COORDINATED CARE

AN OPPORTUNITY TO TRANSFORM MEDICAID

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TABLE OF CONTENTS

COORDINATED CARE

INTRODUCTION

Care coordination improves the quality of health care and reduces costs for high-needs patients.

Medicaid, which helps low-income individuals and families pay for costs associated with medical care, continues to grow year over year while the quality of care for these patients remains unsatisfactory. Dual eligibles, those that are eligible to receive both Medicaid and Medicare (typically the population of individuals 65 years of age and older and certain younger people with disabilities), are particularly vulnerable to poor care coordination as they usually require more medical assistance, have varying payment models between acute and long-term care, and require increased communication between physicians and providers. This fragmentation of care delivery is a major driver of poor quality as well as high costs. Research shows that coordinating care can be transformative, especially when targeted towards these costliest patients. This population often has chronic and co-occurring conditions and must navigate multiple health care systems to receive care. Coordinated care creates positive change for these individuals while reducing Medicaid costs. Currently, no long-term pilot study has been conducted through a state or a small group of states that aims to uncover the impact of coordinated care for Medicaid patients on health outcomes and costs. Specifically, targeting patients with co-occurring, chronic conditions, this study could focus on evaluating the benefits of coordinated care for those with:

- Multiple physical health illnesses
- Multiple chronic conditions including a physical health illness and a mental health illness

Achieving the goals of better coordinated care could have a dramatic impact on the health outcomes of individuals served by Medicaid programs. The following research paper specifically outlines the current coordinated care landscape as well as several initiatives being implemented across the country. Although improved healthcare delivery requires a multifaceted approach, coordinated care is an important way to control costs while delivering improved services for vulnerable and needy patient populations. However, studies on the effectiveness of care coordination have been limited because they target small populations or have difficulty determining the impact on quality of health and cost savings. The aforementioned pilot could show that care coordination can create transformative, scalable and sustainable change for Medicaid patients with the greatest needs.

OVERVIEW

In 2013, the United States spent $2.9 trillion on health care, which made up 17.4 percent of gross domestic product (GDP). Although spending is higher in the U.S. compared to other countries, quality of care is lower in several outcome measures. One major driver of this health care inefficiency is fragmentation in the current system. When providers are paid by service rather than by patient or outcome, there is little incentive to meet patient needs efficiently and to coordinate with other providers. Experts estimate between $158 and $226 billion is lost annually due to overtreatment from lack of care coordination. Surveys show 32 percent of adults reported receiving unnecessary care and 42 percent of physicians thought patients in their own practices received too much care. Further, uncoordinated care can lead to preventable medical errors, which have been estimated to have cost $17 billion in spending in 2008. Finally, fragmented payment and care delivery leads to more paperwork and administrative costs, which are estimated to be between $156 and $183 billion annually.

While the entire health care system could benefit from coordinated care, Medicaid's size and scope make it a logical place to start. Medicaid is the largest payer in the U.S. and covers 68 million Americans, or about 21 percent of the population. Accordingly, the costs are also significant, expected to exceed $500 billion in 2016 and reach $650 billion by 2020. Medicaid spending is the largest or second-largest line item in all state budgets and accounts for an estimated 26 percent of total state spending in 2014.

Coordinated care is a powerful alternative to the current system for improving care and reducing costs for a complicated network of Medicaid participants. This new model is especially important for individuals with co-occurring conditions, who would have to navigate between multiple systems, providers and plans. Out of those dually eligible for Medicaid and Medicare, 60 percent suffer from multiple chronic conditions. Although they represent about 15 percent of the Medicaid population, they account for almost 40 percent of Medicaid spending. In general, those with chronic conditions require more complex health services. Forty percent of the Medicaid population has at least one chronic condition, yet they make up 79 percent of Medicaid spending. Since Medicaid reimburses specialists and primary care physicians (PCPs) at a rate lower than private payers, some Medicaid patients cannot access a physician office regularly. In 2011, 31 percent of physicians refused to accept new Medicaid patients. Those who are unable to access care resort to hospital emergency room (ER) visits, which are much more costly.

