Evaluation status	CMS is still reviewing the state's funding, mechanics and planning protocols. It is not known when that will be complete and hospitals can begin applying for the program.
Dedicated state resources	Yes, the state has hired consultants to assist in developing the protocols of the DSRIP program (Myers and Stauffer).
Stakeholder involvement	A DSRIP steering committee was formed by the state. The steering committee was comprised of representatives of each of the state's hospital associations (New Jersey Hospital Association, Hospital Alliance of New Jersey, New Jersey Council of Teaching Hospitals, Catholic HealthCare Partnership of New Jersey and Fair Share Hospitals Collaborative), one hospital representative per association, the Commissioner of Health, Health Department staff and staff from Myers and Stauffer. Three committee members were designated to chair the committee – one from New Jersey Hospital Association, one from the Hospital Alliance of New Jersey and one from the New Jersey Council of Teaching Hospitals. The DSRIP steering committee met weekly during November and December of 2012 to design the funding, mechanics and planning protocols that were due to CMS by December 31, 2012.
Hospital or association challenges	Hospitals are struggling to plan their projects since the protocols have not yet been approved and a lot of information is unknown. Some New Jersey hospitals receive a significant amount of money through the HRSF program (over $10 million annually). For them, it is necessary to participate in the DSRIP program to try to sustain that funding. Those hospitals are anxious to see the protocols and applications, particularly as we near the end of SFY 2013 (June 30, 2013) and DSRIP payments are scheduled to take over. Hospitals are concerned about potentially having to submit an application and begin a new program in a short window of time, as the approval of the protocols continues to be delayed.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The protocols submitted to CMS specify that any acute care hospital that will receive funds through the HRSF in SFY 2013 is eligible to apply for the DSRIP pool. In New Jersey, every acute care hospital is receiving funds through the HRSF in SFY 2013, so all are eligible to apply for DSRIP, should this be approved by CMS.
Goals/anticipated impact on hospitals/other providers	This is currently unknown as the protocols are still under CMS review. We anticipate that some hospitals may decide not to apply for the program and, therefore, will lose the money that they are currently getting under HRSF. For the ones that do apply and participate, we do not know at this time if they will see an increase or a decrease in their funding under DSRIP.
Association's experience to date	As mentioned above, a representative from the New Jersey Hospital Association was an active member of the state's DSRIP Steering Committee, participating as one of the tri-chairs. In addition, the association continues to have frequent dialogue with the state on the status of the application. We have also hosted an educational session for members on the DSRIP program and plan to have an additional educational session on completing the DSRIP application once the protocols are finalized.

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(All information was provided by the New Mexico Hospital Association)

NEW MEXICO	
Redesign Categories	**Care Coordination Approach** (For New Mexico, all of the responses below relate to an 1115 waiver called Centennial Care that was submitted by the State in August 2012. The State has already awarded new contracts to four Managed Care Organizations (MCO)s and proposes to have the new program running January 2014. The waiver design was developed through a Medicaid Modernization Contract with Alicia Smith and Associates. Some recent developments: • MCOs that were not selected have filed appeals. • CMS has notified the State of a Waiver Agreement in Principle with a notable variation. The State wanted Native Americans to have mandatory participation. CMS is allowing them to opt-in. Background material about Centennial Care can be seen on the State website at: • http://www.hsd.state.nm.us/Medicaid%20Modernization/index.html
Brief Description of Initiative	The four selected MCOs will contract for the entire Medicaid population and their service array. State will "carve in" all Medicaid behavioral health services and all home and community-based and institutional services now provided under the non-Developmental Disability (DD) waivers. The capitation for the MCOs participating in the program will be designed to maximize the incentives to support people in their homes and communities and to begin to address those waiting for services for the current long term care managed care program.
How established	1115 Waiver done administratively without legislative approval.
Status of Initiative	Final CMS approval is still pending. Agreement in Principle on March 5, 2013.
Timeline	Implementation in January 2014
Evaluation status	The State has not yet developed its evaluation methodology. The scope of the evaluation will include measuring program objectives, lessons learned, cost savings, quality improvements and clinical outcomes.
Dedicated state resources	State has established a special bureau to implement Centennial Care comprised of 75 fulltime staff.
Stakeholder involvement	State has welcomed input from the New Mexico Hospital Association through public comment as well as focused discussions. NMHA is active on numerous implementation workgroups as well as the Medicaid Advisory Committee.
Hospital or association challenges	The Sole Community Provider (SCP) program currently gives major funding to 28 hospitals. The waiver would redefine the program and is moving closer to a strict cost-based definition of uncompensated care, which will result in reducing this funding by 40%.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	As a statewide waiver, all hospitals are involved.
Goals/anticipated impact on hospitals/other providers	Uncertain but key concerns are: • Changing MCO partners • Tighter MCO negotiations • Major financial impact on SCP hospitals • Payment reform will be welcomed by some and hardship for others.
Association's experience to date	State staff regularly communicates with NMHA and there is a general inclusion of the provider community. So far, members are unified with NMHA in approaches to the State.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the New Mexico Hospital Association)

NEW MEXICO	
Redesign Categories	**Bundled Episode Payment**
Brief Description of Initiative	Working with integrated hospital/physician networks in the urban areas, the State seeks to pilot bundled payments for three diagnostic categories: diabetes, asthma and pneumonia. The State also seeks a federal match under the waiver for rewards programs that could include nutrition education for diabetes, smoking cessation programs for adolescents with asthma or even retail store gift cards to reward compliance with appointment or drug regimens.
How established	1115 Waiver done administratively without legislative approval.
Status of Initiative	Final CMS approval is still pending. Agreement in Principle on March 5, 2013.
Timeline	Implementation in January 2014
Evaluation status	The State has not yet developed its evaluation. The scope of the evaluation will include measuring program objectives, lessons learned, cost savings, quality improvements and clinical outcomes.
Dedicated state resources	State has established a special bureau to implement Centennial Care comprised of 75 fulltime staff.
Stakeholder involvement	State has welcomed input from the New Mexico Hospital Association through public comment as well as focused discussions. NMHA is active on numerous implementation workgroups as well as the Medicaid Advisory Committee.
Hospital or association challenges	The SCP program currently gives major funding to 28 hospitals. The waiver would redefine the program and is moving closer to a strict cost-based definition of uncompensated care, which will result in reducing this funding by 40%.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	As a statewide waiver, all hospitals are involved.
Goals/anticipated impact on hospitals/other providers	Uncertain but key concerns are: • Changing MCO partners • Tighter MCO negotiations • Major financial impact on SCP hospitals • Payment reform will be welcomed by some and hardship for others.
Association's experience to date	State staff regularly communicates with NMHA and there is a general inclusion of the provider community. So far, members are unified with NMHA in approaches to the State.
NEW MEXICO	
Redesign Categories	**Dually Eligible Demonstration**
Brief Description of Initiative	The State has decided not to pursue a separate capitated integrated care duals demonstration model. The State will continue to include the dually eligible population under Centennial Care to continue to build upon the strength already established by the long term care managed care program.
How established	1115 Waiver done administratively without legislative approval.
Status of Initiative	Final CMS approval is still pending. Agreement in Principle on March 5, 2013.

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(All information was provided by the New Mexico Hospital Association)

Timeline	Implementation in January 2014
Evaluation status	The State has not yet developed its evaluation. The scope of the evaluation will include measuring program objectives, lessons learned, cost savings, quality improvements and clinical outcomes.
Dedicated state resources	State has established a special bureau to implement Centennial Care comprised of 75 fulltime staff.
Stakeholder involvement	State has welcomed input from the New Mexico Hospital Association through public comment as well as focused discussions. NMHA is active on numerous implementation workgroups as well as the Medicaid Advisory Committee.
Hospital or association challenges	The SCP program currently gives major funding to 28 hospitals. The waiver would redefine the program and is moving closer to a strict cost-based definition of uncompensated care, which will result in reducing this funding by 40%.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	As a statewide waiver, all hospitals are involved.
Goals/anticipated impact on hospitals/other providers	Uncertain but key concerns are: • Changing MCO partners • Tighter MCO negotiations • Major financial impact on SCP hospitals • Payment reform will be welcomed by some and hardship for others.
Association's experience to date	State staff regularly communicates with NMHA and there is a general inclusion of the provider community. So far, members are unified with NMHA in approaches to the State.
NEW MEXICO	
Redesign Categories	**Long Term Care/Home and Community-Based Care**
Brief Description of Initiative	Under Centennial Care, the State will create one comprehensive Community Benefit that includes both personal care and the Home and Community Based Services (HCBS) formally provided under a 1915c HCBS waiver. People who are otherwise Medicaid eligible who meet nursing facility level of care (NF LOC) will have access to HCBS and personal care services, without the need for a slot. Those who are not otherwise Medicaid eligible who have incomes below 330% of SSI and meet NF LOC can gain Medicaid eligibility if a slot is available.
How established	1115 Waiver done administratively without legislative approval.
Status of Initiative	Final CMS approval is still pending. Agreement in Principle on March 5, 2013.
Timeline	Implementation in January 2014
Evaluation status	The State has not yet developed its evaluation. The scope of the evaluation will include measuring program objectives, lessons learned, cost savings, quality improvements and clinical outcomes.
Dedicated state resources	State has established a special bureau to implement Centennial Care comprised of 75 fulltime staff.
Stakeholder involvement	State has welcomed input from the New Mexico Hospital Association through public comment as well as focused discussions. NMHA is active on numerous implementation workgroups as well as the Medicaid Advisory Committee.

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(All information was provided by the New Mexico Hospital Association)

Hospital or association challenges	The SCP program currently gives major funding to 28 hospitals. The waiver would redefine the program, with a strict cost-based definition of uncompensated care, which will result in reducing this funding by 40%.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	As a statewide waiver, all hospitals are involved.
Goals/anticipated impact on hospitals/other providers	Uncertain but key concerns are: • Changing MCO partners • Tighter MCO negotiations • Major financial impact on SCP hospitals • Payment reform will be welcomed by some and hardship for others.
Association's experience to date	State staff regularly communicates with NMHA and there is a general inclusion of the provider community. So far, members are unified with NMHA in approaches to the State.
NEW MEXICO	
Redesign Categories	**Other: Behavioral Health**
Brief Description of Initiative	Once a recipient is enrolled in a Behavioral Health Home (BHH), the responsibility for both care management and care coordination is delegated by the MCO to the BHH. Specifically, the BHH nurse care manager will complete and transmit the comprehensive assessment and care plan to the MCO's care manager who has oversight.
How established	1115 Waiver done administratively without legislative approval.
Status of Initiative	Final CMS approval is still pending. Agreement in Principle on March 5, 2013.
Timeline	Implementation in January 2014
Evaluation status	The State has not yet developed its evaluation. The scope of the evaluation will include measuring program objectives, lessons learned, cost savings, quality improvements and clinical outcomes.
Dedicated state resources	State has established a special bureau to implement Centennial Care comprised of 75 fulltime staff.
Stakeholder involvement	State has welcomed input from the New Mexico Hospital Association through public comment as well as focused discussions. NMHA is active on numerous implementation workgroups as well as the Medicaid Advisory Committee.
Hospital or association challenges	The SCP program currently gives major funding to 28 hospitals. The waiver would redefine the program and is moving closer to a strict cost-based definition of uncompensated care, which will result in reducing this funding by 40%.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	As a statewide waiver, all hospitals are involved.
Goals/anticipated impact on hospitals/other providers	Uncertain but key concerns are: • Changing MCO partners • Tighter MCO negotiations • Major financial impact on SCP hospitals • Payment reform will be welcomed by some and hardship for others.

State Medicaid Redesign Initiatives

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(All information was provided by the New Mexico Hospital Association)

Association's experience to date	State staff regularly communicates with NMHA and there is a general inclusion of the provider community. So far, members are unified with NMHA in approaches to the State.

