

March 2023

# Transforming Healthcare in Missouri

*Implementing Accountable Care  
within Medicaid*



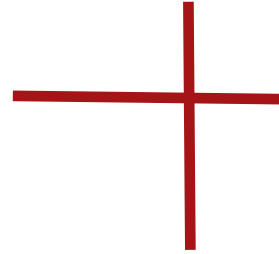
**CENTER FOR HEALTH  
ECONOMICS AND POLICY**

Institute for Public Health at  
Washington University in St. Louis

# CONTENTS



Executive Summary	3
Introduction	4
Keynote Speaker: Meredith Rosenthal, PhD	5
Panel Summary	8
Joseph Pierle, MPA	8
Jodi Woodruff, PhD	10
Andwele Jolly, DPT, MBA, MHA	12
Bill Winfrey, MPP	15
Breakout Sessions	18
Local Community Care Coordination Program	18
Primary Care Health Homes	20
Achieving a Patient-Centered, Equity-Focused Model	22
Achieving Optimal Payment and Regulatory Principles to Promote Population Health	23
Conclusion	25
Abbreviations	26
Full Speaker Bios	27
References	32
Authors & Acknowledgements	33



## Executive Summary

Accountable care organizations (ACOs) are voluntary networks of physicians, hospitals, and other providers that share the responsibility to provide coordinated, high-quality care for patients. This model is mostly utilized by Medicare currently. However, several states have been actively developing ACO initiatives within their Medicaid programs in efforts to improve quality of care and reduce costs. These models implement value-based payment structures and shift some of the responsibility for patient outcomes to providers.<sup>1,2</sup> Such models may drive greater efficiency in state Medicaid programs and lead to the improvement of health outcomes.<sup>3</sup>

In September 2022, the [Center for Health Economics and Policy](#) at Washington University convened stakeholders from a variety of organizations to discuss the possibility of implementing models like ACOs or other value-based payment models into the state's Medicaid program. Participants heard from a keynote speaker whose focus was national, followed by a local panel with Missouri expertise and experience. Attendees then broke into four smaller groups to further discuss accountable care organizations and value-based payment models. Two groups looked specifically at building on existing programs such as the Local Community Care Coordination Program (LCCCP) or the Primary Care Health Home (PCHH) model, while two other groups had the task of designing a model from scratch, one focusing on equity and the other on population health.

This white paper summarizes the models presented and describes related policies in Missouri and the programs that have been successfully implemented. The paper then summarizes the presentations and comments of the keynote speaker, panelists, and stakeholders in attendance and, where appropriate, highlights consensus views.



Center for Health  
Economics and Policy

INSTITUTE FOR PUBLIC HEALTH AT WASHINGTON UNIVERSITY



## Introduction

In September 2022, the Center for Health Economics and Policy of Washington University's Institute for Public Health hosted *Transforming Healthcare in Missouri: Implementing Accountable Care within Medicaid*. The event was the seventh in the Transforming Healthcare in Missouri (THM) series of stakeholder events designed to generate policy dialogue and solutions. Participants included clinicians, researchers, policymakers, managed care organizations, health foundation leaders, and community organizations. This meeting focused on innovative approaches to improving outcomes for Missouri Medicaid beneficiaries with value-based and accountable care models. Participants across stakeholder groups leveraged their expertise to discuss policy solutions. These solutions encouraged widespread adoption of evidence-based models and incorporated community partnerships to promote solutions outside the clinical setting.

Attendees were provided background materials before the event. After panelist presentations, attendees were divided into four facilitated breakout groups, provided with a variety of discussion questions, and asked to evaluate policy solutions based on feasibility, effectiveness, and cost. Each group worked through a series of targeted questions aiming to identify additional key information that is needed, innovative models that may involve new partnerships, and barriers that may need to be overcome through creative yet evidence-based policies to address their group's issues, listed below:

- Local Community Care Coordination Program
- Primary Care Health Homes
- Achieving a Patient-Centered, Equity-Focused Model
- Achieving Optimal Payment and Regulatory Principles to Promote Population Health

**The goal of the event was to enhance collaboration across these various stakeholder groups and potentially find common ground in discussing policies, identifying barriers, and suggesting solutions to implement accountable care in Missouri's Medicaid program.** The innovative ideas discussed by stakeholders are described below. The priorities identified at this convening may be considered for implementation to improve outcomes for Medicaid participants.



## Meredith Rosenthal, PhD

*Professor of Health Economics and Policy*

*Harvard University's T.H. Chan School of Public Health*

Meredith B. Rosenthal, Ph.D. is the C. Boyden Gray Professor of Health Economics and Policy at the Harvard T.H. Chan School of Public Health and the Faculty Chair of Harvard's Advanced Leadership Initiative. Dr. Rosenthal received her Ph.D. in health policy at Harvard University in 1998.

**Meredith Rosenthal, Ph.D.**, is a Professor of Health Economics and Policy at Harvard University's T.H. Chan School of Public Health, and is an expert in value-based and alternative payment models.