Behavioral health issues also complicate the care landscape and put pressure on the current system. In a given year, about 25 percent of American adults suffer from a diagnosable mental disorder, while 17 percent suffer from a co-morbid mental and medical condition. Mental illness can worsen the health of those with chronic conditions. Unfortunately, a large proportion of the nation's poorest suffers from mental illness. In 2009, the U.S. spent $172 billion on behavioral health care, including mental health and substance abuse services, with Medicaid financing the largest portion at 26 percent. Almost half of Medicaid patients are being treated for a mental health illness.

With such widespread inefficiency in care delivery and rising care costs, there is considerable potential to improve the U.S. health care system. Although care coordination is one piece of the health care delivery ecosystem, improvements for Medicaid's costliest patients, those with multiple chronic conditions, can help transform the system into a much more sustainable one. Various states and organizations have started to move towards better coordinated care for patients with complex needs. This shift has shown that care coordination can help to improve the quality of health care and reduce health care costs. A pilot study on coordinated care could advance research in this area as past studies have had limitations in scale and rigor.

WHAT ARE THE CHALLENGES WITHIN THE CURRENT PHYSICAL HEALTH SYSTEM?

One of the major challenges within the current physical health system is creating meaningful Medicaid payment reforms while managing budget restraints, complex patient populations, and diverse sets of stakeholders with contradictory goals. A recent study by the Medicaid and State Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) entitled "Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States" analyzed the challenges and opportunities for payment models in four states – Arkansas, Minnesota, Pennsylvania and Oregon. The findings included several themes that were consistent in each location:

- Budget pressures provided impetus for Medicaid payment reform in these four states, but the subsequent reforms serve a broader purpose and do not necessarily lead to immediate savings.
- The states continue to grapple with how to target Medicaid cost drivers within payment reform models.
- Results of the states' Medicaid payment reforms are largely unavailable at this point.
- Current federal authorities appear to be sufficiently flexible for these states.
- The states are taking an active role in payment care delivery reform beyond traditional Medicaid managed care, but changes in roles for Managed Care Organizations (MCOs) vary.
- These states' Medicaid payment reforms aim to directly influence provider behavior.
- Improved data is key to reform success, but requires significant investment.
- Each state pursued a reform model suited to its market characteristics and environment.
- In securing stakeholder buy-in, these states have balanced flexibility with accountability on multiple levels.
- Designing and implementing payment reform requires important state investments in staff, time and resources.

Since the study referenced above was issued, we have learned that Pennsylvania has issued a request for proposals (RFP) for its physical health MCOs. Included in the RFP are specific MCO targets for payment percentages that must be included in order to pay for "value" versus the standard fee for service. In the RFP, the Commonwealth defines Value-Based Purchasing Strategies as a model which aligns more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality. The Commonwealth is proposing to set goals so that by 2019, 30 percent of the medical portion of the capitation and maternity care revenue rates must be expended through value-based purchasing strategies. Value-based purchasing strategies such as gain-sharing contracts, risk contracts, episodes of care payments, bundled payments and contracting with Centers of Excellence and Accountable Care Organizations will meet this criteria.

The table below shows a detailed view of each state's payment model including which players bear the most risk:

MODEL	PAYER PARTICIPATION	RISK-BEARING ENTITIES	NATURE OF FINANCIAL RISK
ARKANSAS' PAYMENT IMPROVEMENT INITIATIVE (APII)			
Episode-based payments	Medicaid and two commercial payers - Arkansas Blue Cross Blue Shield and QualChoice	Physician practices, hospitals, and other providers	Upside and downside risk. Shared savings bonus or payment back to state based on cost and quality thresholds designated for each type of episode.
MINNESOTA'S HEALTH CARE DELIVERY SYSTEMS (HCDS) DEMONSTRATION			
ACOs with shared savings/risk	Medicaid only (but modeled after the Medicare Shared Savings Program)	Integrated health care delivery systems; primary care or multispecialty provider organizations	Upside and downside risk. ** Shared savings bonus or payment back to state based on Total Cost of Care (TCOC) calculations for core set of Medicaid services.
OREGON'S COORDINATED CARE ORGANIZATION (CCO) PROGRAM			
Community-based approach	Medicaid only (but modeled after the Medicare Shared Savings Program)	Community-based organizations	Upside and downside risk based on covering comprehensive benefit set for defined populations within specific budgets.
PENNSYLVANIA'S PAYMENT REFORM AND TARGETED PAYMENT ADJUSTMENTS			
Pay-for-performance program	Medicaid only	Managed Care Organizations (MCOs) and contracted providers	Mostly upside risk based on quality thresholds for certain health conditions/health care utilization
Targeted payment adjustments	Medicaid only	MCOs and hospitals	Efficiency adjustments: Downside risk for MCOs based on calculation of potentially inefficient care in claims analysis. Hospital payment policies: Downside risk for readmissions within 30 days and for serious adverse events.

*As of fall of 2013.

**Downside risk phased in for integrated delivery systems only.

Additionally, the traditional fee-for-service model used throughout the U.S. physical health system presents physicians with little incentive to meet all the needs of their patients. The fragmentation in the system results in insufficient coordination between primary care physicians and specialists. These issues have a greater effect on those patients with co-existing conditions:

- Quick doctor visits averaging 15 minutes are not enough for patients with complex problems.
- Time is needed to discuss symptoms, concerns, the diagnosis and medications; promote preventive care; and ensure patient understanding.
- Socially disadvantaged patients may have more health problems and gaps in understanding due to differences in race, language, culture and health literacy.
- Those with co-existing conditions typically require more intensive support and supervision, staff with increased levels of skill and experience, professionals with specialized clinical expertise, comprehensive service coordination and monitoring, the presence of consistent back-up and support, and living arrangements that serve fewer people.
- The reimbursement structure often does not cover the costs of primary care's prevention, management and coordination functions.
- Those who do not have ready access to primary care providers, whether physically or financially, may seek treatment at an emergency room, with some delaying needed care for minor conditions until they become serious and more costly to handle.

These challenges can be addressed through coordinated care, which promises better primary care delivery to improve the quality and reduce the costs of health care.

WHAT IS COORDINATED CARE?

Improving care for socially disadvantaged patients (i.e. those on Medicaid) with complex problems not only requires more time, but a more patient-centered, whole-person approach. Better care coordination is one potential solution for the fragmented, payment-oriented system in which patients with complex needs currently receive care. The Agency for Healthcare Research and Quality (AHRQ) broadly defines care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services [by] marshaling personnel and other resources needed to carry out all required patient care activities." There is no one standard definition of care coordination, but many include these key features:

- Comprehensive: All services a patient receives, including services delivered by systems other than the health system, are to be coordinated.
- Patient-centered: Care coordination is intended to meet the needs of the patient and the family, both developmentally and in addressing chronic conditions.
- Access and Follow-up: In addition to connecting patients and their families to services, care coordination is also intended to ensure that services are delivered appropriately and that information flows among care providers and back to the primary care provider.

Care coordination can include activities such as cross-checking that plans and prescriptions fit together, making sure patients take their medications, and helping patients find stability through a consistent set of doctors.

Current studies by the Medicare Coordinated Care Demonstration program show significant improvement in spending and hospitalization rates when targeting the most costly patients. Although coordinated care can initially increase costs due to additional care management activities, doctors are better able to prevent emergency room and hospital visits as well as provide preventive care. Integration of care can help improve patient engagement and better address their needs. However, it is difficult to estimate the impact of care coordination services on health care costs since it is impossible to measure the costs that would have occurred if not for the program. The Medicaid pilot study can play a key role in determining the quality measures to demonstrate the true impact of coordinated care on the current system.