State Medicaid Redesign Initiatives

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(All information was provided by the Healthcare Association of New York State)

NEW YORK	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	The State Fiscal Year 2011-2012 Budget authorized the Commissioner of Health, in collaboration with the Commissioners of the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office of People with Developmental Disabilities, to establish a voluntary Medicaid Health Home Demonstration Program for NYS Medicaid enrollees with chronic conditions. Health home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care. General description of the NYS Health Home initiative can be found at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
How established	The Health Homes initiative was born out of the work of the Medicaid Redesign Team (MRT), which followed the federal Patient Protection and Affordable Care Act (ACA) that established authority for states to develop and receive federal reimbursement for a set of health home services for their state's Medicaid populations with chronic illness. Section 2703 of the ACA allows States to provide, through a state plan amendment (SPA) or waiver program, health home services to Medicaid recipients with chronic medical and/or mental health conditions and/or substance abuse disorders. Care coordination efforts for these populations are eligible for a 90% federal match for the first eight (8) quarters of the approved SPA. The Department of Health (DOH) developed a three-Phased implementation by counties considered most prepared. The numbers of counties in each phase were 10, 13, and 39, for Phases One through Three. Each Phase required a different State Plan Amendment, which can be found on the DOH web site http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm. Phase One SPA approval occurred in January 2012, and Phases 2 and 3 SPAs were approved in December, 2012.
Status of Initiative	Health home enrollees are assigned to a designated health home, which is then responsible for conducting outreach to have that enrollee sign up and elect to be in their health home. Since this is considered a voluntary program, an enrollee may opt out of a health home. Once an enrollee elects to be in a health home, that person is then considered to be receiving active care management. Phase One Counties have been enrolling and rendering services to health home enrollees since that Phase began in February, 2012. Phases 2 and 3 are still finalizing networks and contracts between partners within their health homes and are in the early stages of registering health home enrollees. Of the 5.4 million Medicaid enrollees who access services on a fee-for-service (FFS) or managed care (MCOs) basis, 975,000 (including dual eligibles) were identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental Illness. These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services, enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions. As of March, 2013, over 21,000 people have been assigned to a health home across the state. Of these, 13,000 are enrolled in Medicaid FFS, and 8,000 are enrolled in a Medicaid MCOs. Of the 21,000, almost 12,000 are receiving active care management, while the remaining 9,000 are considered in outreach.
Timeline	Phase 1 began February 1, 2012; Phase 2 began April 1, 2012; Phase 3 began July 1, 2012
Evaluation status	To date, the roll out of health homes has been relatively slow. Initially, the DOH provided lists of enrollees to designated health homes which were fraught with errors that included people who were no longer on Medicaid or could not be located. These initial assignment glitches appear to have been rectified and roll out appears to be occurring more smoothly, especially when a health home identifies people it believes qualifies as a health home enrollee based on their mental and/or health status as having multiple chronic conditions. There are not hard statistics that the state has shared on how many people have been enrolled by either state generated lists, or through provider assignment. Health home providers have indicated their concern that the payment rates for providing the level of outreach and care management is not adequate for the resources needed. This continues to be a discussion point between HANYS and the State. To date, it is not clear what the plan for shared savings will be for this initiative. Since the goal of the program is to improve care, while also reducing admissions, and emergency department visits, there is anticipated to be savings achieved. This also continues to be a discussion point between HANYS and the State.

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(All information was provided by the Healthcare Association of New York State)

Dedicated state resources	The State has dedicated a number of staff to this initiative, but is not clear how many or what is the actual funding level. The monthly care management fee is new funding that the State contributes a 10% match along with the federal 90%. Initially, the State indicated that they hoped to receive additional funding for this program through the upcoming Medicaid 1115 waiver, but the status of that is not clear at this time. There was also $15 million in health home infrastructure funding that was included in the recently passed 2013-14 State Budget, but that will not be available until April, 2014.
Stakeholder involvement	HANYS is a member of the State-hosted Health Home -- Managed Care Consolidated Workgroup, which is a group of Health Homes, downstream partners and managed care organizations as well as state partner agencies. This group was initially formed for Phase One designated health homes, to discuss issues related to enrollee assignment, data sharing, and resource allocation between and amongst health home network partners. The initial meeting for the Phase 2 and 3 health homes will be held on April 22, 2013. We are not considered to be an active member of this group, and have been invited as an observer. However, being present for the dialogue between health home network partners will inform HANYS of member needs and any advocacy efforts with the DOH. Additionally, the State has worked with HANYS to provide educational initiatives to our members since the inception of the program. We have sought clarification on questions from the State, and pushed for higher rates, on behalf of those providers who wished to be designated as health homes.
Hospital or association challenges	There are a number of challenges associated with the health home initiative: a) Hospital member participation as a health home has been low. To date, hospital-led health homes number nine, six, and six respectively for each of the phases. This participation is from a member base of almost 200 hospitals. b) Enrollee assignment had significant issues, yet was an issue completely out of control of the association, and entirely within the state's purview. c) Monthly care management fees are not adequate to support provider resources needed to develop health home networks, systems for data sharing, and outreach efforts. d) Many unknowns are still involved in this initiative, including the value of shared savings, and whether there will be any additional funding to support and develop health home efforts going forward. The ACA calls for the 90% federal match to end eight months after each phase has begun, so there are future funding concerns about the care management fees. e) Hospitals have indicated that the state has not provided enough information about potential health home enrollees to help them adequately staff and fund. Challenges to the medical home initiative are largely financial. There is a cost to achieving NCQA Primary Care Medical Homes (PCMH) certification, and many providers expressed concern about this. Furthermore, as PCMH standards are updated, it is likely that a PCMH requirement to achieve a fully functioning EHR will create its own challenges.
Local, regional, or statewide	This is a statewide initiative that is being rolled out in three phases by selected counties, determined based on their readiness to accept these patients into a network of providers and community resources.
Open to all or restricted to selected hospitals	The health home program is open to all hospitals. Additionally, the ACA requires that any patients who are enrolled in a health home, be identified and notification given to his/her health home, if they present to an emergency room, which is not part of their assigned health home.
Goals/anticipated impact on hospitals/other providers	The funding resources needed to develop and operate health homes appear to be inadequate. By its very nature, the health home model urges more engagement and coordination with outside organizations not normally within the purview of the hospital, including community support networks such as visiting nurses and housing support. For medical homes, the add-on incentive payments are expected to encourage wider use of the PCMH certification, which appears to have happened.
Association's experience to date	Not all members have chosen to engage in this program, and those that have appear to operate independently and within the workgroup created by the state. Despite our efforts to convene groups of members involved in this program, it is our experience that, in addition to the concerns stated previously, there are start-up issues associated with this program. HANYS expects that our participation in the upcoming Health Home—Managed Care Consolidated Workgroup will yield more involvement and member input. It will also help the association to better understand the challenges faced by our members, and therefore inform our advocacy efforts going forward. HANYS has hosted a number of educational sessions on the initiative, as well as guidance on how to achieve NCQA PCMH recognition.

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(All information was provided by the Healthcare Association of New York State)

NEW YORK	
Redesign Categories	• **Accountable Care Organization** • **Care Coordination Approach** • **Bundled Episode Payment** • **Shared Savings/Shared Risk**
Brief Description of Initiative	HANYS participated in the New York State Governor's 2011 Medicaid Redesign Team (MRT), along with other stakeholders. The MRT report included recommendations on how New York State could encourage the development of innovative payment and delivery models including: accountable care organizations, bundling, gain-sharing, clinical integration, and other shared savings and/or risk-sharing arrangements. MRT developed a set of principles which recommended that innovative payment models should: • Be transparent and fair, increase access to high-quality health care services in the appropriate setting, and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved. • Reduce fragmentation of health care services and promote fully integrated patient-centered/directed models where possible. • Be accountable for patient outcomes and improved health of the population being served. • Be scalable and flexible to allow providers in all settings and communities (regardless of size) to participate, reinforce health system planning, and preserve an efficient essential community provider network. • Allow for flexible multi-year phase-in to recognize administrative complexities, including network development and systems requirements (i.e., information technology). • Align payment policy with quality goals. • Reward improved performance and continued high performance. • Incorporate strong evaluation component and technical assistance to assure successful implementation. The current proposed New York 1115 Medicaid waiver includes three funds related to development of innovative payment systems: 1. Hospital Transition — This program would help New York's voluntary hospitals transform into integrated delivery systems and transition from a volume-driven business model to an outcome-based integrated delivery system model. Transition funding would provide for such areas as capital investment in expanded health information technology, primary care/outpatient services linked to acute care bed reductions, workforce retraining, and developing networks to provide the full continuum of care and to focus on services necessary to reduce potentially preventable admissions and readmissions. 2. Public Hospital Innovation — These funds would be provided to public hospitals to test innovative payment and service delivery models. Plans would be designed to reduce Medicaid expenditures, enhance efficiency, and improve care for Medicaid members and the uninsured population within the public hospital setting. 3. New Care Models — These funds would be available to practitioners, health care agencies, and other providers to develop partnerships and test new models of care that create incentives to coordinate care, improve quality and outcomes, reduce disparities, and contain costs.
How established	The state has begun discussions with CMS on an 1115 waiver that would include these programs.
Status of Initiative	Initial discussions with CMS are underway. An 1115 waiver plan has been submitted to CMS.
Timeline	The proposed waiver would establish a five-year timeframe to develop and implement the selected projects. Successful models would later be considered for expansion and potential roll-out to the Medicaid program.
Evaluation status	N/A
Dedicated state resources	Not yet; pending CMS approval.
Stakeholder involvement	HANYS and other provider associations were included among the stakeholders that participated in MRT, which initiated this process and continues to provide input to the state as waiver discussions progress.
Hospital or association challenges	The innovative models that will be tested will require fundamental change in payments and care delivery. Hospitals will be required to move from a volume-driven fee-for-service model to new models that focus on outcomes, efficiency, and quality.

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(All information was provided by the Healthcare Association of New York State)

Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	All hospitals are potentially eligible.
Goals/anticipated impact on hospitals/other providers	Short-term, this could provide badly needed funds to help hospitals transform care delivery and payment systems. Long-term, hospitals will be challenged to operate more efficiently and effectively. Shared savings arrangements could be established in the future to provide incentives and support for this transformation.
Association's experience to date	Members have participated throughout this process in HANYS-initiated workgroups and have provided input to guide association activities. These workgroups are ongoing to help develop plans for future implementation.
NEW YORK	
Redesign Categories	**Global Budgeting/Payment**
Brief Description of Initiative	The state fiscal year (SFY) 2011-2012 budget established a permanent cap on the New York State Medicaid spending. The cap equals the state's share of Department of Health (DOH) Medicaid spending, with year-to-year growth limited to the ten-year rolling average of the medical component of the U.S. Consumer Price Index (CPI), currently 3.9%. Actual spending for the first year of the cap, SFY 2011-2012, was $14 million below the $15.3 billion cap. The cap for SFY 2012-2013 is budgeted to be $15.9 billion, with spending expected to finish $200 million below projections. This cap is centerpiece of an overall program of Medicaid reform that will make many structural changes to delivery system in order to stay within the cap. DOH and the Division of Budget (DOB) are charged with monitoring and reporting program spending on a monthly basis to determine if spending growth is expected to exceed the forecasted Medicaid spending cap. The Commissioner of Health (COH) was granted "super powers" to ensure spending remains under the cap. If spending is projected to exceed the spending cap, COH will develop and implement a plan of action (known as a "Medicaid Savings Allocation Plan") to bring spending in line with the cap. Medicaid Savings Allocation Plans could include actions such as modifying/suspending reimbursement methods (e.g., fees, premium levels, rates) and modifying program benefits. To date, the cap has not been exceeded.
How established	The Medicaid global spending cap initiative originated with the work of the New York State Governor's Medicaid Redesign Team (MRT), and through legislative action as part of the enacted SFY 2011-2012 state budget. MRT was established by the Governor and included state agency leaders/officials and representatives from all sectors of health care. The MRT Web site can be found at www.health.ny.gov/health_care/medicaid/redesign.
Status of Initiative	The Medicaid global spending cap has been in place since the passage of the 2011-2012 SFY budget, beginning April 1, 2011. With the state facing a significant budget deficit, the Governor created MRT to address health and Medicaid spending, one of the largest areas of spending in the state budget. The Governor established MRT by Executive Order, bringing together HANYS and other stakeholders and experts from throughout the state to work collaboratively to reform the system and reduce spending. To date, the state has issued monthly reports to evaluate spending, which has thus far remained under the cap. Progress updates from MRT initiatives are posted online at www.health.ny.gov/health_care/medicaid/redesign. In Phase 1, MRT adopted and the legislature enacted 78 recommendations to achieve $2.2 billion in state savings for SFY 2011-2012. MRT continued its work in Phase 2 by establishing ten issue-specific workgroups to address more complex issues and to evaluate the implementation of certain recommendations enacted in Phase 1. These workgroups provided an additional 175 stakeholders the opportunity to participate in the MRT process. All workgroup meetings were public and multiple public hearings were held. More information on the MRT Phase 2 workgroups is available online at www.health.ny.gov/health_care/medicaid/redesign/additional_info_wrk_grps.htm. HANYS and its members participated on many of these workgroups. Additionally, HANYS has been an active member of the Medicaid Global Spending Cap Advisory Group convened by DOH and DOB. The three meetings of this group primarily focused on recommendations from Advisory Group participants to modify the global cap and achieve shared savings. The Advisory Group will next meet in the fall of 2013 and, in the meantime, DOH and DOB plan to convene staff-level workgroups with Advisory Group organizations to present recommendations for shared savings for consideration in the 2014-2015 Executive Budget. To assist in the evaluation of the global cap, HANYS and other associations have been given access to a data mining tool, developed by Salient Management Company, a state subcontractor, which is used to monitor Medicaid spending. Several HANYS staff have been trained on the use of the tool and given access to timelier Medicaid fee-for-service and Medicaid managed care encounter data. Additional training is being scheduled on how the state uses these data to tie to the monthly global cap reports and examine spending trends.

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(All information was provided by the Healthcare Association of New York State)

Timeline	The Medicaid global spending cap, which is a cap on year-to-year growth, is permanent in statute. The COH "super powers" to reduce spending to remain under the cap were initially granted for two SFYs. In the two subsequent SFYs, these "powers" were extended. The most recent (2013-2014) state budget authorizes adjustments to the cap to account for spending resulting from natural or other types of disasters. It also requires more detail in monthly reports regarding drivers of spending increases and decreases.
Evaluation status	To date, the state share of actual Medicaid spending has not exceeded projected Medicaid spending. The state projects that spending will end up about $200 million under the cap at the end of SFY 2012-2013. The $200 million in reduced spending is projected to occur as a result of: 1) $130 million in lower than expected utilization/costs; 2) $40 million in higher local administration savings; and 3) $30 million in lower state operations spending. Spending under the 2011-2012 global cap was $14 million below the $15.3 billion target.
Dedicated state resources	The state appears to have assigned existing personnel and reallocated resources to this initiative. The actual funding level attributed to this initiative is not clear.
Stakeholder involvement	HANYS has regular contact with DOH on issues related to the Medicaid global spending cap. With actual spending close to the global cap, HANYS has worked with DOH and other associations to track the state's cash situation and develop a plan to reduce the state's accounts receivable, which are dollars owed by providers to the state because of outstanding Medicaid liability related to retroactive rate adjustments. HANYS, along with other associations, urged providers to accelerate any of these payments, as it also would serve to prevent the accrual of interest charges on the amounts owed. HANYS served on the full MRT. A list of MRT members can be found at www.health.ny.gov/health_care/medicaid/redesign/members.htm. HANYS and member organizations served on many of the MRT Phase 2 workgroups; a list of MRT workgroups and members can be found at www.health.ny.gov/health_care/medicaid/redesign/additional_info_wrk_grps.htm.
Hospital or association challenges	There are a number of challenges associated with the Medicaid global cap initiative: a. While the cap is in place, enrollment in the Medicaid program continues to grow. Medicaid total enrollment reached 5,288,868 enrollees at the end of February 2013. This reflects an increase of roughly 240,600 enrollees, or 4.8%, since March 2012 and a total increase of 392,000 since the cap was instituted in April 2011. Much of this enrollment growth is due to the continued sluggish economy and is the result of state policies that encourage enrollment. b. Providers continue to be asked to do more with less. Provider payments have been cut 2% across the board since the SFY2010-2011, and providers have not received a Medicaid trend (inflation) factor increase since 2007. Yet, provider costs continue to rise due to the implementation of new technology and new initiatives originating from the MRT and ACA. c. There is a lack of transparency with regard to what is included in projected spending, and what is actually considered to be part of the cap. d. Until the most recent state budget, there was no provision to allow for exclusions of certain spending increases related to natural disasters, which were beyond the control of providers. HANYS will continue to advocate for other exclusions to reduce provider exposure from future spending cuts.
Local, regional, or statewide	This is a statewide initiative that applies to the state share of DOH Medicaid spending. Medicaid spending related to the Office of Mental Health, the Office for People With Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services is excluded from the cap calculations.
Open to all or restricted to selected hospitals	The global spending cap applies to overall spending, with the exceptions noted in the answer above.
Goals/anticipated impact on hospitals/other providers	This is unknown. If the state share of Medicaid spending exceeds the spending cap, the Commissioner of Health is authorized to implement a Medicaid Savings Allocation Plan, which grants authority to make uniform and non-uniform payment reductions among provider sectors and geographic regions, including reductions in payment rates, fees, premium levels, and benefits.
Association's experience to date	HANYS' experience with this initiative has mostly been through our collaborative efforts with DOH and other associations. We will continue to participate in future Medicaid Global Spending Cap Advisory Group meetings and participate in the staff-level advisory group meetings this summer to devise shared savings recommendations for consideration in the SFY 2014-2015 Executive Budget. Furthermore, HANYS will continue to educate members on the status of the Medicaid global spending projections and track and examine actual spending. HANYS will pursue additional training on the Salient data mining tool, solicit member input, and seek to evaluate alternatives for Medicaid savings if the cap is pierced, and advocate that any plan to reduce spending, if needed, be taken off of actual payments rather than rates.

State Medicaid Redesign Initiatives

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(All information was provided by the Healthcare Association of New York State)

NEW YORK	
Redesign Categories	• **Medicaid Managed Care Expansion** • **Other: Behavioral Health Organizations**
Brief Description of Initiative	Risk-Bearing Managed Care Entities for High-Need Behavioral Health Populations and BHOs Behavioral Health Organizations/Special Needs Plan: As part of the 2011-2012 New York State budget, all Medicaid behavioral health fee-for-service recipients will be transitioned out of fee-for-service (FFS) and into managed care plans. The transition will occur in two phases: the first phase implements regional behavioral health organizations (BHOs) to track and monitor fee-for-service inpatient admissions, collect concurrent review data, and assist with discharge planning. The second phase will transition all enrollees into managed care through either traditional plans or special needs plans.
How established	The original strategy was developed through a 2011 statewide Medicaid Redesign Team (MRT) initiative that was charged with looking for ways to reduce Medicaid spending in the state. MRT established a Behavioral Health Subcommittee that supported the recommendation, on which HANYS participated.
Status of Initiative	Phase 1 is underway, with five regional BHOs working with hospitals to track inpatient Medicaid FFS admissions. Phase 2 is currently scheduled to begin in April 2014.
Timeline	Phase 1 continues until Phase 2 is fully operational, which is scheduled for April 2014. A request for proposals (RFP) is being developed for managed care companies to apply to provide the risk-bearing services for the population. This is scheduled to be released this fall, with awards announced by winter.
Evaluation status	The data being collected by the current Phase 1 BHOs was streamlined in fall 2012, to include data on only those high-need, most complex individuals. The process has been very burdensome for hospital providers and although the streamlined process has helped, most hospitals have needed additional staff resources to meet the BHO requirements.
Dedicated state resources	The New York State Office of Mental Health (OMH) (lead agency) has dedicated staff resources on this project. OMH is also working in conjunction with the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and has a staff person assigned to the project, but that position is not solely dedicated to this project. There was separate funding included in the state budget to pay the Phase 1 BHOs an administrative fee.
Stakeholder involvement	HANYS has been very involved in working with the BHOs and hospitals to identify concerns and help address problems that may occur. We are also in constant contact with the state agencies to provide input on areas of concern. HANYS' contact with the agencies, in part, led to the streamlined process for data collection that was implemented last year. Many other provider groups are also very involved with the BHO process. Each BHO has several meetings each year that provider groups and hospitals attend.
Hospital or association challenges	The challenge with Phase 1 of the initiative is that hospitals are required to report admissions and provide concurrent review for Medicaid FFS individuals, but the BHO is not paying for the care. So, there is an additional layer of process, but not related to payment.
Local, regional, or statewide	It is a statewide initiative with five regional BHOs implemented across the state.
Open to all or restricted to selected hospitals	All hospitals with inpatient psychiatric, inpatient detoxification or inpatient chemical dependency rehabilitation programs are required to participate and report their FFS Medicaid admissions.
Goals/anticipated impact on hospitals/other providers	Once Phase 2 is implemented, hospitals will deal with the managed care companies or special needs plans and will be paid by the managed care plans for all of the services provided to behavioral health populations in Medicaid. There will no longer be Medicaid FFS for these populations.
Association's experience to date	Phase 1 of the initiative was designed to be a transitional phase to allow providers to prepare for movement to full managed care. However, many of our hospital members are already dealing with managed care plans and this additional requirement is just another paperwork burden for them. Members have been supportive and compliant, but have expressed frustration and concerns. HANYS had hoped that the Phase 1 initiative would be collecting and sharing some useful data regarding collaborations of care, discharge planning, and lack of available discharge options. However, the data collected so far has not been compiled in a useful way to try and identify areas of need for the full movement into managed care.

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NEW YORK	
Redesign Categories	• **Medicaid Managed Care Expansion** • **Care Coordination Approach**
Brief Description of Initiative	Medicaid Managed Care (MMC) Expansion (MRT 1458): The proposal to expand Medicaid managed care enrollment involves enrolling more high-cost/high-need populations into managed care to promote better care management and coordination of services. This proposal comes from the New York State Governor's 2011 Medicaid Redesign Team (MRT). The state plans to eliminate most of the existing Medicaid managed care exemption and exclusion categories to expand benefits, populations, and required enrollment over a period of three years. Medicaid Mandatory Transition to Managed Long Term Care [MRT 90]: Mandatory managed long-term care (MLTC) enrollment requires Medicaid beneficiaries who are age 21 and older, dually eligible, and in need of community-based long-term care services for more than 120 days to enroll into one of the managed long-term care plan options available in the state, to the extent such options are available in their social services district. Currently, the three program options available for MLTC are a partially-capitated program, Program for All-Inclusive Care for the Elderly (PACE), or Medicaid Advantage Plus. Mandatory enrollment began in New York City and will be phased in throughout the rest of the state as plan capacity is developed. Information on both of these measures can be found on the New York's MRT Web site at www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm.
How established	For expanding managed care, waivers are required to expand benefits and populations, including CMS approval of state plan amendments. For the MLTC program, CMS approved necessary changes to the state's 1115 waivers, the Partnership Plan 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2.
Status of Initiative	Due to the size of New York State, the differences between upstate and downstate, the need to interface existing waivers into a broader Medicaid coverage agenda, and the sequential nature of the Department of Health's (DOH's) implementation schedule, the program is in many different phases at one time across the state. CMS approval is being granted in phases to fully implement managed care expansions. Effective August 1, 2011, the provision of personal care services became the responsibility of the Medicaid managed care organizations (MCOs). Since then, MMC expansions of non-dual populations have been identified: 3,100 non-dual individuals, 62% in New York City, and 38% across the rest of the state including those with human immunodeficiency virus (HIV), and Chronic Illness Demonstration Project (CIDP) homeless and consumer-directed participants. Added benefits include dental, orthodontia, consumer-directed personal care services, personal emergency response systems, pharmacy and medical/surgical supplies, and personal care services. CMS approved mandatory MLTC enrollment in August 2012. Enrollment for designated populations began in September 2012 in New York City. Since then, populations have been expanded and enrollment now includes Nassau, Suffolk, and Westchester counties. Enrollment is expanding to new regions and more populations upstate as access allows. It is anticipated enrollment will be conducted in all counties of the state by June 2014.
Timeline	August 2011 - December 2014
Evaluation status	Ongoing
Dedicated state resources	Yes. In an 1115 Medicaid waiver request, the state designated the reinvestment of federal savings, with a corresponding state match of savings from a number of MRT cost-cutting measures, including the establishment of a global state cap on Medicaid spending. There will be federal reinvestment if an 1115 waiver is granted. The project is directed by DOH's Director of the Division of Long-Term Care. A number of existing DOH policies will be integrated into the transition such as use of the Uniform Assessment System to determine clinical eligibility for MLTC and expansion of New York's single point of information and assistance known as NY Connects.
Stakeholder involvement	HANYS has participated in a number of implementation workgroups, regularly scheduled DOH conference calls, and attended DOH informational Webinars on all aspects of the transition. All project meeting and informational materials have been posted to public Web sites for review and opportunities to comment to DOH directly are ongoing through a publicly posted e-mail address. DOH has established a Web page dedicated to stakeholder engagement: www.health.ny.gov/health_care/medicaid/redesign/stakehldr_engage_process.htm.