Dr. Rosenthal began her presentation by noting that policy makers and researchers recognize that misaligned payment models have undermined the health of the population. Since the 1980s, Medicare and other payers have incrementally addressed reimbursement with prospective payment systems, resource-based relative value scales for professional services, and pay-for-performance models.

Value-based payment (VBP) broadly focuses on reforming spending and quality together. VBP has many forms, and the structure of payment differs depending on where it is applied in the delivery system. Forms include:

- Accountable Care Organizations (ACOs).
- Patient-Centered Medical Homes (PCMH) with mixed payment for primary care settings.
- Bundled or episode payment with incentives for quality, particularly for subspecialty care.

To continue to reform payment systems and models, Dr. Rosenthal stated that shortcomings in Medicare policy need to be addressed. Commercial insurers and Medicaid have played crucial roles; however, Medicare moves the market and contributes the majority of the evidence to date. Earlier Medicare experiments like the Acute Care Episode demonstration and coronary artery bypass graft (CABG) bundled payment paved the way for the current foundations of payment and reimbursement models.

So far, VBP reform has had mixed success. A major theme has been the heterogeneity of impact over time, across providers. The voluntary nature of some programs creates challenges to the interpretation of findings, even as it provides insight on what kinds of models may work best.

**Accountable Care Organizations (ACOs)** are both a delivery model and payment vehicle, specifically designed as a vehicle for integrated and coordinated care across the continuum. Patients are attributed to an ACO, and quality indicators serve as both a threshold and multiplier for savings. Providers can opt in, and there are requirements such as governance, primary care, and IT capacity. Overall, net savings to Medicare have been modest, while the quality of performance has been high. The more experience they gain in the program, the better ACOs perform, and those that are physician-centric have saved more than hospital-centric ACOs.

While most ACO models currently involve Medicare beneficiaries, several state Medicaid agencies have been actively developing ACO initiatives since 2012 to improve the care provided and reduce costs. These models implement value-based payment structures (VBP), enhance coordination of care, and shift more of the responsibility for patient outcomes directly to providers.<sup>1,2</sup>

Dr. Rosenthal noted that twelve states' Medicaid programs adopted ACOs directly (as opposed to having ACOs through managed care). Controlled studies that compared states which did adopt ACOs to states that didn't adopt ACOs showed reductions in emergency department admissions and quality improvements; however, only Vermont demonstrated cost savings. Oregon specifically targeted health disparities, and Minnesota and Massachusetts added new incentives to reduce disparities and address the social determinants of health within their ACO programs.

In the early 2000s, primary care advocates and federal policy makers promoted primary care reform based on PCMHs. Their goals were to:

- Improve value throughout the healthcare system by strengthening its primary care foundation.
- Elevate primary care in order to stem workforce losses.

Across all the PCMH initiatives, there is evidence of cost savings; however, the effect varies. Some initiatives reduced emergency department admission, and others reduced hospitalization without a consistent pattern. The Medicare Comprehensive Primary Care Initiative saw ED admission improvements as well, but no improvements in terms of cost, hospitalization, quality, or patient experience.

Over the decades, The Centers for Medicare and Medicaid Services (CMS) have fielded demonstrations and opt-in bundled payment programs. CMS determined that payment for all Medicare Part A and B services that were required for the procedures were appropriate to pay, as well as 90 days of post-operative care. Quality measures that were tracked were complication rates and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.

A study of comprehensive care for joint replacements found evidence of reduction in discharges to post-acute care, i.e., facilities where patients are rehabilitated. There was no evidence of increased volumes or changes in patient load, which demonstrated that providers were responding to incentives.

Overall, such evidence has led to the conclusion that payment incentives matter. Providers are prepared to deliver care that meets the performance benchmarks set by payment reforms. However, there is much that is unknown about how providers respond to such incentives and how these incentives impact access and equity. CMS is focusing on narrowing the number of VBP options, with the potential of moving closer to making these models mandatory.

A panel discussion followed the keynote speaker and focused on local implementation of value-based and alternative payment models. The comments that follow have been lightly edited for clarity but are as true to the participants' comments as feasible.



### Joseph Pierle, MPA

*CEO for the Missouri Primary Care Association and Missouri Health Plus*

Joseph E. Pierle, MPA, is a native Missourian. He was appointed chief executive officer of the Missouri Primary Care Association in April 1999. The Association serves as a voice for the medically underserved and represents Missouri's Community Health Centers. Prior to this position, he worked for United States Senator Christopher S. Bond in Washington D.C., serving as an advisor on issues concerning health, children, the elderly, and veterans.

**What has been the experience of MPCA in engaging with Missouri Medicaid to build care delivery and financial models that promote accountable care? What is going well, and what needs improvement?**

"I'm very passionate about what I do. I'm very passionate about underserved populations and I don't want to assume everybody knows what a Federally Qualified Health Center (FQHC) or Community Mental Health Centers (CMHC) are. So I've spent 23 years working for FQHCs such as People's Health Center or Family Care Health Centers in South Saint Louis. We exist to serve underserved populations, so most of the populations we serve are either uninsured or thankfully because of Medicaid expansion, they have Medicaid coverage - so Medicaid is important to us.

