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CHCS Center for Health Care Strategies, Inc.

Financing Project ECHO: Options for State Medicaid Programs

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IN BRIEF

Project ECHO®, a unique model for expanding access to specialty health care services, can bolster state Medicaid program efforts to improve care in underserved areas. With a handful of states using Medicaid funds to support Project ECHO, more states are interested in pursuing ECHO models to enhance services for at-risk populations. 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. This brief is a product of the *Project ECHO Medicaid Learning Collaborative* made possible with support from the Leona M. and Harry B. Helmsley Charitable Trust and the GE Foundation.

As states continue to advance health care transformation initiatives to achieve better outcomes at lower costs, Medicaid programs are increasingly recognizing the potential of using workforce innovation strategies such as Project ECHO® to support these efforts. Through its unique model of linking expert specialist teams at academic medical centers (known as *hubs*) with primary care clinicians in local communities (known as *spokes*), Project ECHO expands access to specialty care in underserved areas, increasing the likelihood that patients get the care they need, when they need it.

This brief outlines Medicaid financing mechanisms that states may consider to support Project ECHO. It explores Project ECHO financing approaches currently being used as well as emerging options, with a look at financing models in four states: **California**, **Colorado**, **New Mexico**, and **Oregon**. It also presents design considerations to help states tailor an approach to specific delivery system environments.

What Is Project ECHO?

Project ECHO (Extension for Community Healthcare Outcomes), launched in 2003, by Dr. Sanjeev Arora at the University of New Mexico Health Sciences Center, was originally developed to address the need for better Hepatitis C care.[1] Now, more than 130 academic organizations lead ECHO projects in 30-plus states and 23 countries to address more than 65 complex medical conditions. The ECHO model is designed to enhance the health care workforce in underserved areas by providing community-based primary care providers with knowledge and support to manage

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patients with complex conditions. It engages providers via weekly videoconferences, and connects them with specialist mentors at an academic medical center, known as hubs. Through tele-mentoring and guided practice, participating providers develop the competencies needed to effectively manage their complex patients independently and in their communities.

Unlike teleconsultations, the goal of ECHO is to expand the capacity of primary care providers to independently manage their patients with complex health care needs. A 2011 study found that patients receiving care from primary care providers who participated in ECHO received care that was either comparable or, in some circumstances, better than those who received care from specialists at the University of New Mexico Health Sciences Center.[2]

Transforming Primary Care: Project ECHO and Medicaid

Project ECHO has the potential to support states' health care transformation goals for achieving better outcomes and reducing costs. Medicaid, as the nation's primary health care payer for low-income Americans, is uniquely positioned to benefit from Project ECHO for multiple reasons. First, access to specialty care is challenging for Medicaid, given its generally limited specialist participation relative to other payers due to comparatively low reimbursement rates. As a result, beneficiaries may have to travel long distances and may experience significant waiting times before getting access to needed specialty care. Second, Project ECHO specifically aims to build primary care capacity among safety net providers. With the majority of ECHO-participating primary care providers representing federally qualified and other community health centers, patients with Medicaid coverage comprise the largest group that stands to benefit from improved quality and breadth of care provided in these safety net settings.

Given these opportunities to improve services for Medicaid beneficiaries, stakeholder interest in identifying Medicaid financing mechanisms to fund ECHO has been increasing, particularly as awareness of the model has grown. Many ECHO hubs are looking to their Medicaid agencies for funding support, and likewise, a growing number of states are viewing Project ECHO as a potential means to cost-effectively expand access to care.

Overview of Existing State Models

To date, four states have used Medicaid funds to finance Project ECHO activities: New Mexico, Oregon, California, and Colorado. The following summaries highlight the strategies and models used to secure Medicaid support for ECHO programs in each of these states. In some cases, this support has been at the state agency level; in other cases, delivery system partners have leveraged more broadly defined Medicaid funding opportunities or incentive structures to support ECHO implementation.