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Hospital or association challenges	• Understanding the integration of these measures with federal reforms from ACA and other state reform measures. • Understanding the role of providers as contractors with MLTC plans and managed care. • Providers participating directly in the shared savings generated by programs.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The initiative is open to all providers and focused on high-cost/high-need Medicaid populations and will eventually encompass all acute and post-acute services.
Goals/anticipated impact on hospitals/other providers	A new sense of competitiveness will be generated, as well as new opportunities for providers to partner with others and develop new program efficiencies and an appreciation for their own quality performance as a marketing tool with managed care.
Association's experience to date	HANYS continues to be engaged with DOH and CMS to understand the interface of these new reforms and provide members with information. Members are assessing this new environment, their long-term missions and organizational goals, and making strategic business decisions about new models of care and new relationships. HANYS' previous advocacy and education work in the managed care arena offers members added value in understanding this new statewide managed care environment.
NEW YORK	
Redesign Categories	• **Care Coordination** • **Long-Term Care/Home and Community-based Care**
Brief Description of Initiative	Balancing Incentive Program (BIP) Initiative: This project aims to improve access to home- and community-based long-term care services for those with physical or behavioral health needs, and/or intellectual disabilities throughout New York State. Interventions to achieve this include improved access to information, inclusion of these populations in the use of New York's Uniform Assessment System, and Conflict-Free Case Management Services. Details are available online at: www.health.ny.gov/health_care/medicaid/redesign/docs/revised_bip_program_application.pdf
How established	Grant award from the Centers for Medicare and Medicaid Services (CMS) under Section 10202 of the Affordable Care Act (ACA).
Status of Initiative	CMS approval for the New York State Department of Health (DOH) proposal has been secured and implementation steps are is just being developed.
Timeline	April 1, 2013 - September 30, 2015.
Evaluation status	N/A New initiative
Dedicated state resources	Yes. The oversight and operating agency for BIP implementation is led by DOH's Director of the Division of Long-Term Care, plus a 2% state funding match.
Stakeholder involvement	HANYS participated in DOH's orientation Webinar and will embrace more opportunities for continued involvement through DOH workgroups.

Hospital or association challenges	This initiative continues to promote deinstitutionalization and more home- and community- based service options. HANYS will: • analyze BIP policy changes for implications on the discharge and transitions process for the target populations; • keep providers informed of the progress of the BIP Initiative; and, • advocate for provider education about new policies and processes.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	The BIP initiative is focused on patient populations with physical or behavioral health needs, and/or intellectual disabilities throughout New York State, and increasing their access to home- and community-based services.
Goals/anticipated impact on hospitals/other providers	Expedited discharges and transitions from institutions to home- and community-based services of those target populations.
Association's experience to date	It is too soon to determine.
NEW YORK	
Redesign Categories	**Care Coordination Approach**
Brief Description of Initiative	Reduction of Pressure Ulcers: The Gold Success Through Assessment, Management, and Prevention (STAMP) program is a process for educating, establishing and supporting cross-setting provider collaborations to improve systems of care and communication about pressure ulcers during patient/resident/client transitions across the continuum of care. Details are available online at www.hanys.org/quality/clinical_operational_initiatives/gold_stamp.
How established	Gold STAMP was originally established by a coalition of 13 organizations, which voluntarily convened and provided evidence-based resources and education across the continuum of care and statewide to improve the assessment, management and prevention of pressure ulcers. Through this in-kind work, assessment tools, an electronic resource guide, an audio conference and ten regional education programs were conducted. Gold STAMP was then designated as a 2011 New York State Governor's Medicaid Redesign Team (MRT) Intervention (MRT #191) with targeted Medicaid savings. There are two funding tracks for Gold STAMP. The New York State Department of Health (DOH) MRT track is funded by a state budget appropriation awarded annually. A second Gold STAMP track is being funded by a NY Health Foundation Grant awarded to a coalition of associations known as the Empire Quality Partnership, of which HANYS is a member.
Status of Initiative	Gold STAMP has been fully implemented in 12 cross-setting provider collaboratives across the state that have been funded as noted above. Each collaborative is supported by an onsite Gold STAMP coach or facilitator who assists with monthly collaborative meetings and acts as a liaison between the providers and Gold STAMP project leaders. In total, there are 21 hospitals, 25 nursing homes, 14 home care agencies and two hospices engaged in the 12 collaboratives.
Timeline	October 2010 through September 30, 2013
Evaluation status	The NY Health Foundation track will be complete September 2013. The MRT track will continue as state budget funding has been approved for SFY 2013-2014.
Dedicated state resources	Yes. DOH staff from the Division of Residential Services, Quality and Surveillance co-chair and support the coalition activities. In addition, the state budget has included three consecutive years of appropriations to fund the MRT track of Gold STAMP activities. DOH has contracted with the University of Albany School of Public Health to conduct the MRT track of Gold STAMP. Details are available online at www.albany.edu/sph/cphce/goldstamp.shtml.

Stakeholder involvement	Stakeholder involvement was the originating force behind Gold STAMP. This included the development of all the Gold STAMP tools and resources, and providing statewide education via audio conferences and regional meetings. The majority of the coalition members are provider associations from all sectors of the continuum. HANYS co-chairs the 13 member coalition along with DOH staff and is a principal partner in the Empire Quality Partnership, the group conducting the NY Health Foundation Grant project. Coalition members have also made all Gold STAMP materials available to the public through their Web sites. Details are available online at www.empirequality.org.
Hospital or association challenges	Sustainability and expansion of Gold STAMP without permanent funding.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Gold STAMP tools and resources are available to all. The providers participating in the collaboratives were identified by their stated level of interest for future engagement after attending education about Gold STAMP. A Request for Applications was sent to those interested providers outlining the application process and the set of criteria. Respondents' applications were then evaluated against those criteria and several were selected for participation as a collaborative.
Goals/anticipated impact on hospitals/other providers	HANYS is evaluating Gold STAMP and the cross-setting provider interaction and collaborative process it promotes for care coordination and communication about pressure ulcers. It is anticipated such interaction and collaboration could be of benefit in producing similar quality improvements for any number of cross-setting clinical issues. Anecdotally, the Gold STAMP collaboration has facilitated additional collaborations between participating providers. DOH is also tracking Medicaid costs and pressure ulcer prevalence and seen a decided trend of decline in both across all health care sectors that correlate to the initiation of statewide Gold STAMP education.
Association's experience to date	Anecdotally and from process data collected to date, the collaborative process had been very positive for all providers participating in a Gold STAMP collaborative. Many cross-setting relationships have expanded to other quality improvement initiatives between providers outside of Gold STAMP. In addition, nursing home pressure ulcer prevalence data (the most reliable and accessible data nationally and statewide) continues to decrease since Gold STAMP education and the collaborative were initiated.
NEW YORK	
Redesign Categories	**Dually Eligible Demonstration – Capitated Model and Managed Fee-for-Service Model**
Brief Description of Initiative	New York State was selected as one of 15 states to submit a proposal under the State Demonstration to Integrate Care for Dual Eligible Individuals. The state submitted their proposal to CMS on May 25, 2012. The original proposal included a capitated Fully Integrated Duals Advantage (FIDA) program and a managed fee-for-service model (Health Homes). http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf . On April 18, the State issued an addendum to their proposal that changes the target population and the timeframe of the demonstration. The demonstration will now run from April 2014 through December 2017 and include both community- and facility-based dual eligible individuals. The State will no longer be pursuing the managed fee-for-service model. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-04-24_addendum_to_fida.pdf
How established	CMMI Initiative
Status of Initiative	State is working on the Memorandum of Understanding (MOU) with CMS for the capitated model. State is still in discussions with CMS. Details are available at: www.health.ny.gov/health_care/medicaid/redesign/docs/2013-03-13_stakeholder_mtg.ppt.
Timeline	Demonstration will run from April 2014 through December 2017. Enrollment for the community-based duals will begin April 2014 and facility-based duals will begin to be enrolled in October 2014.
Evaluation status	N/A — demonstration has not begun yet.
Dedicated state resources	The state applied for funding from CMS in January 2013. Awards are expected in April after a MOUs signed.

Stakeholder involvement	The state held stakeholder webinars during the development of the proposal and allowed for a comment period. HANYS submitted comments on their proposal. Based on feedback, the state revised its initial proposal to include a Medicaid FFS component. The state also created four workgroups to focus on specific topics: Plan Qualifications and Quality Metrics; Outreach and Enrollment; Navigation, Appeals and Grievances; and Finance. HANYS participated on all four workgroups and provided feedback to the state on the development of the demonstration. The state continues to hold Webinars to keep stakeholders updated on the progress. The state has indicated it may reconvene the workgroups as necessary, as the details are worked out with CMS. Meeting minutes, Webinar slides, and question-and-answer documents are located on the state's Web site under "MRT 101" at: www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm
Hospital or association challenges	• Transitioning from a FFS to managed care model of payment for the dual eligible population. • Satisfying combined Medicare and Medicaid quality metrics. • Identifying measures that appropriately evaluate performance in the areas of care coordination and management.
Local, regional, or statewide	The capitated approach of the demonstration is limited to eight downstate counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester.
Open to all or restricted to selected hospitals	In order to be a FIDA plan in the capitated model, they must currently operate as a Program of All-inclusive Care for the Elderly (PACE), managed long-term care, Medicaid managed care or Medicaid Advantage Plus plan in New York State and must meet all FIDA requirements. Any provider (acute and post-acute) that services the dual-eligible population in one of the demonstration counties is encouraged to participate in the demonstration. In order to participate in the MFFS model, providers must be part of a state designated Health Home.
Goals/anticipated impact on hospitals/other providers	In the capitated approach, CMS and the State will enter into an agreement with the FIDA plans to provide services to the dual-eligible population while achieving a savings target (% of baseline Medicare/Medicaid spending) which is to be determined. Providers will need to contract with a FIDA plan and negotiate rates for services previously provided on a FFS basis.
Association's experience to date	Providers are in the process of evaluating what this means for them. The terms of the MOU will help them get ready for the demonstration.
NEW YORK	
Redesign Categories	**Other: Hospital Transition Program and Capital Stabilization for Safety Net**
Brief Description of Initiative	The hospital transition initiative would provide funding to create integrated delivery systems at safety net hospitals. This short-term financial assistance would assist hospitals with transitioning from a volume-driven business model to an integrated outcome-based delivery system. The capital stabilization initiative would be used to transform, preserve and strengthen safety net hospitals. Unlike other capital programs, this is a limited, short-term infusion of funding to facilitate long-term structural sustainability. The funds would be focused into three key areas: technical assistance to hospital boards, transitional capital and balance sheet restructuring.
How established	New York State has submitted a Medicaid 1115 waiver request to the Centers for Medicare and Medicaid Services (CMS) which includes this initiative.
Status of Initiative	The waiver request is currently being evaluated by CMS.
Timeline	Pending with CMS.
Evaluation status	N/A
Dedicated state resources	Existing New York State Department of Health (DOH) staff was used to develop the waiver.