"To me the biggest threat to value-based care is workforce challenges, as the workforce is spent. We're burned-out with initiative fatigue; there's always one more thing to do. You've asked us to manage our care teams, metrics from

\*Transcript lightly edited for clarity.



## Panel Summary (Continued)

Managed Care Organizations (MCOs), and metrics from Medicaid. Then the Medicare Advantage plans have their own metrics. So just imagine how confusing that can be for a care team. We have physicians and nurses and community health workers and behavioral health specialists all working together.

Who are our folks going to manage? They're going to manage the value-based care contract where they can earn the most money. And that's fundamentally, I think, what's wrong with value-based care. We have a misalignment of metrics and we have too many metrics within our system on the Missouri Primary Care side of the business. We connect to every FQHC EHR every night, and we pull all the clinical data. We pull all the social determinant data that our frontline staff are collecting, and we are collecting a lot of social determinant data, but what do we do with it?

One thing I like to say when we're talking about value-based care and value-based payments: sometimes we use them interchangeably and to me we shouldn't. In my opinion, they're two different things. The payment is what we received to provide value-based care, but where value-based care and the payment systems are flawed is when we're not making investments in the infrastructure to be successful in value-based care.

For the data analytics, the amount of money we spend is simply outrageous – we started saying a long time ago we're drowning in data. We got the clinical data and EHR. We've got data on admissions, discharges, and transfers from the hospitals. We have claims data from the MCOs. We're collecting social determinant data. So, what we have is a team of analysts trying to make sense of all this and then feed it back to our care teams. In return, they have real-time actionable data before that patient even comes in the door to receive care. I stress the importance of data analytics and data infrastructure because there's a misalignment around data. Data is expensive and there are way too many metrics. We have some MCOs in Missouri that are keeping up to their national metrics instead of the state metrics. The conditions and the expectations that the state puts on the MCOs ultimately trickle down to the provider level. MCOs are only successful if we are successful in managing those patients, and making sure we're coordinating their care, managing their care, and addressing total cost of care.

Luckily, we have been successful. We've earned shared savings. We've saved money on total cost of care through our Medicaid plans, but then our Medicaid plans cap us on how much we can receive in shared savings. So that's kind of a disincentive. We might earn seven million dollars in shared savings, but they only let us keep a little bit of that.”

\*Transcript lightly edited for clarity.



## Jodi Woodruff, PhD

*University of Missouri – St. Louis, Missouri  
Institute of Mental Health*

Dr. Woodruff is a health services researcher with expertise in chronic disease, mental health and substance use disorders. She directs the Health Data Science lab at the Missouri Institute of Mental Health at the University of Missouri-St. Louis. She and her team focus their research on risk-stratification methods and symptom cluster identification to target delivery of care to optimize health outcomes using administrative claims data, clinical registry, and public health data.

**What do the data from Missouri Medicaid’s Primary Care Health Home model suggest is the most salient opportunity on which to build additional levels of accountability and outcome improvement?**

“We get most of our data either directly from Medicaid or from Joe’s MPCA. A lot of what they accumulate, they send our way to so that we can look at those metrics. One thing that I thought was interesting in the earlier presentation was the discussion about why it is that we see hospital-based clinics not doing as well as primary care-based clinics and I think some of that might be in those metrics and that data that that’s being used.”

\*Transcript lightly edited for clarity.

“We have never been focused on hospitalization reduction. We've never been focused on emergency department reduction, although there've been different initiatives. We've been focused on clinical measures and so we get the clinical data from MPCA. We can look and see it how each one of those clinics is doing managing the health of the population because we're not going to reduce emergency department visits and we're not going to reduce hospitalizations if people aren't receiving the care that they need. If we can't manage their blood pressure, if we can't work with them to manage their blood sugar levels, and if we can't work with them to change their diet so that they can manage their health better, then we really have no opportunity to change those other metrics. So, I think that that's key and that's the data that we fed back to them, and just one of the things that worked extremely well for us early on. We showed everybody the data, so everybody saw how they were doing compared to everybody else. This is the Show-Me State, and they wanted to see the data and it built some competition.

When we talked with other states, they were struggling to get the data together. Now, mind you, we are still drowning in data, but we use the data that we have, that we know we need to share, because we know that those are the metrics that must be impacted for us to see change. When we talked with other states that were not sharing data, or they were only sharing it back to one organization, but not the network of organizations, we said why not give sharing more data a try and see how it works. Try to beat your neighbor. It encouraged and incentivized them to do better when they saw the data, and it motivated them to do better when they saw it was also possible that somebody else can do better. Those were those were strategies that the health home used specifically around data that has been helpful. We also were one of the only states that submitted data to CMS literally from the beginning and have continuously done so even if they weren't asking for it, and we've done that and fed it back to the agencies in the state as well every year.”

