CHCS Center for Health Care Strategies, Inc.

TECHNICAL ASSISTANCE TOOL | SEPTEMBER 2017

Medicaid Financing Models for Project ECHO

IN BRIEF

This technical assistance tool outlines Medicaid financing options for supporting Project ECHO — including approaches that are currently being used as well as strategies that are not yet operational. It was developed by the Center for Health Care Strategies as part of the *Project ECHO Medicaid Learning Collaborative,* a multi-state learning collaborative to promote long-term Medicaid policy and financing strategies for Project ECHO in states across the country.

Project ECHO® offers an innovative model to extend the reach of specialty health care services. By linking expert specialist teams at an academic medical center (aka hub) with primary care clinicians in local communities (aka spokes), Project ECHO expands access to specialty care in underserved areas.[*] Medicaid, as the primary health care payer for low-income Americans, is particularly well positioned to benefit from Project ECHO. As such, Medicaid stakeholders across the country are pursuing options to leverage Medicaid financing to support Project ECHO implementation and sustainability. Several state Medicaid agencies have sought and received federal approval for an explicit financing model, while in other states, health systems are implementing Project ECHO with Medicaid funds earned through performance-based incentive programs.

This technical assistance tool, developed by the Center for Health Care Strategies to support the *Project ECHO Medicaid Learning Collaborative*, summarizes Medicaid financing mechanisms that states may consider to support Project ECHO. The following tables outline approaches currently in use as well as strategies that have been vetted with state and federal partners but are not yet operational. The options are organized in three categories:

- **Managed care**;
- **Care management programs**; and
- **Value-based payment strategies and integrated care programs**.

This array of financing strategies offer the potential to align with a range of Medicaid delivery system environments and provide opportunities to evolve financing of Project ECHO toward an increasingly outcomes-focused payment system.

[*] To learn more about Project ECHO, visit https://echo.unm.edu/about-echo/our-story/.

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Managed Care

Capitated Rate	
How It Works	A state could either contractually require its managed care organizations (MCO) to support Project ECHO, or include outcomes-based incentives that implicitly encourage use of Project ECHO. If new funding is authorized, funds could be added to the capitation rate as a direct service or an administrative expense. This approach leverages managed care platforms where they exist, enabling a coordinated approach for all beneficiaries while still allowing some flexibility for plans to tailor ECHO efforts to their own needs and priorities.
Federal Authority	1115 Waiver; 1915(b) Waiver
State Examples	**New Mexico:** Centennial Care ▪ Purpose: Reduce the need for unnecessary treatment and costs associated with travel to urban areas to seek treatment from specialists. ▪ State supports Project ECHO as a primary care provider extended network operated by the University of New Mexico Health Sciences Center. ▪ All four Medicaid MCOs are explicitly required to contract with the ECHO Institute to support the costs of the extended primary care provider network. ▪ Allocation for annual Project ECHO Medicaid funding is developed and provided by the state through the capitation rate on a PMPM basis. ▪ Documented through Centennial Care contracts and rate certification letters. **Oregon:** Health Share of Oregon, a Coordinated Care Organization (CCO) ▪ Purpose: Support effective medication management for individuals with psychiatric conditions. ▪ CCO contracted with Oregon Health & Sciences University (OHSU) to serve as the hub for this initial clinic. Other CCOs are exploring similar partnerships. ▪ Leverages implicit state incentives, with the CCO supporting cost of OHSU operation with flexible funds under a three percent claims withhold tied to population-based quality metrics.
Resources	Medicaid and CHIP Managed Care Final Rule; Centennial Care Contract (see p. 87); Overview of Oregon Waiver by Oregon Health Policy Review Board

In Lieu of and Value-Added Services	
How It Works	*In lieu of* services refer to services or settings not covered in a Medicaid state plan or MCO contract, but are identified by the state as a medically appropriate, cost-effective alternative to a service that is covered. States can authorize MCOs in their contracts to provide specific *in lieu of* services, for use by members on a voluntary basis, and can include the costs of these services in rate calculations. *Value added* services are also services outside of the Medicaid benefit package, but are delivered at managed care plans' discretion and not specified via contract. *Value-added* services seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. Either of these mechanisms may present attractive ECHO financing options, particularly for states that want to support the ECHO model, but are unable to make an upfront capital investment.
Federal Authority	42 C.F.R. §438.3(e)(2), and standards set forth in the Medicaid and Children's Health Insurance Program Managed Care Final Rule (effective July 5, 2016).
Possible Model	▪ The state could identify Project ECHO as a cost-effective service *in lieu of* other covered specialty care benefits, or could encourage its MCOs to finance Project ECHO as a *value-added* service as a way to improve quality and reduce avoidable inpatient care. ▪ Unlike *in lieu of* services, value-added services cannot be included in MCO rate calculations, but can be included as incurred claims in the numerator for the medical loss ratio calculation. ▪ Whereas *in lieu of* provides for a more prescriptive or explicit approach, states could still support use of the *value-added* approach by serving as a convener of the health plans, and by providing claims data to the hubs to help build a case for this investment.
Resources	Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526; 42 C.F.R. §438.3(e)(2)