Stakeholder involvement	HANYS and HANYS' members provided input to the state on the development of these proposals and other aspects of the proposed Medicaid waiver.
Hospital or association challenges	• Moving from a volume-driven business model to an integrated outcome-based delivery system. • Securing the long-term fiscal stability of safety net providers in a transforming health care system.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Limited to hospitals/systems that meet safety net criteria.
Goals/anticipated impact on hospitals/other providers	To be determined
Association's experience to date	The definition of safety net provider will have implications for those who can receive funds from a limited available pool.
NEW YORK	
Redesign Categories	**Other: Essential Community Provider Network (ECPN) and Vital Access Providers (VAPs)**
Brief Description of Initiative	The 2011 New York State Governor's Medicaid Redesign Team (MRT) recommended two initiatives to ensure access to care for patients. The first, ECPN, would provide hospitals, nursing homes, diagnostic and treatment centers (D&TCs) or home health providers with short-term funding to meet operational goals. These operational goals include facility closure, merger, integration or reconfiguration of services. The second, VAP, provides the same types of providers with long term funding to meet community health needs.
How established	Changes will be made to the state plan amendment.
Status of Initiative	ECPN—To be determined. VAP—Working with CMS to develop approvable state plan.
Timeline	ECPN—To be determined. VAP—First or second quarter of 2013.
Evaluation status	N/A
Dedicated state resources	Existing New York State Department of Health (DOH) staff are being used to develop and operationalize these recommendations.
Stakeholder involvement	ECPN—To be determined. VAP—HANYS and other associations worked collectively with DOH to define VAPs and assist with application process and development of regulations.
Hospital or association challenges	ECPN—To be determined. VAP—Providers have to complete a short application containing their proposal for how the rate enhancement would improve community health needs.
Local, regional, or statewide	ECPN—To be determined. VAP—Statewide.
Open to all or restricted to selected hospitals	ECPN—To be determined. VAP—Open to all hospital/systems with the caveat that proposals will be evaluated in the context of ensuring community need.
Goals/anticipated impact on hospitals/other providers	ECPN—To be determined. VAP—For selected providers there will be a rate enhancement which will be used to fund approved operational initiatives associated with meeting community health needs.

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Association's experience to date	ECPN—To be determined. VAP— The initiative has been delayed numerous times by DOH, presumably due to lack of staff time. These delays have led to anxiety for applicants awaiting decisions on applications.
NEW YORK	
Redesign Categories	**Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	Early Elective Delivery MRT Payment Policy: In 2012, the New York State Legislature enacted a proposal from the Governor and the Medicaid Redesign Team (MRT) to reduce Medicaid payments by 10% for hospitals and physicians that perform deliveries (both induced labor and cesarean sections) prior to 39 weeks gestation, without a documented medical indication. This policy will apply to Medicaid fee-for-service and Medicaid managed care programs.
How established	The program was established in the state fiscal year (SFY) 2012-2013 budget, following the recommendation of MRT, which was appointed by the Governor.
Status of Initiative	The initiative was in the final 2012-2013 state budget and is in the implementation phase.
Timeline	The policy has been delayed for several months, in part because new codes are anticipated to take effect in October, thereby making it easier to track and monitor the number of early elective deliveries in the state. The policy may be implemented retroactively to January 1, 2013.
Evaluation status	The initiative has not yet been implemented, so evaluation has not occurred.
Dedicated state resources	New York State's Department of Health (DOH) Medicaid finance/reimbursement and hospital quality/patient safety staff have been assigned to implement the policy change.
Stakeholder involvement	HANYS was a member of MRT, which recommended a number of reforms to reduce spending and improve quality of care. Hospital associations have been involved in the development of the guidance to implement the initiative. In addition, DOH consulted with the American College of Obstetricians and Gynecologists (ACOG) to come up with the list of exclusions for early deliveries that would be considered to be medically necessary.
Hospital or association challenges	HANYS and other associations had initial concerns that the list of exclusions, while based on ACOG's guidance, may not be broad enough to capture all appropriate deliveries prior to 39-weeks gestation. DOH and ACOG have made additional changes and the list currently appears fairly comprehensive. In addition, members also expressed concerns that there is not an appeals process associated with the policy. HANYS is also concerned about the practical implementation of the policy through coding elements on claims. Hospital and physician claims will be handled separately and eventually matched up. Questions also exist as to how and when managed care plans will implement this policy. The plans will receive a reduced payment from the state, when appropriate.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Payment changes apply to hospitals and physicians that bill for obstetrical services
Goals/anticipated impact on hospitals/other providers	The payment policy is anticipated to have a $5 million impact on hospitals and physicians in SFY 2012-2013 and a $5 million impact in SFY 2013-2014. In addition to payment reductions for providers, system-wide savings are anticipated through reduction of neonatal intensive care unit admissions, reduced hospital length of stay, and decreased rate of future cesarean sections.
Association's experience to date	HANYS has collaborated with other hospital associations.

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NEW YORK	
Redesign Categories	**Other: Eliminating Health Disparities**
Brief Description of Initiative	As part of the New York State Governor's Medicaid Redesign Team (MRT) Initiative, a workgroup was created to review health disparities. This initiative is related to MRT recommendation #990, *Explore the Establishment of Reimbursement Rates to Support Efforts to Address Health Disparities.* Details are available online at: www.health.ny.gov/health_care/medicaid/redesign/health_disparities_workgroup.htm. This workgroup advised the Department of Health (DOH) on specific initiatives related to health disparities, including establishment of reimbursement rates to support providers' efforts to offer culturally competent care and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation and gender expression. The workgroup also: • advised DOH about incorporating interpretation and translation services to patients with limited English proficiency and who are hearing impaired; • addressed health disparities among people with disabilities, including people with psychiatric disabilities and substance use disorders, and their need for equal access to primary and preventive health care services; • explored issues related to charity care and the uninsured; advised DOH about data collection efforts related to health disparities including advice to ensure consistency with federal requirements as defined under Section 4302 of the Affordable Care Act (ACA); and • advised DOH about use of a Disparities Impact Assessment to evaluate all MRT recommendations.
How established	This health disparity initiative was established through a state health reform redesign process. In 2013, New York State is using a state grant awarded through the 2012 budget, and is working with the State University of New York to develop and produce educational Webinars about the value and importance of collecting health disparity data. DOH is working to revise some of its state databases to add health disparity information. In addition, as part of the NYS Prevention Agenda, hospitals and county health departments will be choosing two of five priority areas to work on between 2013-2017. DOH is requesting hospitals and counties reduce disparities for specific populations that are disproportionately impacted by goals and objectives related to the priority areas.
Status of Initiative	Some of the recommendations are in the implementation phase. Implemented recommendations include: • Data Collection/Metrics to measure Disparities: DOH is working on expanding its data collection standards as required by the ACA to include detailed reporting on race and ethnicity, and gender identification. Webinars will be scheduled late in 2013 to educate hospitals about the changes. • Address Disparities in Treatment at Teaching Facilities: The New York State Assembly held a public hearing on this issue in May 2012. The hearing focused on reviewing disparities in health care access and outcomes related to hospital outpatient care. There was state legislation introduced A.7699-A, which would require academic medical centers to provide outpatient specialty care in an integrated setting staffed by attending physicians and residents. As part of the 2013-2017 Prevention Agenda, hospitals need to work on reducing disparities from 2013 to 2017 in the following areas: • the percentage of premature deaths; • age-adjusted rate of preventable hospitalizations among adults; • the rate of assault-related hospitalizations; • percentage of adults who are obese; • decrease the prevalence of cigarette smoking by adults; • increasing percentage of adults who receive colorectal cancer screening; • reduce the asthma emergency department visit rate; • increase the percentage of health plan members with hypertension who have controlled their blood pressure; • increase the percentage of adult health plan members with diabetes whose blood glucose is in good control; • reduce the newly-diagnosed human immunodeficiency virus (HIV) case rate; • reduce the percentage of pre-term births; • increase the percentage if infants exclusively breastfed in the hospital; • reduce the rate of maternal mortality in New York State; and • reduce the percentage of third-grade children with evidence of untreated tooth decay, among other areas.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Healthcare Association of New York State)

Timeline	No specific timeline
Evaluation status	Ongoing
Dedicated state resources	Regarding data collection for health disparities, the state allocated money through its 2012 state budget process. In addition, as part of the New York State Prevention Agenda, DOH has put forth some staffing resources to assist hospitals in identifying health disparities within their priority areas for the Prevention Agenda.
Stakeholder involvement	As part of the MRT's Health Disparities Workgroup, DOH involved consumer groups interested in disparities, community-based organizations, the New York Academy of Medicine, New York State Mental Health Association, Weill Cornell Medical College and health care providers.
Hospital or association challenges	Some hospitals are challenged with identifying a health disparity. HANYS is working with DOH to provide education to hospitals. In terms of health disparity data collection, hospitals need to be educated about the changes and HANYS is partnering with DOH to provide webinar programs on this issue.
Local, regional, or statewide	Statewide initiative
Open to all or restricted to selected hospitals	Open to all hospitals
Goals/anticipated impact on hospitals/other providers	Hospitals need education on issues related to disparity. HANYS is collaborating with the DOH to ensure education is provided.
Association's experience to date	HANYS has a rich history of collaboration through its Community Health Advocacy Agenda. HANYS will continue to utilize this experience to assist members on issues related to health disparities.
NEW YORK	
Redesign Categories	• **Incentives for Prevention of Chronic Diseases** • **Other: Chronic Disease Prevention**
Brief Description of Initiative	In 2008, New York State unveiled its Prevention Agenda, with ten health priorities to make New York the healthiest state in the nation. Hospital and county health departments worked together to identify their local priorities and develop action plans to achieve measurable progress. The majority of hospitals chose chronic disease as their priority. In 2013, New York State released its 2013- 2017 Prevention Agenda, which builds on its original initiative by refocusing efforts into five priority areas. This new Prevention Agenda encourages hospitals to continue to collaborate with their local health departments and other community-based organizations and requires hospitals to identify evidence-based interventions to be effective in meeting their goals. The 2013- 2017 Prevention Agenda focuses on five areas: • prevent chronic disease; • promote healthy and safe environment; • promote healthy women, infants, children; • promote mental health and prevent substance abuse; and • prevent sexually-transmitted infections, vaccine preventable disease and health care-associated Infections. A group of 58 Prevention Agenda objectives were chosen to be tracked annually by New York State. Particular initiatives around chronic disease include: increasing access to quality chronic disease preventive care and management in both clinical and community settings, promoting the use of evidence-based care to manage chronic diseases and promoting culturally relevant chronic disease self-management education.
How established	This initiative was established directly through the New York State Department of Health (DOH) and the New York State Public Health and Health Planning Council (PHHPC).
Status of Initiative	This initiative is in the implementation phase. It was officially unveiled in January 2013. Details are available online at: www.health.ny.gov/prevention/prevention_agenda.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Healthcare Association of New York State)