\*Transcript lightly edited for clarity.



## Andwele Jolly, DPT, MBA, MHA

*President and Chief Executive Officer, St. Louis Integrated Health Network (IHN)*

Andwele Jolly serves as the president and chief executive officer of the St. Louis Integrated Health Network (IHN), a nonprofit network comprised of the largest health care systems, public health departments, and Federally Qualified Health Centers in the St. Louis region. In his role, Jolly strives to co-create and advance strategies that improve quality, access, and affordability of healthcare for the medically underserved.

**As Missouri moves toward a more outcome-focused approach, it is possible to build in more attention to addressing the SDOH, which typically relies more heavily on community organizations. But for Medicaid to lean into this effort, we also need to ensure coordination and accountability for these services. Could you speak to the Community Based Organization landscape - how ready are CBOs to partner with clinicians, to collect and report data, and to receive funding based on outcomes?**

“I’m a physical therapist by trade, and we study movement and how things move, not only biomechanically, but how that person integrates in society and in their communities and how the community receives that individual. The Integrated Health Network (IHN) - a great health network that also focuses on the medically underserved, really tries hard to work and address the social determinants of health. And what does that mean?”

\*Transcript lightly edited for clarity.

“That means you also must address systemic and structural racism, and racial inequities. In terms of how do we address social determinants of health, and then the other part around the question regarding community-based organizations, I think it's important to define our terms. I define community-based organizations as non-profits or for-profit (now even in the virtual and digital space) that are organized, driven, operated, and governed by community residents to identify and address the social needs of that community for economic and health and well-being.

Additionally - why is the burden heavily weighed upon the community-based organizations? Is it really the community-based organizations that need to be prepared or is it a broader Accountable Care Organization? As Joe mentioned it's hard for even the health centers to organize and understand data and get information. It's even harder to communicate between hospital systems and community health centers - are they even prepared to even communicate to community-based organizations? There's a survey of 22 ACOs in which 95% of them identified as health safety net organizations and only about 9% are currently sharing data with community-based organizations, with only 14% planning to share that data.

It's hard to say if it's the community-based organizations that need to be prepared or if there is a conversation that needs to be had by both parties to identify what the needs are, what data do we need to look at, and what are the metrics. How do we come up with a common way of identifying the social needs of the patients within the system so that we can appropriately identify common standards for evaluating partnerships between health service organizations and community-based organizations?

We need to step back a little bit and say has that work has been done? Is there data around that? That's still a landscape we need to figure out between community-based organizations and health service delivery organizations. What are the current relationships in terms of how, through Medicaid payments and other payment models, do health service delivery organizations and community-based organizations interact? One strategy is around direct services in which Medicaid may fund a community health center to run a program like the PCHH and PCMH model to address social determinants of health in which they may have community health workers who interface with a community base organization. As an example, to coordinate the care for services for that patient, whether it's housing, transportation, legal services, or other needs that are there in need of addressing.”

\*Transcript lightly edited for clarity.

“Other ways you can think about relationships between funders, healthcare service delivery organizations, and community-based organizations is around developing payments or interface between the health centers as an example and community-based organizations. What does that funding relationship look like from a pass-through funding mechanism? Are community-based organizations and community health centers prepared to invest in capacity building to ensure that both parties are capable from a staffing perspective, from a financial research perspective, and from a data transparency perspective?”

These are all sorts of things that I think together service delivery organizations and community-based organizations need to figure out to have true value-based care models and payment systems that can lead to true shared savings and/or sustainability for long-term needs when we talk about medicalizing the social needs of patients in our communities. I don't want to go on too much longer, but there are other strategies around ... resourc[ing] the patients themselves through funding directly so they can choose and be empowered to identify which Community Based organizations they want to interface with.

There are multiple different ways in which we can talk about capacity building from the workforce, data, or infrastructure perspectives, and there are other ways we can think about creating sustainable models for interactions between the medical and community-based services that patients may need.”

\*Transcript lightly edited for clarity.





## Bill Winfrey, MPP

*Director, ATI Advisory*

Bill Winfrey is a Director at ATI Advisory, a professional services firm focused on transforming the delivery of healthcare and aging services for highest-need older adults. He recently left the Center for Medicare and Medicaid Innovation (CMMI), an organization housed within the federal Centers for Medicare & Medicaid Services (CMS) that is tasked with developing, testing, and scaling models to improve the cost and quality of healthcare.

**In your experience with CMMI, are there any states that come to mind whose work could be an example, or a cautionary tale, to Missouri Medicaid? Are there brand-new opportunities on the horizon?**

“You must create partnerships between the clinical and social service sectors that never existed before, so I think one thing that CMMI and CMS have always struggled with is trying to understand that agency's role in what I see is essentially community development - bridging these partnerships and creating infrastructure in communities. We're asking an organization who has traditionally operated as an insurance company to enter this new space, but you know, I think there is an opportunity to think of an insurance company and think about the role of both payers and providers in terms of helping build this infrastructure.”