PHYSICAL HEALTH: COORDINATED CARE MODELS AND STUDIES

Coordinated care that targets the costliest patients and uses a whole-patient approach has been shown to improve patient health care and reduce costs in the physical health realm. The next two sub-sections highlight the studies that support this conclusion, and the third sub-section introduces the critical concept of replication and scaling.

TARGETING THE COSTLIEST PATIENTS

Hot spotting, or targeting the costliest patients, helped physician Dr. Jeffery Brenner reduce costs for Camden, New Jersey's medical facilities.

- His approach targeted the top one percent of the individuals using Camden's medical facilities, or about 1,000 people, who made up 30 percent of its costs.
- For the first 36 patients, hospital and emergency room visits decreased 40 percent, while hospital bills decreased 56 percent from an average of $1.2 million per month to just over $500,000.

TAKING A WHOLE-PERSON APPROACH

In Atlantic City, New Jersey, Rushika Fernandopulle runs the Special Care Center, a clinic serving one-third of the costliest 10 percent of a local casino workers union, which opened in 2007. By caring for its patients on a whole-person level, the center is able to provide enhanced care.

- The center charges a monthly fee per patient instead of per office visit so doctors focus on service and patients can come in as much as they need.
- Health coaches work with patients on an ongoing basis to review progress and discuss next steps in treatment.
- After a year in the program, the 1,200 patients saw a decrease in hospital and emergency room visits by 40 percent and in surgical procedures by 25 percent. Patients with high cholesterol saw an average 50-point decrease in their HDL levels. Sixty-three percent of smokers with heart and lung disease quit smoking.
- While it was difficult to determine through the study whether this clinic reduced costs, especially due to the small sample size, by comparing this group of union workers with a similar group in Las Vegas, an economist found a 25 percent reduction in costs.

CREATING A REPLICABLE MODEL

Dr. Fernandopulle founded Iora Health in 2012 in New Orleans, Louisiana, and now serves as its chief executive to scale the practice across the country. Iora Health has 11 practices and plans to open at least 10 more in 2015.

- Iora's practices partner with employers, health insurance companies and private Medicare plans, rather than accepting all patients.
- Iora's small size makes it hard to conduct a cost savings analysis with statistical significance.
- Iora reported that one of its practices saw a decrease in total spending of 12 percent and in hospitalizations of 37 percent compared with a control group, but could not report which practice due to confidentiality with the sponsor.

Although these physical health models show transformative change, the next challenge is to scale these operations, as Iora Health is attempting by opening more practices.

BEHAVIORAL HEALTH ISSUES

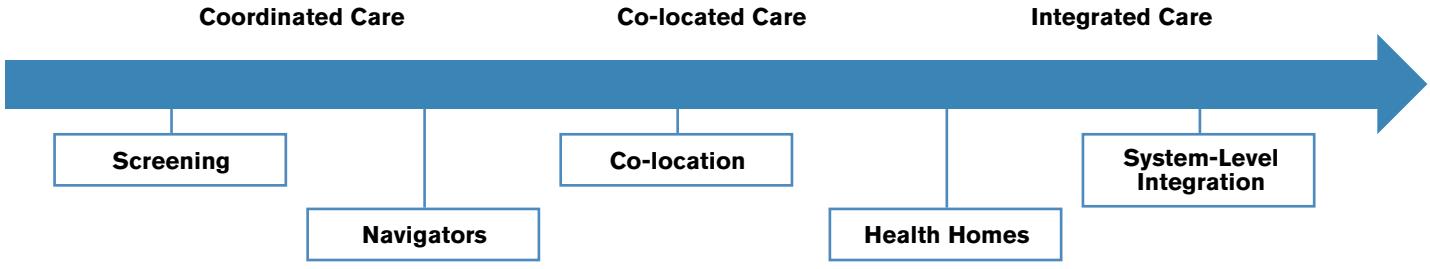
According to a 2006 report by the National Association of State Mental Health Program Directors, adults with serious mental illness (SMI) have much higher risk factors from preventable conditions such as cardiovascular and pulmonary disease. On average, they die 25 years earlier than the general population. They also have higher rates of substance abuse, smoking, obesity, homelessness, and poverty. However, the mental health, physical health and substance abuse systems are all separate, which can lead to inadequate care.