Timeline	2013-2017
Evaluation status	DOH will collect data from hospitals through the submission of their required Community Service Plans and from the local county health departments through their community needs assessment and community health improvement plans. Hospital and local county health department plans are due to DOH in fall 2013. DOH will receive annual updates from hospitals and counties to track progress.
Dedicated state resources	New York State has its public health staff working on this initiative. In addition, DOH and the Robert Wood Johnson Foundation awarded a grant to HANYS and five other regional collaboratives to engage counties across New York State (except New York City) to develop and implement community health assessments and improvement plans in conjunction with New York State's Prevention Agenda 2013-2017.
Stakeholder involvement	HANYS has been a partner and leader of this initiative since its inception. HANYS participated on an ad-hoc committee that was part of the planning phase to develop priority goals and action plans for hospitals and counties.
Hospital or association challenges	While creating multi-stakeholder coalitions for community health improvement is challenging, HANYS is committed to assisting our members throughout these critical efforts. In addition, the hospitals are challenged with developing evidence-based interventions and measurement.
Local, regional, or statewide	This is a statewide initiative.
Open to all or restricted to selected hospitals	The Prevention Agenda involves all voluntary hospitals in New York State.
Goals/anticipated impact on hospitals/other providers	While hospitals bear the cost of these activities, they do support the transition to patient-centered care and population health management.
Association's experience to date	HANYS is a key leader in this initiative. HANYS has collaborated with DOH to ensure that this initiative is realistic for hospitals to complete. HANYS is a long-time collaborator on community health initiatives across the state and has positioned its members to participate in this initiative.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the North Dakota Hospital Association)

NORTH DAKOTA	
Redesign Categories	**Other: Medicaid Coverage Expansion**
Brief Description of Initiative	Medicaid expansion bill was signed by the Governor on April 16, 2013. The law becomes effective January 1, 2014 and sunsets on July 31, 2017.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

OHIO	
Redesign Categories	**Accountable Care Organization**
Brief Description of Initiative	Partners for Kids--a Physician Hospital Organization (PHO) developed by a joint endeavor between physicians and Nationwide Children's Hospital
How established	Nationwide Insurance officials partnered with the state of Ohio to assume financial risk in treating children who were covered by the Medicaid managed care program in central and southeast Ohio. To help run the program, they formed a nonprofit physician-hospital organization called Partners for Kids that includes not only Nationwide-employed physicians but also other physicians working in the community. Under the arrangement, Partners for Kids receives a capitated fee to care for about 285,000 pediatric Medicaid recipients. The organization contracts with three Medicaid managed care plans that retain a percentage of the Medicaid premium to provide claims processing, member relations and other medical management functions. The hospital and physicians assume the business risk for clinical and financial outcomes.
Status of Initiative	Effort has been in place since 2010.
Timeline	Ongoing and children's hospitals can join in at any time.
Evaluation status	Unknown
Dedicated state resources	No, other than minimal staff time necessary to ensure withholds are implemented.
Stakeholder involvement	The OHA and the Ohio Children's Hospital Association advocated for children's hospitals to have the ability to establish these sub-capitation arrangements. Participation is now up to individual hospitals and their contracted health plans.
Hospital or association challenges	Potential population management issues
Local, regional, or statewide	Locally administered but open to all children's hospitals statewide
Open to all or restricted to selected hospitals	Open to all children's hospitals
Goals/anticipated impact on hospitals/other providers	Enabling children's hospitals to better coordinate care of children in communities and to integrate care across continuum with other providers.
Association's experience to date	Positive feedback from the one hospital participating – but otherwise OHA continues to monitor future developments.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

OHIO	
Redesign Categories	**Medicaid Managed Care Expansion**
Brief Description of Initiative	Ohio is adding 37,000 Aged, Blind or Disabled (ABD) children currently served in its fee-for-service program into its managed care program.
How established	State-initiated
Status of Initiative	Planning phase
Timeline	Enrollment begins July 2013
Evaluation status	N/A
Dedicated state resources	Yes, state is providing additional capitated rates for plans.
Stakeholder involvement	OHA was not consulted
Hospital or association challenges	Increased leverage for managed care, reduction in potential Upper Payment Limit (UPL).
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Yes
Goals/anticipated impact on hospitals/other providers	Potential reduction in supplemental Medicaid payments.
Association's experience to date	OHA and its members remain skeptical in benefits of managed care and will continue to monitor.
OHIO	
Redesign Categories	**Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	Catalyst for Payment Reform – CPR is an independent, national non-profit organization that leverages the collective strength of private- and public-sector health-care purchasers to achieve better value and quality in health care. Participants in CPR share the belief that payment reforms should promote health by rewarding the delivery of quality, cost-effective and affordable care that is patient-centered. Participants work to tailor payment strategies to improve the performance of the health-care system. In particular, CPR purchasers agree to use CPR's model health-plan contract language on payment reform to drive quality outcomes for consumers.
How established	Led by Governor's Office of Health Transformation to become first state Medicaid agency to contract with CPR
Status of Initiative	Currently being implemented

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

Timeline	3-5 years
Evaluation status	Measures are around what percentage of total payments to providers are based on value instead of volume.
Dedicated state resources	No
Stakeholder involvement	Select providers within association have been invited to participate on an advisory council.
Hospital or association challenges	Could potentially align public and private payers thereby minimizing hospitals' ability to negotiate.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	Open to all
Goals/anticipated impact on hospitals/other providers	Could potentially align public and private payers thereby minimizing hospitals' ability to negotiate.
Association's experience to date	Members are supportive but cautious.
OHIO	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	Mental Health Health Homes – patient-centered medical homes (as designated under the Affordable Care Act ACA)) for Severe Persistent Mental Illness (SPMI) patients meant to address both physical and behavioral health needs. Care managers will be embedded in Patient-Centered Medical Homes (PCMH) to provide intensive care coordination and develop an individualized care plan for each consumer to address both medical and non-medical needs.
How established	Governor Kasich's Jobs Budget (HB 153) authorized Ohio Medicaid to design a person-centered system of care, called a health home, to improve care coordination for high-risk beneficiaries. Ohio Medicaid teamed up with Ohio Department of Mental Health and Ohio Department of Alcohol and Drug Addiction Services to focus first on creating health homes for Medicaid beneficiaries with SPMI.
Status of Initiative	Ohio Medicaid received federal approval and in October 2012 began claiming enhanced federal match to pay for care coordination in SPMI-focused health homes.
Timeline	As of October 2012, it was first implemented in five Ohio counties, including Adams, Butler, Lawrence, Lucas and Scioto. Within a year, the benefit delivered by community behavioral health providers will be available statewide.
Evaluation status	The state's October 2012 State plan Amendment outlines plans for an evaluation.
Dedicated state resources	No
Stakeholder involvement	OHA participated in benefit design and establishing the requirements that health homes need to connect with hospitals.
Hospital or association challenges	Limitations of health homes to connect with hospitals electronically.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

Local, regional, or statewide	Initially this is a regional initiative.
Open to all or restricted to selected hospitals	Yes
Goals/anticipated impact on hospitals/other providers	Improved patient flow through the health care system, better disease management and potential decrease in emergency department usage.
Association's experience to date	Challenges with communicating with the mental health system but OHA members are unified.
Redesign Categories	**Dually Eligible Demonstration Capitated Model**
Brief Description of Initiative	The Centers for Medicare & Medicaid Services (CMS) and the State of Ohio, Office of Medical Assistance (State/Ohio Medicaid) will establish a Federal-State partnership to implement the Demonstration to Develop an Integrated Care Delivery System (Demonstration) to better serve individuals eligible for both Medicare and Medicaid. The Federal-State partnership will include a three-way contract with Integrated Care Delivery System (ICDS) Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic area(s).
How established	CMMI initiative
Status of Initiative	Ohio has an MOU with the federal government to proceed and has contracted with five Medicaid managed care plans in seven regions.
Timeline	Voluntary enrollment begins September 2013. The Demonstration will begin on September 1, 2013 and continue until December 31, 2016.
Evaluation status	Unknown
Dedicated state resources	No
Stakeholder involvement	The Area Agencies on Aging were involved in design and implementation.
Hospital or association challenges	Hospitals are skeptical of managed care benefits and are concerned about ability for Medicaid and Medicare to work together.
Local, regional, or statewide	Regional: Seven regions concentrated around urban areas.
Open to all or restricted to selected hospitals	All hospitals in the selected regions.
Goals/anticipated impact on hospitals/other providers	Unknown
Association's experience to date	OHA was marginally involved in design phase; mostly monitoring now.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

OHIO	
Redesign Categories	**Long-Term Care/Home and Community-Based Care**
Brief Description of Initiative	The state has budgeted more money for home and community-based care and less for nursing facility care in order to rebalance the system. In addition, the way nursing facilities are reimbursed has changed to include a performance quality incentive.
How established	Program was established through budget appropriations.
Status of Initiative	Nursing facilities have completed a biennium of performance payments.
Timeline	Performance measures have become more rigorous in the SFY 14-15 budget bill just introduced by the governor.
Evaluation status	The Administration has enhanced the tracking and sharing of data regarding nursing home quality so that policy makers, facilities and families receive regularly updated information. The Department of Health (ODH) is compiling facility survey, complaint and resident–assessment data into quarterly Nursing Home Tracking Reports.
Dedicated state resources	Redistribution of funds - no net increase.
Stakeholder involvement	No hospital involvement unless a hospital has a unit that provides nursing facility level of care.
Hospital or association challenges	None at this time
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	N/A
Goals/anticipated impact on hospitals/other providers	Could possibly reduce readmissions.
Association's experience to date	Monitoring

OHIO	
Redesign Categories	**CMMI State Innovation Multi-payer Model Design Project**
Brief Description of Initiative	State Innovation Model (SIM) Design Award -- Ohio will use the SIM grant to develop a comprehensive plan to expand the use of patient-centered medical homes (PCMH) and episode-based payments for acute medical events to most Ohioans who receive coverage under Medicaid, Medicare and commercial health plans.
How established	Response to CMMI grant, building off of payment reform work led by Governor's Office of Health Transformation
Status of Initiative	Grant was awarded in February 2013
Timeline	The state has 6 months to submit its plan to CMS.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

Evaluation status	N/A
Dedicated state resources	The state and its partners will contribute $4.1 million in funding and in-kind resources for the design phase of the SIM project.
Stakeholder involvement	Governor's Council on Payment Reform – certain providers invited
Hospital or association challenges	Defining parameters and logistics of episode based payments
Local, regional, or statewide	Intended to be statewide but is still in design phase
Open to all or restricted to selected hospitals	Assumed to be open to all but unknown at this time
Goals/anticipated impact on hospitals/other providers	Anticipate an overall reduction in reimbursements in certain types of episodes but remains to be seen how hospitals manage.
Association's experience to date	Members are supportive in movement to bundled payments but devil is in the details.
OHIO	
Redesign Categories	**Comprehensive Primary Care Initiative**
Brief Description of Initiative	The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare will work with commercial and state health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.
How established	CMMI initiative -- Section 3021 of the Affordable Care Act
Status of Initiative	Practices were selected through a competitive application process based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by accreditation bodies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure.
Timeline	The Initiative was announced in October 2011. The 500 Participating Primary Care Practices was announced in August 2012.
Evaluation status	Unknown
Dedicated state resources	No
Stakeholder involvement	One of our regional hospital associations was involved in planning.
Hospital or association challenges	Hospitals are further along with Health Information Technology than community providers.
Local, regional, or statewide	Regional
Open to all or restricted to selected hospitals	Limited to region

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Ohio Hospital Association)

Goals/anticipated impact on hospitals/other providers	Increase in appropriate use of hospital services
Association's experience to date	Positive

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Utah Hospital Association)