\*Transcript lightly edited for clarity.

“Some of the examples that come to mind especially thinking about the context of Missouri is Arizona, which is an interesting state that has done some really innovative things in the Medicaid Program. One of the examples that always comes to mind for me is that Managed Care Organizations that are operating in Arizona Medicaid are required to reinvest six percent of revenue on an annual basis in community development - a recognition by the state and the Medicaid agency that there is this critical role that Managed Care Organizations play in terms of building these bridges and in terms of helping the populations that they serve who deal with social needs, social determinants of health, and social risks at disproportionate levels.

Another example that I think everybody has probably heard about at some point in the last couple years is North Carolina. As they've undergone the transition from fee-for-service to managed care, they built in a lot of interesting examples about essentially creating regional hubs that are that link and are creating the connections between the healthcare and the social service organizations. They went a step further than a lot of folks had gone previously and created essentially a fee schedule for social services.

Medicaid can not only help create the infrastructure in the state, but they can actually pay for housing, for first month's rent, for a number of different things that we all know are critical to promoting health.

One other state that comes to mind is New York State. And again, I think they've had a lot of groundwork laid with several Medicaid waivers that they've had over the years. But what I like about them is that they've kind of taken an incremental approach and they just submitted a waiver to CMS. I haven't followed the details of it but their previous waiver work was essentially requiring Managed Care Organizations through contracting with the state to have social service organizations or community based organizations in network with the healthcare entities.

It represents this kind of incremental approach to think about how do you start from the ground up? How do you start from these connections not existing to layering them in some formal way into Medicaid. So those are some of the examples that come to mind. I think the other place that's worth looking for innovation, I was just checking on the latest data, but you look at states that have expanded 12-month postpartum coverage under Medicaid and it's a really interesting mix of states.

\*Transcript lightly edited for clarity.



It's not just the traditional players, but as of September 8th, I think it was Indiana, Kansas, Kentucky and Tennessee that were all on the list. So just generally thinking about where to look for opportunities and where to look for innovation in kind of an environment that is similar to Missouri. Those are some of the examples that come to mind.

The one other thing that I'd say - CMMI is a great tool for bringing change to Medicare and Medicaid - it has traditionally struggled to innovate in Medicaid, and I think there are two major reasons. I think the first one is the data; the quality of the data makes it difficult to understand potential impacts of a program on the front end and then because of the way CMMI is designed – it's designed to test models – and so there has to be kind of a reasonable belief of being able to say something definitive at the end of the day.

I think people are still concerned about the quality of Medicaid data and their ability to do that. The other thing is the replicability, so CMMI doesn't create a model in most circumstances, doesn't create a single model for a single state. When I think of innovation and Medicaid, I think a lot more of the existing waivers and the experimentation that they allow as opposed to CMMI. CMMI is certainly trying and again, what I saw from this administration and the priority placed on health equity, there was a lot of interest in thinking about the safety net.

Dr. Rosenthal had mentioned the group from Massachusetts. I can't tell you how many times we brought them in to try to figure out how they were creating [a model for] having FQHCs take on risk through an ACO. I think the other place to think about if CMMI is of interest to the state is the essentially the headline topics. If you look back over the work in Medicaid over the past five or six years, and there's been a pediatric model but they've been primarily focused on opioids, there's been a maternal opioid misuse model. Now, there's a lot of talk around maternal health. So, kind of the 'issues of the day' is where CMMI tends to place its energy when it comes to thinking about how we innovate in Medicaid.”

\*Transcript lightly edited for clarity.

This section highlights the ideas and solutions put forth by each of the meeting's four breakout groups and briefly summarizes the consensus on different discussions.

Two of the four breakout sessions focused on improving existing models (the Local Community Care Coordination Program and the Primary Care Health Home model), while the other two considered the best options if Missouri were to start from scratch prioritizing a patient-centered and equity-focused model or a model to promote population health.

### Local Community Care Coordination Program

The MO HealthNet Division (MHD) established the Local Community Care Coordination Program (LCCCP) in its 2017 contract with managed care organizations (MCOs). The vision for the LCCCP was to transform the delivery of healthcare by strengthening relationships between local members and providers, enabling the members to have access to various tools and supports to meet their own health goals, all while requiring MCOs to offer financial incentives to providers who performed well in the new model. This was considered the first step towards the creation of ACOs or other advanced payment models, as there were better health outcomes and more effective use of resources.

In the discussion of the LCCCP, attendees identified that such a program was able to lower emergency room admissions, but still faced a variety of issues that threatened its success.

- There is a lack of communication; providers don't talk with each other.
- Hospital systems and clinics all use different electronic health records, creating a lack of a centralized platform.
- The MCOs set much higher expectations for LCCCPs in terms of quality metrics than the state sets for the MCOs themselves.
- The needs of urban and rural populations are very different, especially with respect to contacting patients. Accuracy of contact information in rural areas is very poor, and this results in problems with care coordination.