Network Adequacy	
How It Works	States are required by federal rules to include access and network adequacy standards in their contracts with Medicaid MCOs. By including "ECHO-certified" primary care providers as eligible for meeting specialty care network requirements, states could provide significant incentives for MCOs to invest directly in Project ECHO. Primary care providers that participate in an ECHO program and develop expertise in a particular clinical area could be counted as offering specialty care within a health plan's network.
Federal Authority	42 C.F.R. §438 and standards set forth in the Medicaid and Children's Health Insurance Program Managed Care Final Rule (effective July 5, 2016) require states to ensure the availability of health care services as well as the adequacy of the supply of those service providers to individuals in their managed care plans. Specifically, provider networks must include a sufficient number of providers that are distributed geographically across the service area; ensure access to timely care; and offer an appropriate range of preventive, primary care, and specialty services.
Possible Model	States could develop certification standards, which could include, for example, participation in a minimum number of ECHO program sessions, an assessment of medical knowledge based on national guidelines, and the recommendation of the ECHO program's specialist leader.
Resources	State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval - January 20, 2017

Care Management Models

Disease Management Program	
How It Works	State uses Project ECHO to support a disease management program that provides a "set of interventions designed to improve the health of individuals, especially those with chronic conditions." This approach offers states the opportunity to evolve the disease management model into a program that can be effectively embedded into primary care practices.
Federal Authority	Administrative claiming for disease management activities per SMDL #04-002. Allows for direct medical service or administrative function.
State Example	**Colorado:** Accountable Care Collaborative Chronic Pain Disease Management Program, 2015 - 2017 ▪ Purpose: Address rise in prescription abuse and improve the health of Medicaid recipients with chronic pain through provider education. ▪ State Medicaid agency contracted with Community Health Center, Inc. (CHC) in Connecticut to manage Colorado's Chronic Pain program using the ECHO model. CHC used a specialist panel from the Integrated Pain Clinic at the University of Arizona. ▪ CHC was paid a lump sum based on the number of participating Colorado physicians.
Resources	SMDL #04-002

Medicaid Health Homes	
Approach	States could include participation in Project ECHO among other Medicaid health home provider capability requirements. Payments can be tiered based on provider capacity.
Federal Authority	Section 2703 of Affordable Care Act: Allows reimbursement for care management/care coordination services for Medicaid beneficiaries with targeted chronic conditions.
Possible Model	▪ State-defined health home provider qualifications require or provide enhanced payments for Project ECHO participation. This option may fit particularly well for states that define health homes as networks of providers including hospitals and ambulatory settings. ▪ Spokes could contract with hub and remit portion of health home payment to fund administrative costs. ▪ Payment to hub could be explicit program component or separate agreement between spoke and hub. ▪ Coordination of the distribution of funds between providers and hub could be challenging.
Resources	Section 2703 of the Affordable Care Act adds Section 1945 to the Social Security Act; Health Home information Resource Center

Value-Based Payment Strategies and Integrated Care Models

Delivery System Reform Incentive Payment (DSRIP) Program or similar	
How It Works	State provides incentive payments to reward providers for performance on delivery system transformation projects for a defined period of time. States could include projects and outcomes targets that align with the ECHO model, e.g., increasing access to care, improving coordination among primary care and specialty providers, and driving better outcomes for individuals with chronic conditions. Providers could opt to implement/support Project ECHO as a mechanism for achieving selected goals and associated incentives. DSRIP funding could serve as transitional funding to support initial infrastructure building, and as a pathway to establish a more permanent, value-based financing model.
Federal Authority	1115 Waiver
Possible Model	▪ States identify Project ECHO as an effort eligible for funding through DSRIP; or, states can encourage participating DSRIP providers to pursue projects that align with the ECHO model. ▪ Participating providers implement ECHO as a mechanism for delivering outcomes that are directly incentivized through DSRIP. ▪ Payments based on achievement of pre-determined milestones.
Resources	An Overview of Delivery System Reform Incentive Payment Waivers (Kaiser Family Foundation, September 2014); Delivery System Reform Incentive Payment: State Program Tracking (Center for Health Care Strategies, December 2016)