UTAH	
Redesign Categories	• **Global Budgeting/Payment** • **Accountable Care Organization** • **Shared Savings/Shared Risk** • **Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	Generally falls under a captivated ACO approach through 4 approved health plans. Operates on Utah's Wasatch Front which encompasses 4 large urban counties.
How established	State initiated but required an 1115 Waiver.
Status of Initiative	Initial implementation effective January 1, 2013.
Timeline	Ongoing program. Payments are now being made on a per member/per month (PMPM) basis. Plans are incentivized to move from fee-for-service (FFS) delivery on an encounter basis to a true managed care model where hospitals, physicians and plans share risk for unnecessary use of medical services. This transition in delivery will take months to implement.
Evaluation status	Too early to evaluate
Dedicated state resources	Yes. They have committed to keep aggregate Medicaid funding level at FY2012 level, to not claw back any savings the ACOs are able to achieve and to grow the future funding by increasing PMPM amounts at the average rate of growth for all other areas of the State budget.
Stakeholder involvement	UHA and Leavitt Partners have co-founded a Collaborative made up of all key provider groups, insurance plans, quality organizations, Health Data Organizations and key state officials to provide a robust policy/problem solving environment that will help all players stay focused on successful transition to sustainable ACOs.
Hospital or association challenges	There are many but key ones are to insure a true managed care delivery model exists when looking back in a year rather than a FFS approach under a PMPM reimbursement system, and how to engage physicians in a true risk sharing arrangement that will address excessive delivery of services.
Local, regional, or statewide	Operates on Utah's Wasatch Front which encompasses four large urban counties.
Open to all or restricted to selected hospitals	Operates on Utah's Wasatch Front which encompasses four large urban counties.
Goals/anticipated impact on hospitals/other providers	Potential impact is huge in a positive sense if real transformation can be accomplished. If successful in Medicaid population has additional potential in commercial market as well.
Association's experience to date	Too early to say.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Washington State Hospital Association)

WASHINGTON	
Redesign Categories	**Other: "ER is for Emergencies" Initiative**
Brief Description of Initiative	In 2011, Washington State's Medicaid agency announced it would stop paying for all "unnecessary" emergency room (ER) visits for Medicaid patients. As a means of avoiding this proposed payment cut, the Washington State Hospital Association, along with the medical association and emergency room physicians, negotiated with legislators in 2012 to require hospitals to adopt seven best practices to reduce unnecessary emergency room use. If enough hospitals attested to having adopted these practices by July 1, 2012, the no-payment policy would not go into effect. Although the budget proviso required hospitals representing just 75% of Medicaid ER visits to participate, 100% of hospitals with an emergency room in Washington State adopted these best practices before the July 1 deadline. The best practices included: • Adoption of an electronic system to exchange information about ER use, • Participation in the state's prescription monitoring program, • Adoption of narcotics guidelines, • Follow-up with primary care, and other practices. The best practices were expected to save $31.2 million over twelve months. Preliminary data show the program will save $33 million.
How established	Through a budget proviso adopted by the Washington State Legislature in 2012.
Status of Initiative	The program was fully implemented.
Timeline	April 2012 through October 2013. The budget proviso was adopted in April 2012. By July 1, 2012, 100% of Washington State's hospitals with an emergency room attested they had implemented the seven best practices required by the budget proviso. The state's Health Care Authority reported to the legislature on January 15, 2013 that the program is expected to save $33 million from July 1, 2012 until June 30, 2013. The Authority plans to issue a report in October 2013 concluding how much the program actually saved over this 12-month period.
Evaluation status	N/A
Dedicated state resources	No
Stakeholder involvement	The Washington State Hospital Association worked with the Washington State Medical Association, the Washington Chapter of the American College of Emergency Physicians, and state legislators and staff to adopt the 2012 budget proviso. The hospital association took the lead in getting our members to implement the seven best practices throughout the state. We also took the lead in gathering data to measure our success.
Hospital or association challenges	This initiative required an intense effort over a very short period of time. Hospitals and the association were given two and a half months to adopt the seven best practices or face a payment cut. Now that the seven best practices have been implemented and the savings have been achieved, we would like our state to improve access to primary care, expand behavioral health and chemical dependency services, and expand access to dental care to further reduce ER expenditures.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	All hospitals/health systems with an emergency room were allowed to participate, and 100% of them did participate.
Goals/anticipated impact on hospitals/other providers	The state is expecting to save $33 million for the July 2012 through June 2013 time period.
Association's experience to date	N/A

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Washington State Hospital Association)

WASHINGTON	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	In 2007, the state passed legislation for the state Medicaid agency to come up with a medical home initiative that paid for care management.
How established	In 2007, the state passed legislation for our state agency managing Medicaid to come up with a medical home initiative that paid for care management.
Status of Initiative	Implemented. The effort took nearly 4 years to get off the ground and negotiated between the participating parties.
Timeline	Start date was Spring 2011
Evaluation status	N/A
Dedicated state resources	No
Stakeholder involvement	We were not involved, but monitored the activities. We encouraged our members to apply.
Hospital or association challenges	N/A
Local, regional, or statewide	Local
Open to all or restricted to selected hospitals	Select group. The group included a couple of our health system's medical groups. The pilot developed a new payment mechanism to reward primary care practices for better outcomes through prevention of emergency room use and inpatient hospitalization. Participating primary care practices include: • Evergreen Primary Care Centers (Canyon Park and Redmond) • Overlake Medical Clinic (Bellevue) • Polyclinic (Downtown and First Hill) • Rockwood Clinic (Cheney and Medical Lake) • UW Medicine Kent/Des Moines Clinic (Kent) • Olympic Physicians (Shelton) • Valley Medical Group, Newcastle Primary Care and Covington Primary Care(Newcastle and Covington) • Summit View Clinic (Puyallup). Through the pilot, practices also receive a per member per month payment of $2.50 to help cover care management, expanded access and hours, registry maintenance and team management. Participating health insurers include: Aetna, Cigna, Group Health, Regence, Premera, Molina and Community Health Plan of Washington. These insurers are participating on behalf of commercially insured, Medicare Advantage, Basic Health and Healthy Options enrollees.
Goals/anticipated impact on hospitals/other providers	Unclear, but the goal is to reduce emergency department visits.
Association's experience to date	Initially, we put out information about the CMS rules, but we have not been participating in ongoing conversations with hospitals about the Medicare Shared Savings model.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Washington State Hospital Association)

WASHINGTON	
Redesign Categories	**Dually Eligible Demonstration—Capitated Model and Managed Fee-for-Service Model**
Brief Description of Initiative	In 2012, Washington submitted a proposal to CMS to participate in the dual eligible demonstration project outlined in the Affordable Care Act. Our state is pursuing both the fee-for-service and capitated model.
How established	State demonstration project. Washington was one of the initial states to receive a planning grant.
Status of Initiative	Development phase on capitated model (two counties); Implementation phase on fee-for-service model (CMS approval pending).
Timeline	Enrollment for fee-for-service model beginning July 1, 2013; Capitated model to begin on January 1, 2014 for two counties.
Evaluation status	N/A
Dedicated state resources	Yes, provided by the federal grant.
Stakeholder involvement	A select group of stakeholders sits on an advisory committee. We received updates from the project manager.
Hospital or association challenges	Communication and payment issues regarding this demonstration is challenging for the association. The state's project has been difficult to follow, even with the association being on the advisory committee. The general updates provided from the state do not include major discussion items like network adequacy questions. Instead, they focus on technical aspects of the conversations with CMS. In November, WSHA spent hours reviewing the 3-way draft contract language that was not acceptable to hospitals/health systems. We are still waiting for the last draft of the contract. The first draft contract inadvertently would have paid hospitals Medicaid rates for the duals population. We are still optimistic that this effort will be better for patients and produce better outcomes.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	All hospitals/health systems, but they needed to express interest.
Goals/anticipated impact on hospitals/other providers	The state is expecting to save $4 million in the next biennial budget (2013-2015). This reduction is expected to materialize through lower emergency room use and the sharing in savings with Medicare.
Association's experience to date	Hospitals could participate in the duals project as "care coordinators" or the lead entity establishing the networks for care. To date, only a small handful of hospitals have expressed interest in this work.
WASHINGTON	
Redesign Categories	**CMMI State Innovation Multi-payer Model Testing Project**
Brief Description of Initiative	In 2012, the Washington State Health Care Authority submitted a CMMI grant proposal to build statewide accountable care organizations using a multi-payer collaborative approach that changes how health care is provided and paid.
How established	Washington State applied for a CMMI grant in 2012 and received a $1 million grant in February 2013. The state plans to apply for another CMMI grant in 2013.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Washington State Hospital Association)

Status of Initiative	CMS awarded Washington State with a $1 million "Model Pre-Testing Award" to continue developing a comprehensive State Health Care Innovation Plan that will improve care and lower costs through an integrated care approach. The state plans to use the $1 million grant to continue working on its comprehensive plan and resubmit it back to CMS for further consideration.
Timeline	The grant began April 1, 2013 with the state submitting a comprehensive plan to CMS in 6 months.
Evaluation status	Just began in April 2013
Dedicated state resources	Yes, Washington State's Health Care Authority appointed Ms. Karen J. Merrikin, an attorney who recently worked as a Senior Strategic and Health Reform Consultant with Group Health Cooperative, to lead its State Innovations Model project effective April 1, 2013.
Stakeholder involvement	The state will be seeking input from stakeholders including WSHA in completing its 2013 comprehensive grant application. In its 2012 grant proposal, the state received 81 endorsement letters from stakeholders including providers, carriers, employers and other organizations. In the 2012 state grant proposal, WSHA would work with the Washington State Department of Health to coordinate, disseminate and promote quality of care delivery and payment improvement.
Hospital or association challenges	There are two challenges with the 2013 comprehensive grant application: (1) It may be difficult to garner input from stakeholders given the requirement to resubmit a comprehensive plan in 6 months. (2) It is unclear how the state plans to address access in rural health care. In its 2012 grant proposal, the state didn't focus on transforming rural health care.
Local, regional, or statewide	The 2012 grant request was a statewide initiative. WSHA assumes that the state will be submitting a statewide initiative in 2013.
Open to all or restricted to selected hospitals	It is open to all hospitals. However, the state didn't account for the differences in urban and rural hospitals in its original 2012 grant proposal. It is WSHA's hope to include a rural perspective in the 2013 comprehensive grant application.
Goals/anticipated impact on hospitals/other providers	Hospitals and other providers will face different payment models under the state's envisioned goal. There will be much more focus on developing and implementing a bundled payment model in which a single payment will be given to providers for an episode of care. There will also be more focus on transparency, requiring hospitals and other providers to disclose pricing information and outcome data so that purchasers and consumers can make better health care decisions.
Association's experience to date	While there is interest among WSHA's members to address both payment reforms and transparency, there is no unified position on either issue. Nevertheless, WSHA is moving forward to help its members understand the ramifications of these changes on how they operate and are paid in the future.
WASHINGTON	
Redesign Categories	**Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	In 2012, the Washington State legislature enacted legislation to provide non-critical access hospitals a one percent increase in Medicaid payment for meeting benchmarks on five outcome measures through the Washington State's Medicaid Quality Incentive program.
How established	Washington State passed legislation in 2010 requiring a Medicaid Quality Incentive program. State plan was submitted and approved.
Status of Initiative	It is an ongoing program in which non-critical access hospitals receive a one percent increase in Medicaid inpatient reimbursements for meeting the state's benchmarks on five outcome measures.
Timeline	Quality measures developed for calendar year 2011 and payment increases effective for state fiscal year 2013.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Washington State Hospital Association)

Evaluation status	Hospitals required to receive acceptable scores on benchmarks in five outcome metrics: health care worker flu immunization, patient discharge information, elective deliveries prior to 39 weeks, preventable ER visits and justification for discharging patients with antipsychotic medication.
Dedicated state resources	Yes, payment is funded in part from hospitals contributions and federal matching dollars.
Stakeholder involvement	WSHA was very involved in working with the state to determine the measures selected. WSHA was involved in collecting and analyzing data for some of the measures as well as assisting hospitals comply with the program's requirements. WSHA organized and sponsored outreach and educational materials to hospitals.
Hospital or association challenges	The 2010 statute will sunset in July 2013. The Washington State legislature is considering continuing the program in the current legislative session. WSHA is working with the state to determine what type of incentives or measures will be used if the program is reauthorized.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	It is open to all non-critical access hospitals in the state.
Goals/anticipated impact on hospitals/other providers	Almost all eligible hospitals were able to receive the one percent increase in payments and considerable progress was made on the quality measures selected.
Association's experience to date	WSHA worked with its members in implementing the project and determining the quality measures selected.