The participants of this group suggested a few changes in policies to improve the coordination of patient care between community providers, the state, and MCOs. They mentioned several actions that could improve the model:

- Creating stronger contract provisions for Managed Care Organizations, with higher performance expectations from the state.
- Approaching community care with a centralized platform and community exchange, designed to connect social services and providers.
- Financially incentivizing organizations and providers to come together; everyone needs to be involved.

The group expressed a lot of concern for the rural populations in Missouri, especially due to differing manifestations of the social determinants of health. The group discussed how providers are scarce in such areas and need to be further incentivized to move into rural areas. With an urgent need for providers, it was suggested that funding should be dispersed to any organization willing to address social determinants of health. Lastly, the group was interested in a team-based approach including community partners to prevent patients from falling through cracks overall.

### Primary Care Health Homes

The Primary Care Health Home (PCHH) model operates under the authority of Section 2703 of the Affordable Care Act, which created Patient-Centered Medical Homes.<sup>4</sup> The goal of this model is to provide appropriate care management for Medicaid patients with complex medical situations, as well as to coordinate care.

The second group focused on the PCHH model and addressed challenges the program faces. Discussion included evaluating the program's effectiveness, reporting challenges, and considering how value-based payment or ACO strategies could improve it. To begin, they identified some of the positive aspects of this program:

- The relationships that providers have built with other members on their team, as well as the relationship between providers and physicians.
- The ability of this model to effectively gauge the need of the community in terms of resources and barriers, as PCHHs operate at a local level.

Current challenges brought up by the participants were mostly related to staffing and were encountered primarily at the rural setting, a common observation with the previous group discussion as well. Issues such as lack of staffing, turnover, and lack of training on data infrastructure were identified. The group discussed staffing issues as stemming from causes such as:

- The reluctance of health care workers to relocate to rural areas, especially due to a lack of resources (such as stores and schools).
- Rural areas being perceived as more costly than urban areas, with longer distances to drive, needs for four-wheel drive vehicles, and the potential need to send children to private schools for better education.
- Urban-area healthcare centers offering better benefits in terms of sign-on bonuses and competitive pay.

Other challenges for the PCHH model included:

- The high number of patients with cognitive impairments who struggle with adhering to medication regimens, either with not taking or incorrectly taking their medications.
- The use of nurses or behavioral health professionals to address issues patients face relating to SDOH, as this is an inefficient use of resources considering they are not working at the top of their licenses.

A solution posed by the participants in this group was the integration of community health workers (CHWs). Suggested strategies included increasing their pay, adding them to care teams, and assigning them a manageable caseload comparable to their peers on care teams. The suggestion for funding the addition of community health workers was increasing the per-member per-month (PMPM) that currently funds the PCHH model. Community health workers would serve as a bridge between providers and patients and would do much to address the challenges listed above.

Funding CHWs by increasing the PMPM is a strategy that is likely to improve existing PCHH metrics at the clinic level. But overall, this and other similar strategies may have a greater impact at the program level, suggesting the need to design the VBP or ACO approach at a larger scale. Metrics such as short-term cost/utilization at the clinic level might not show savings due to low volumes of patients. But these outcomes might be more likely to be detected across the PCHH program if funding is added for CHWs, for example.

Finally, in considering changing opportunities due to Medicaid expansion, since more individuals will qualify for enrollment in health homes, the group discussed the need for better integration and coordination between MCO care management and the supports provided by health home nurse care managers. The MCOs' care management systems rely to some extent on self-advocacy (e.g. patients taking the initiative, reaching out) in patient populations, rather than allowing direct contact by a provider/clinic, and this leads to a potential for patients waiting until issues become urgent to utilize their care managers (undermining preventative healthcare goals).

### Achieving a Patient-Centered, Equity-Focused Model

A third group focused on how a patient-centered, equity-focused model could benefit the state as it expands Medicaid, with major points listed below:

- Reduce the administrative complexity of Medicaid and communicate with payers appropriately.
- Publicly report services covered, as there are patients who remain unaware of these.
- Recruit more trauma-informed and trained community health workers to offset the need for psychiatrists within community behavioral health clinics.
- Have providers work up to the top of their licenses to relieve any pressure on specialists.
- Prioritize key health issues in the state and have community health centers train with those issues in mind.

### Achieving Optimal Payment and Regulatory Principles to Promote Population Health

Participants in the fourth group focused on designing accountable care organizations in Missouri, and the optimal design for these ACOs. Major points from the discussion were:

- There is a need for unified, consensus-based quality metrics across the state, to reduce the burden on providers of collecting data and to focus energy on key areas of health with the most opportunities for improvement.
- A strong data infrastructure needs to be built, with interoperable technology being a requirement such that data can be shared seamlessly between providers at different sites and community-based organizations (CBOs) where appropriate.
- In terms of value-based reimbursement, mechanisms for creating shared accountability between providers and CBOs for achieving good patient outcomes should be explored.
- Full integration of the community into the accountable care organization (e.g. ACO REACH).
- Instead of paying for checking boxes, payment should be based on results, including better patient outcomes and better patient experience.