Mental illness is twice as prevalent among Medicaid participants as the general population. About 49 percent of Medicaid patients with disabilities have a psychiatric illness. Medicaid is a major source of spending for mental health services and is the largest single spender in public mental health services. It makes up over 25 percent of the nation's spending for behavioral health care. Various Medicaid directors and states have started pursuing better coordination between physical and mental health care systems since Medicaid is the largest driver of behavioral health care spending for those with SMI.

SUCCESSFUL MEDICAID MODELS FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

Two themes emerge in integrating physical and behavioral health (mental health and substance abuse) services — the importance of identifying all of a patient's health care needs and person-centered care. The Kaiser Family Foundation compiled Medicaid models that show successful strategies in integrating physical and behavioral health systems, connecting each to one of five approaches along a continuum of integration (see figure below). The following five sub-sections each summarize one of the approaches.

CONTINUUM OF PHYSICAL AND BEHAVIORAL HEALTH CARE INTEGRATION



30 states and the District of Columbia offer "Certified Peer Specialists," mentors who have personal experience with behavioral health needs and who have been trained and certified to help patients, while working under professionals.

UNIVERSAL SCREENING

Having physical and behavioral health providers screen for conditions in the other category increases early identification of conditions. It is more common for primary care physicians to screen for behavioral health issues.

- > 1 million children and adolescents experience problems suggestive of a pre-psychosis risk state.
- Early intervention may prevent the onset of psychosis among at-risk individuals.
- Individuals getting treated for one diagnosis may develop another.

NAVIGATORS

Navigators help patients understand and utilize the system by seeking care, interacting with providers and improving the overall support received. They can be nurses, social workers, or trained professionals who help to build patient engagement. The following programs demonstrate how navigators play a key role in the coordinated care process:

- "Wellness Recovery Teams" piloted in Montgomery County, PA use a navigator model.
  - **Navigator teams**: A registered nurse (RN) and a health professional, both with behavioral health training and experience
  - **Target population**: Adults with SMI and at least one chronic medical condition
  - **Method**: Create a virtual multidisciplinary treatment team by building relationships with all professionals involved in the patient's care
  - **Responsibilities**: Review client medications and reconcile if necessary, provide clinical insights and behavioral health consultations to the primary care physicians, coach patients before medical visits about what to expect and what information to share
  - **Results**: First six months of pilot compared to preceding six months show:
    - Emergency room visits fell by 11 percent
    - Psychiatric and medical inpatient admissions fell 43 percent and 56 percent
    - 90 percent made progress toward recovery from substance abuse
    - 44 percent of patients reported improved health
- 30 states and the District of Columbia offer "Certified Peer Specialists," mentors who have personal experience with behavioral health needs and who have been trained and certified to help patients, while working under professionals.
  - Experience and relatively low cost allows them to give more face time.
  - Peers may help patients recently discharged from mental hospitals find housing, employment and social support to prevent readmission.
  - Peers also provide health coaching to help patients improve and maintain physical health.
  - A study of 80 patients showed an improvement in self-management capacity — the ability to manage their illness and health behaviors — of 7.7 percent versus a decline of 5.7 percent for the control group.

CO-LOCATION

Having physical and behavioral health care at the same site may remove a significant barrier that some patients face in receiving multiple services.

- The Affordable Care Act (ACA) created a five-year $11 billion trust fund for health centers, allowing them to expand their medical, oral and behavioral health services. Some health centers offer broader services to treat individuals with more serious and chronic mental health illnesses.

- Genesee Health System's health center and Hope Network, a human services agency mainly serving low-income populations, are located on a shared campus in Michigan.
    - Hope Network connects patients with primary care providers in the health center, who share patient medical information and coordinate treatment plans with Hope Network.
    - Hope Network's navigator teams monitor and support clients who receive care at the health center, and connect patients with specialty care and community-based services.
    - Psychiatric inpatient admissions per person per year fell from an average of 1.95 to .48.