Care Coordination Payments	
Approach	Through models such as patient-centered medical homes, states can provide tiered care coordination payments to providers based on a set of clearly defined services or characteristics that aim to improve health outcomes for all beneficiaries. Participation in Project ECHO, and resulting increases in capacity to treat complex conditions, could be included among tiering criteria.
Federal Authority	▪ Integrated Care Models as referenced in SMDL #12-002 ▪ Optional state plan services authorized as PCCM under sections 1905(a)(25) and, by reference, 1905(t)(1)
Possible Model	▪ Eligible providers are rewarded for Project ECHO participation through a higher care coordination payment. ▪ Portion of enhanced payment could potentially be remitted to hub to fund administrative costs (e.g., a subscription model). ▪ Payment to hub could be an explicit program component or separate agreement between spoke and hub.
Resources	SMDL #12-002

Episodes of Care	
Approach	Organizations enter into bundled payment arrangements that include financial and performance accountability for episodes of care. Organizations receive a single prospective payment for a defined episode, or continue to receive payment under the usual arrangements, which are reconciled retrospectively against a predetermined target price for an episode of care.
Federal Authority	▪ Medicaid 1115 waivers and/or State Plan Amendments ▪ Integrated Care Models as referenced in SMDL #13-005
Possible Model	▪ Rather than an explicit funding requirement, state creates incentives and flexibility for health systems to use Project ECHO to drive outcomes. ▪ Payment for an episode, or bundle of services, would be used by participating providers to cover the costs related to Project ECHO. ▪ May work best in the context of bundled payments for chronic conditions. ▪ Allocation of payments would be determined by participating providers.
Resources	SMDL #13-005

Shared Savings	
Approach	State makes retrospective payments based upon savings achieved for attributed population, relative to projected total cost of care. ▪ Typically less prescriptive regarding service delivery and provider qualifications. ▪ Often entails new relationships between hospitals and community providers.
Federal Authority	▪ Medicaid 1115 waivers and/or State Plan Amendments, depending on antitrust context, consumer choice, scope of services and other program attributes ▪ Medicare Shared Savings Programs and Pioneer Accountable Care Organizations (ACOs)
Possible Model	▪ ACOs embed Project ECHO within provider network, internally funded through shared savings. ▪ State could require or encourage use of Project ECHO in ACO qualifications. ▪ ACOs would define how payments are allocated between hub and spokes.
Resources	SMDL #13-005

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ABOUT THE PROJECT ECHO MEDICAID LEARNING COLLABORATIVE

With support from the Leona M. and Harry B. Helmsley Charitable Trust and the GE Foundation, CHCS and the ECHO Institute lead the *Project ECHO Medicaid Learning Collaborative,* a multi-state learning collaborative to develop and promote long-term Medicaid policy and financing strategies for establishing and sustaining Project ECHO in states across the country. Through the collaborative, CHCS is facilitating peer-to-peer problem solving and sharing of financing strategies, and assisting state Medicaid agencies in advancing the ECHO model in their states. Nine state Medicaid agencies participate in the collaborative: Colorado, Kansas, Missouri, Montana, Nevada, New Jersey, Oregon, Vermont, and Utah. To learn more and get involved, contact Greg Howe at **ghowe@chcs.org** or visit **www.chcs.org/project-echo**.

ADDITIONAL RESOURCES

- **Financing Project ECHO: Options for State Medicaid Programs** - This brief outlines an array of financing options, including approaches currently in use as well as new options, and highlights how four states — California, Colorado, New Mexico, and Oregon — leveraged Medicaid support for ECHO. It outlines design considerations for specific delivery system environments as well as broad considerations for long-term sustainability of Project ECHO approaches.
- **Medicaid Financing For Project ECHO: Strategies for Engaging State Medicaid Officials** - This fact sheet is designed for ECHO hub leaders who are interested in building the case for Medicaid financing with their state policymakers. It outlines considerations for engaging state Medicaid officials and includes a primer on the Medicaid program.