In addition to the discussion about ACOs, participants mentioned points about Managed Care Organizations (MCOs) as well, including the following:

- MCOs are good at assessing risk and identifying high utilizers; they would take a targeted approach in the addressing of social determinants of health (SDOH) in a manner likely to affect short-term clinical risk.
- Broad initiatives addressing the underlying causes of SDOH might take longer to yield cost-savings.
- In terms of MCO contracts, experiences from other states in terms of shifting reimbursement towards value are not being used as examples.
- To incent continued movement towards value-based care, Missouri could require specified percentages of MCO payments to be made within value-based contracts with providers and penalize MCOs for failing to meet these requirements.

Other ideas regarding optimal payment strategies to promote population health included:

- Carving out a new financing model for complex patients whose utilization exceeds an actuarial target.
- Creating a new payment model for hospitals and providers, especially in rural communities, that do not have the volume to remain profitable and sustainable financially, but with the right support, could engage in population health management and community-building to improve broader health outcomes.
- Addressing historic divestment in communities to improve community health through place-based payment strategies that circumvent the challenge of demonstrating short-term return on investment in individuals and instead focus on broader population-based goals.

The final challenge discussed was the need to comply with CMS guidance for Missouri to obtain federal matching funds. Historically, payment for SDOH-related services has been allowed strictly in cases of medical necessity, but several states have recently obtained waivers that might grant greater flexibility for Medicaid or the MCOs to invest in strategies that address SDOH more broadly.<sup>5</sup> There may be new options available to Missouri, although it is still not clear how far a state may go in addressing SDOH at the community level. Limitations may still exist that tie services to individuals with specific health risks, making it more difficult to take a truly population-level approach. A model that attributes all Medicaid participants to an organization that agrees to be accountable for their health outcomes, with risk, can potentially make population-level improvements with a broader set of strategic priorities.



In 2017, Missouri Medicaid took the first step toward adopting ACOs and other advanced payment models by establishing the Local Community Care Coordination Program (LCCCP). Better health outcomes were observed, and resources were utilized more appropriately. Providers were financially incentivized to perform better, and local members of the system had access to support to help them reach their health goals. The LCCCP had its benefits, but there were challenges noted as well. Provider communication was lacking, and hospital systems/clinics all operated with different electronic health records, creating a lack of a centralized platform. MCOs set higher expectations for LCCCPs than the expectations set by the state for its MCOs.

The Primary Care Health Home (PCHH) model, introduced to Missouri in 2012, has showed promising results in the state, but there is not a current system of reimbursement for quality care in place. Nevertheless, those enrolled in the program had significant improvements in health. Emergency room admissions were lowered significantly, and the decreased utilization resulted in savings to the state.

While Medicaid and commercial insurers have played crucial roles in reforming payment systems and models, Medicare leads the way. The market moves with Medicare, where most of the evidence in these models are seen. While ACOs mostly involve beneficiaries in Medicare, several state Medicaid agencies have adopted initiatives to improve care and reduce costs. There is a need for Medicaid agencies across states to keep pace with Medicare reform and research, and learn from the Medicare system, so state Medicaid programs can adopt the successful elements.

Across the speakers' presentations and breakout discussions, a few key themes emerged. To build on Medicaid payment systems and models, unified approaches and strong infrastructures with interoperable structures need to be established. Innovative approaches within the community include addressing social determinants of health based on rural or urban settings through strengthened models and support for providers and members. Determining the appropriate level of intervention, i.e., at the individual or community level, is another important facet of the conversation.

By addressing observed issues and challenges already observed within existing models, such as lack of a centralized electronic health record system, the models would be strengthened. Support for both providers and members would not only further strengthen models like the LCCCP or PCHH, but would enable providers to deliver higher-quality care, and would help members to move towards their own health goals. Effective partnerships with the community will be a crucial part of ensuring better health outcomes.

## Abbreviations

ACOs: Accountable Care Organizations  
CABG: Coronary Artery Bypass Graft surgery  
CAHPS: Consumer Assessment of Healthcare Providers and Systems  
CHW: Community Health Workers  
CMS: Centers for Medicare & Medicaid Services  
CMHC: Community Mental Health Center  
ED: Emergency Department  
FFS: Fee for Service  
FQHC: Federally Qualified Health Center  
ICU: Intensive Care Unit  
LCCCP: Local Community Care Coordination Program  
MCOs: Managed Care Organizations  
MDSS: Missouri Department of Social Services  
MHD: MO HealthNet Division  
MPCA: Missouri Primary Care Association  
P4P: Pay for Performance  
PCHH: Primary Care Health Home  
PCMH: Patient Centered Medical Homes  
PCP: Primary Care Provider  
PPS: Prospective Payment Systems  
REACH: Realizing Equity, Access, and Community Health  
RBRVS: Resource-Based Relative Value Scale  
SDOH: Social Determinants of Health  
VBP: Value Based Payment



## Meredith Rosenthal, PhD

*Professor of Health Economics and Policy*

*Harvard University's T.H. Chan School of Public Health*

Meredith B. Rosenthal, Ph.D. is the C. Boyden Gray Professor of Health Economics and Policy at the Harvard TH Chan School of Public Health and the Faculty Chair of Harvard's Advanced Leadership Initiative. Dr. Rosenthal received her Ph.D. in health policy at Harvard University in 1998.