HEALTH HOMES

Health homes are an approach to patient care delivery that are patient-centered, coordinated across the health care system, and administered by a team of professionals led by a patient's primary care physician. Health homes are a new Medicaid state plan option established by the Affordable Care Act for individuals with complex conditions and needs. Health homes help these patients receive comprehensive care management, transitional care, and referrals to community and social services.

- This model emphasizes a strong primary care foundation, which has been shown to reduce costs, hospitalizations, and emergency department use and to improve the quality of care.
- Health homes are an outgrowth and enhancement of Patient-Centered Medical Homes (PCMH).
    - A single clinician assumes responsibility for coordinating care.
    - They provide access to primary health care teams built around patients' needs.
    - Both health homes and PCMHs provide care coordination as a core service, but health homes focus more specifically on high-need patients with chronic conditions.
- The Affordable Care Act provides temporary 90 percent federal Medicaid matching.

Many states are now beginning to adopt coordinated care models, especially health homes and PCMHs, in an attempt to improve the quality of health care they provide and reduce costs. However, there is no standardized set of outcome measures and evaluations vary in size, scope, and generalizability. Another challenge is selecting an appropriate study design to accurately reflect patient outcomes related to PCMH implementation. PCMH interventions may take a minimum of two to four years to achieve transformation. The time is right to conduct a well-run study to properly measure the impacts of these ventures. Two notable cases are the statewide homes run in North Carolina and New York.

CASE STUDY 1: NORTH CAROLINA

Community Care of North Carolina (CCNC) presents the most compelling data on the medical home model with strong evidence for cost savings, better quality of care, and improved healthcare utilization. CCNC is a public-private partnership that uses a medical home model to provide primary care and care management to low-income, high-cost, high-needs patients. It grew from a pilot project of nine networks in nine counties to 14 networks encompassing the entire state. Individuals are linked to a physician who acts as a "medical home" that provides acute and preventive care, manages chronic illnesses, coordinates specialty care and provides 24-hour coverage. Networks engage with physicians and case managers to provide targeted education and care coordination, implement best practice guidelines, and monitor results.

An evaluation conducted by Milliman showed that CCNC's model resulted in total savings of approximately $382 million or $25.40 per person per month (PMPM) – around 5 percent of the total – in FY2010, when compared to non-CCNC members and adjusted for health status. Treo Solutions showed that these savings can be attributed to lower inpatient and emergency room utilization, which offset the CCNC population increase by 48 percent and the overall illness burden increase of the enrolled population by seven percent from 2007 to 2010. For the adult non-ABD (aged, blind and disabled) population, observed inpatient utilization rates for the enrolled are less than those for the unenrolled by 40 to 50 percent for admission rates, 60 percent for potentially preventable admission rates and 35 to 40 percent for potentially preventable readmission rates. This population also saw lower rates of ER visits by 20 to 26 percent over the four years.

Coordinated Care Snapshot #1: Community Care of North Carolina (CCNC)

Model Type: Enhanced medical home model

Initial Year: 1998

Target Population: Low-income, high-cost, high-needs patients

Reach: Over one million individuals enrolled in Medicaid, the federal-state Children's Health Insurance Program (CHIP) and the HealthNet Program

Network Structure: Physicians, case managers, hospitals, social service agencies and county health departments

Network Size: 14 Community Care networks covering all 100 counties

Services: Care coordination, disease and care management and quality improvement

Payment Structure: Networks receive an enhanced care management fee of $3 PMPM or $5 PMPM for elderly or disabled enrollees. Physicians receive $2.50 PMPM or $5 PMPM for elderly or disabled enrollees.