State Medicaid Redesign Initiatives

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(All information was provided by the West Virginia Hospital Association)

WEST VIRGINIA	
Redesign Categories	• **Medicaid Managed Care Expansion** • **Medical Homes Initiatives**
Brief Description of Initiative	N/A
How established	Medical Homes is a state-based initiative that is currently in the state plan amendment development stage.
Status of Initiative	N/A
Timeline	N/A
Evaluation status	N/A
Dedicated state resources	No special funding that we are aware of.
Stakeholder involvement	N/A
Hospital or association challenges	N/A
Local, regional, or statewide	Statewide

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Wisconsin Hospital Association)

WISCONSIN	
Redesign Categories	**Pay for Performance/Value-based Purchasing**
Brief Description of Initiative	The Department of Health Services withholds 1.5% on each fee-for-service Medicaid claim for hospitals. The withheld amount is returned to the hospital if the hospital meets certain performance measures. Any funding not returned to the hospital is used for bonuses for other hospitals that met or exceeded performance criteria.
How established	State Plan Amendment
Status of Initiative	Implementation
Timeline	The first year measurement period is complete. The first year payout is expected at the end of the calendar year. The second year measurement period has begun.
Evaluation status	N/A
Dedicated state resources	Yes, state contracted staff work on development of measures, monitoring and reporting.
Stakeholder involvement	WHA had significant involvement in the planning. In the first year, WHA successfully delayed the implementation until appropriate measures could be obtained, communicated and planned for by hospitals.
Hospital or association challenges	1. Lack of state expertise in quality reporting and measurement. 2. In the planning phases, WHA had to convey our key principles, one of which was that the measures should not result in greater administrative burden for hospitals, and the program should seek measures within the control of the hospitals. Thus far, WHA has been able to ensure measures are both within the control of the hospital and are consistent with other measures that hospitals already have to report. 3. Measurement is only for fee-for-service Medicaid. Given the large percentage of the Medicaid population enrolled in managed care, it is difficult to find appropriate measures of a sufficient sample size for all hospitals. Many rural hospitals have only one applicable measure. 4. Hospital Medicaid payments in the state are low. This is coupled with the fact that measurement is for fee-for-service Medicaid only. Therefore, it is highly questionable that a pay-for-performance program such as this will really drive change. It is important that the program not grow to a significant number of measures, not become administratively burdensome for hospitals and not result in significant loss of already minimal payment.
Local, regional, or statewide	Statewide
Open to all or restricted to selected hospitals	As noted above, all hospitals are subject to the pay for performance program, but measurement is only for fee-for-service Medicaid. Given the large percentage of the Medicaid population enrolled in managed care, it is difficult to find appropriate measures of a sufficient sample size for all hospitals. Many rural hospitals have only one applicable measure.
Goals/anticipated impact on hospitals/other providers	Statewide the program is supposed to be budget neutral. Depending upon how any individual hospital performs, funding could be somewhat redistributive.
Association's experience to date	Collaboration has been good as WHA has worked with hospitals and the Rural Wisconsin Healthcare Cooperative to provide measures to DHS for their consideration. Member unity is good given the limited scope of the program. However, it is important to note that there is high skepticism of the program making a difference, given the reasons noted.
WISCONSIN	
Redesign Categories	**Medical Homes Initiative**
Brief Description of Initiative	The Department of Health Services has been seeking to implement one or more medical homes for various Medicaid population groups. Projects were approved by the legislature last year, most of which were never implemented. One project in the Milwaukee area – a medical home initiative for foster care children – has just begun.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Wisconsin Hospital Association)

How established	State initiated innovation and State Plan Amendment
Status of Initiative	Planning phase for most population groups. Implementation phase for a medical home initiative for foster care children.
Timeline	No set timeline has been established.
Evaluation status	N/A
Dedicated state resources	No funding, but some resources.
Stakeholder involvement	The state Department of Health Services has worked with various hospitals throughout the state. Other stakeholders have an interest as well, but there is no statewide group with regular meetings to discuss medical home initiatives.
Hospital or association challenges	1. Lack of state expertise and data to understand key population groups. 2. An interest by the state in showing savings to the Medicaid program from medical home initiatives upon implementation. It is important for the state to understand that initially there may be added costs for the coordination of care that needs to occur. Only after a period of time should the state consider program savings.
Local, regional, or statewide	Various projects are being contemplated for various population groups. These may ultimately result in local, regional or statewide initiatives.
Open to all or restricted to selected hospitals	Various projects are being contemplated for various population groups. These may ultimately result in local, regional or statewide initiatives that are open to all or a more limited number of hospitals.
Goals/anticipated impact on hospitals/other providers	Hospitals and other providers are very interested in models that better align and coordinate care.
Association's experience to date	The Medicaid medical home initiatives are targeted for specific fee-for-service Medicaid population groups. Given the low volumes, and difficulty in accessing data from the state, it is difficult to get members interested in participation.
WISCONSIN	
Redesign Categories	**Dually Eligible Demonstration Capitated Model**
Brief Description of Initiative	Capitated model for the provision of Medicare- and Medicaid-funded care to persons residing in nursing home settings.
How established	CMMI Initiative
Status of Initiative	CMS approval pending
Timeline	Unknown, pending CMS approval.

State Medicaid Redesign Initiatives

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(All information was provided by the Wisconsin Hospital Association)

Evaluation status	N/A
Dedicated state resources	Yes, the state has dedicated staff resources
Stakeholder involvement	Several stakeholder groups have been included in regular meetings over the past year. Stakeholder reaction is mixed. WHA has had limited involvement thus far, given the limited scope of the proposal (limited to Medicaid fee-for-service institutional populations – about 15,000 people).
Hospital or association challenges	Initially, the impact on hospitals is limited, given the limited population scope. The challenge is in maintaining an understanding of this project, without spending a significant amount of time now, but being prepared in the event the proposal is modified significantly.
Local, regional, or statewide	A three-year phased approach is planned, beginning in Southeast Wisconsin and eventually reaching statewide.
Open to all or restricted to selected hospitals	N/A
Goals/anticipated impact on hospitals/other providers	Initially, the impact on hospitals is limited, given the limited population scope.
Association's experience to date	Given the myriad of issues members are currently facing, this project has been seen as a lower priority.

State Medicaid Redesign Initiatives

April 2013 Survey Responses

(All information was provided by the Wyoming Hospital Association)

WYOMING	
Redesign Categories	• **Global Budgeting/Payment** • **Care Coordination Approach** • **Bundled Episode Payment** • **Medical Homes Initiative** • **Dually Eligible Demonstration Capitated Model** • **Longer Term Care/Home and Community-Based Care** • **Incentives for Prevention of Chronic Diseases**
Brief Description of Initiative	All components currently under evaluation result from the extensive provisions included in legislation advanced in the 2013 General Session of the Wyoming Legislature. Original Senate File 60 – Enrolled Act No. 82 provides multiple point references toward the Wyoming Department of Health in addressing and evaluating all aspects of reform and redesign of the Medicaid program, including each of those areas identified above.
How established	Via directives in the new 2013 legislation, the Wyoming Department of Health (WDH) will proceed with a reform and redesign of the Wyoming Medicaid program to include the elements that were identified by the department in its final report on the Medicaid options study performed pursuant to 2012 legislative directive, with additional support and direction endorsed by the Governor's office as well.
Status of Initiative	The initial components of evaluation and analysis will be monitored by the Joint Labor, Health and Social Services Committee (LHSS) of the Legislature (first interim session to be held June 4-5, 2013).
Timeline	Following the June 4-5 interim session – the sequence of interim reports will be delivered by the Department at interim meetings August 26-27 and again November 4-5. The Department is charged to deliver formal preliminary report to be dated October 1, 2013 that will be reviewed at the November 4-5 session.
Evaluation status	Per all aspects of what is to be determined via the directives of the 2013 legislation referenced above – the June 4-5 Joint LHSS Committee meeting will be the first official indication of status.
Dedicated state resources	Yes, per the provisions of the 2013 legislation cited here – a relatively small appropriation of $120,000. This funding is dedicated for the WDH for purpose of studying and developing an implementation plan for Medicaid reform pursuant to the legislation. The funding is for a period to conclude June 30, 2014. The WDH does have the authority to contract with experts and consultants as may be useful in conducting any study provided or commissioned per the legislation.
Stakeholder involvement	We expect that various avenues for involvement will indeed be available to WHA and other provider organizations. We have a standing monthly meeting with the WDH Director and his senior staff, so will certainly expect that to be a regular forum in which to have discussion and dialogue take place of this subject of potential Medicaid reform and redesign. In addition, per the legislation specifically, the WDH is directed to formally hold a minimum of two information meetings to provide opportunity for clients, guardians and service providers affected by proposed program changes. The Department held a number of public forums and provider forums in 2012 within the context of discussion of Medicaid options study, which serves as somewhat of a precursor to the next steps identified by the 2013 legislation that is referenced and cited here. We have been given indication that similar format will be implemented for upcoming public and provider input and consult.
Hospital or association challenges	In discussions with WHA member hospitals, it is clear that the State's interest in investigating various aspects of a managed care program is of primary concern. Wyoming is one of only a small handful of states that currently has no real 'managed care' presence – from Medicaid considerations or otherwise. WHA is aware, as our members are as well, that a move to a more value-driven program is inevitable. The reform/redesign considerations identified by the current legislation, as such, is not necessarily alarming; It simply identifies the growing intent and necessity to find balance in cost/quality/access for all providers and within a conservatively managed state budget. Hospitals in Wyoming are increasingly looking to the 'triple aim' focus in all regard, with commitment to patient-centered medical home modeling, effective work in care transitions, value-based practices underway on a variety of levels involving hospitals, physician practices and other provider groups.

State Medicaid Redesign Initiatives

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(All information was provided by the Wyoming Hospital Association)

Local, regional, or statewide	For the most part, these efforts are driven by statewide interest and initiative, but often implemented on a local or regional level to begin – ahead of transitioning to full engagement by all hospitals. As a subset of hospitals, programs and projects that are specific to Critical Access Hospitals (CAHs) are sometimes treated separately as a CAH network plan. WHA also has a select few for-profit hospitals within the membership, which obviously causes some degree of differing concern and perspective from the majority of hospitals in the state.
Open to all or restricted to selected hospitals	As pertains to hospitals and WHA member interests, for the most part, we are a relatively homogeneous in our perspective. The two larger regional medical centers have formed what is titled "Wyoming Integrated Care Network", so that indeed represents an organized initiative that is to some degree exclusive. Patient-centered medical home modeling and preparations have been the primary focus of this group to date and does indeed have practical application to that aspect of potential interests of the Medicaid reform/redesign efforts being considered.
Goals/anticipated impact on hospitals/other providers	At this very early stage of analysis and evaluation being given by the WDH in these Medicaid reform/redesign endeavors, it is generally premature in the moment to have any legitimate or tangible projections of specific impacts at this time.
Association's experience to date	Yes, WHA membership is very engaged and mindful of the wide variety of potential reform and/or redesign elements to be considered by our Department of Health. We obviously followed the legislation very carefully though the 2013 legislative session, gave appropriate testimony in several committee hearings, provided input on several occasions of suggested amendment language. As a result, our WHA membership is generally very well-versed in the dynamics of the legislative intent and the manner in which the WDH, the Joint LHSS Legislative Committee and the Governor's Office plan to carry forward with this evaluation and analysis. In our role in providing diligent advocacy representing our member hospitals, it will clearly be very important for us to stay abreast of the work that lies ahead, both formally and informally, in assuring that the specific interests of hospital providers are represented and understood by those that will be considering revamped Medicaid policy in our state.