Her research examines the design and impact of market-oriented health policy mechanisms, with a particular focus on the use of financial incentives to alter consumer and provider behavior. Her previous projects focused on the design and impacts of pay for performance, high-deductible and tiered network health plans, and payer-sponsored patient centered medical homes.

Dr. Rosenthal's recent research examines the structure and performance of health systems across the U.S., vertical integration of physician practices, and market factors driving cancer drug pricing trends. Dr. Rosenthal is a member of the Massachusetts Center for Health Information and Analysis oversight commission. Dr. Rosenthal was elected to the Institute of Medicine in 2014.



## Joseph Pierle, MPA

*CEO for the Missouri Primary Care Association and Missouri Health Plus*

Joseph E. Pierle, MPA, was appointed chief executive officer of the Missouri Primary Care Association in April 1999. The Association serves as a voice for the medically underserved and represents Missouri’s Community Health Centers. Prior to this position, he worked for United States Senator Christopher S. Bond in Washington D.C., serving as an advisor on issues concerning health, children, the elderly, and veterans.

Mr. Pierle also serves as CEO of Missouri Health Plus, a clinically integrated network of FQHCs and CMHCs, helping such organizations thrive under value-based care. Currently, he is a member of Missouri MO Healthnet (Medicaid) Oversight Committee and Missouri School of Dentistry & Oral Health (MOSDOH) Council.



### **Jodi Woodruff, PhD**

*University of Missouri – St. Louis, Missouri  
Institute of Mental Health*

Dr. Woodruff is a health services researcher with expertise in chronic disease, mental health and substance use disorders. She directs the Health Data Science lab at the Missouri Institute of Mental Health at the University of Missouri-St. Louis. She and her team focus their research on risk-stratification methods and symptom cluster identification to target delivery of care to optimize health outcomes using administrative claims data, clinical registry, and public health data.

She is also the evaluator for the Missouri Primary Care Health Home (PCHH) and Community Mental Health Center (CMHC) Healthcare Home initiatives which focus on coordinated, integrated care to improve health outcomes for Medicaid enrollees who live with chronic disease and behavioral health concerns.



### **Andwele Jolly, DPT, MBA, MHA**

*President and Chief Executive Officer, St. Louis Integrated Health Network (IHN)*

Dr. Andwele Jolly serves as the president and chief executive officer of the St. Louis Integrated Health Network (IHN), a nonprofit network comprised of the largest health care systems, public health departments, and Federally Qualified Health Centers in the St. Louis region. In his role, Jolly strives to co-create and advance strategies that improve quality, access, and affordability of healthcare for the medically underserved. As part of his service to improve community health, Jolly has served on the boards of CareSTL Health, the Provider Services Advisory Board of the St. Louis Regional Health Commission, Missouri Foundation for Health, and the St. Louis Chapter of the National Association of Health Services Executives. In acknowledgment of his work in community, Jolly was selected to the 46th Leadership St. Louis Class of FOCUS St. Louis.

Jolly earned a bachelor's degree in psychology and a clinical doctorate in physical therapy from Washington University in St. Louis. He also earned master's degrees in business administration and health administration from Georgia State University.



### **Bill Winfrey, MPP**

*Director, ATI Advisory*

Bill Winfrey is a Director at ATI Advisory, a professional services firm focused on transforming the delivery of healthcare and aging services for highest-need older adults. He recently left the Center for Medicare and Medicaid Innovation (CMMI), an office within the federal Centers for Medicare & Medicaid Services (CMS) that is tasked with developing, testing, and scaling models to improve the cost and quality of healthcare.

At CMMI, he was focused specifically on health equity, the social determinants of health, and the links between the healthcare and social service sectors. He is also a St. Louis native and current resident who is especially interested in the health and healthcare systems of his home city and state. Winfrey holds a Master of Public Policy degree from the Trachtenberg School at George Washington University and a bachelor's degree in Political Science from St. Louis University.

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# ACKNOWLEDGEMENTS

Thanks to the speakers and stakeholders who attended the *Transforming Healthcare in Missouri: Implementing Accountable Care within Medicaid* event and offered their experience and insight.



*The views and opinions expressed in this white paper are those of the authors and do not reflect the official policy or position of Washington University.*