CASE STUDY 2: NEW YORK

At $50 billion annually, New York's Medicaid program is the most expensive in the country, not only because it is a populous state and Medicaid covers 26 percent of its residents, but also because New York spends the most in the nation at over $10,000 per Medicaid enrollee. Yet, New York dramatically underinvests in primary care; more than five million New York residents do not have ready access to a primary care provider. In 2009, it ranked 12th highest among the states in hospitalizations for conditions that are typically preventable with good primary care and fifth highest for the number of days spent in the hospital per 1,000 people. Reducing New York hospital admissions, readmissions, and length of stay to the national average would save almost $10 billion. With this in mind, New York has also been developing medical homes to improve its primary care delivery, especially for its neediest patients.

Certain high-need populations drive the majority of spending on healthcare. The elderly and disabled make up 24 percent of Medicaid recipients, yet use 72 percent of the spending, compared to the national average of 64 percent. New York spends the most per enrollee, almost twice as much as the national average, in both categories at $22,159 for elderly and $28,223 for the disabled.

Six million individuals have a chronic disease and comprise $100 to $110 billion or about 65 percent of New York's total spending on hospitalizations, medications, medical treatments and long-term care. Chronic disease costs about $16,000 per capita per year, and those with one chronic condition spend twice as much as those with none. Many of these hospitalizations could be avoided with better access to a primary care system that focuses on prevention and management of chronic disease.

Coordinated Care Snapshot #2:
New York Statewide PCMHs and Adirondack Medical Home Demonstration (ADK)

Model Type: PCMH model

Initial Year: 2010

Target Population: All Medicaid enrollees

Reach: Over 1.4 million MMC and Child Health Plus (CHPlus) enrollees

Network Structure: Physicians, nurse practitioners, physicians assistants, community health centers, hospitals and payers

Network Size: 4,461 providers in 2012

Services: Care coordination, disease and care management, health information technology

Payment Structure: Depending on the provider's level of National Committee for Quality Assurance (NCQA) recognition, community-based providers who meet the standards for a PCMH receive $5.50 to $16.75 per visit for Medicaid fee-for-service patients and office-based providers receive $7 to $21.25. Providers receive $2 to $6 PMPM for Medicaid managed care patients.

The high costs for high-needs patients can be reduced using the PCMH model. The Centers for Medicare and Medicaid Services (CMS) and private health insurance plans have been sponsoring multiple projects to pilot PCMHs and transform existing practices into PCMHs. Using a matched comparison of Medicaid Managed Care (MMC) members (PCMH vs. non-PCMH), the New York State Department of Health showed that adult PCMH members were more likely to have received preventive care and performed better on some chronic disease control measures. WellPoint's Single Health Plan Model New York PCMH showed that over a period from 2007 to 2010, adults in a medical home had 11 percent fewer ER visits and children had 17 percent fewer ER visits, compared to a control group.

SYSTEM-LEVEL INTEGRATION OF CARE

System-level integration of care directly provides for patients while bearing the financial risk for the entire complement of acute physical and behavioral health services. While other care models may stop short of fully integrating services for those with both SMI and physical health issues and accepting total fiscal accountability, this approach truly emphasizes a whole-person oriented care system.

- In Maricopa County, Arizona, funding and accountability for those with SMI comes from one entity that manages behavioral health, substance use disorders, and physical health.
- This managed care entity is required to provide health education, primary prevention, family involvement, early identification and illness intervention, etc.
- Additionally, this plan has to meet specific benchmarks designed to measure performance in improving care and patient experience.

CONCLUSION

Increased care coordination has the potential to create transformative, scalable, and sustainable change for Medicaid patients with the greatest needs. By targeting patients who are most costly and have the highest need, better care coordination has the potential to have a significant impact on Medicaid patients. Studies on the effectiveness of care coordination so far have been limited either because of a small sample size or difficulty determining effectiveness in improved quality of health and cost savings.

A long-term study with a state or a small group of states to discover the impact of coordinated care for Medicaid patients will prove if and how this system would improve patient outcomes and reduce Medicaid costs and will also help determine the best practices in which care coordination can scale and be transformative. If, as expected, the study proves the aforementioned hypothesis, these best practices could be implemented in other states to drive a broader Medicaid transformation.

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