New Mexico: State-Directed Funding through Managed Care Contracts

With the approval of its 1115 waiver known as Centennial Care effective January 2014, New Mexico became the first state to garner approval from the Centers for Medicare & Medicaid Services (CMS)

to use Medicaid funds for Project ECHO. Under the waiver's managed care provisions, the state requires its four Medicaid managed care organizations (MCOs) to support Project ECHO as a way to expand the capacity of the primary care provider network, with the goal of improving access and reducing costs associated with travel from rural counties to seek treatment from specialists. The MCOs are required to contract with the University of New Mexico Health Sciences Center, which operates ECHO programs in New Mexico.

Allocation for annual Project ECHO Medicaid funding is developed and provided by the state to the MCOs through the capitation rate on a per-member, per-month (PMPM) basis. These actuarially developed rates are documented through managed care contracts and rate certification letters. The aggregate funding amount was developed based on Medicaid's share of ECHO operating expenses, as estimated based on patient panel composition among participating primary care providers. This amount is shared across all participating Medicaid MCOs, calculated based on monthly enrollment.

> *"Project ECHO is critical to our efforts to support health care providers in New Mexico's rural and frontier counties with access to medical expertise and evidence-based treatment practices. It allows Medicaid members to receive specialty care in their community from providers they trust, and reduces the logistics and costs associated with traveling to urban areas to seek treatment from specialists."*
>
> *- Nancy Smith-Leslie, Director, Medical Assistance Division, New Mexico Human Services Department*

Oregon and California: MCO-Led Investments in ECHO to Address Key Priorities

Oregon

In 2012, Oregon launched its statewide Coordinated Care Organization (CCO) model, a type of accountable care organization. Specifically, a CCO is a network of health care provider organizations – including physical health, mental health, substance use disorders, and sometimes dental – that have agreed to work together in their local communities to serve enrollees in Oregon's Medicaid program.[3] CCOs have the flexibility and financial incentives to support new models of care and pay for services that improve quality and reduce costs.

Each of Oregon's 16 CCOs receives a global payment for coordinating and providing health care for a geographically defined population and is held accountable for health outcomes. CCO budgets include flexible funds under a three percent claims withhold tied to population-based quality metrics. With these funds, two CCOs, Health Share of Oregon and Columbia Pacific, have opted to contract with Oregon Health & Sciences University to serve as the ECHO hub to support effective medication management for individuals with psychiatric conditions. Whereas Oregon's Medicaid agency has not put forth explicit provisions or requirements for funding the ECHO model, Health Share has leveraged its performance-based flexible funding to invest in ECHO, with an expectation that ECHO will help drive improved outcomes for targeted members.

California

Four Medicaid MCOs are partnering with the ECHO hub at the University of California at Davis to provide support for a three-year ECHO pilot, focused on developing the capacity of community-based clinicians to safely and effectively treat pain in rural and underserved areas. Grant funding from the California Health Care Foundation supported the first year of the pilot, with a goal of transitioning to sustainable funding during subsequent years. Accordingly, early in the planning

process, the four participating MCOs focused on sustainability and designed a robust evaluation of claims data to assess return on investment (ROI). All four MCOs have signed service agreements with the hub to provide access to the program for practices within the health plans' networks. As in Oregon, California does not require or provide explicit incentives for its Medicaid MCOs to partner with ECHO hubs. Instead, expected improvements in quality and cost outcomes from the pilot have supported MCO participation to date, and results of the ROI analysis will likely drive the case for Medicaid MCOs to continue to use Medicaid dollars to support the ECHO model.

Colorado: State-Directed Funding through a Disease Management Program

Colorado's *Accountable Care Collaborative Chronic Pain Disease Management Program* was launched in March 2015, to address the rise in prescription opioid abuse and improve the health of Medicaid recipients with chronic pain. The state tapped existing expertise in other states to propel the model forward. The 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 as the hub. The Colorado state legislature authorized a two-year budget appropriation to fund implementation of the program, which ended in March 2017. The state is currently analyzing claims data to evaluate the program.

CMS approval for Colorado's program was based on a federal Medicaid authority that allows states to support a disease management program that provides a "set of interventions designed to improve the health of individuals, especially those with chronic conditions."[4] These programs can be implemented either as direct medical services for beneficiaries, or as training and supports to providers to promote adherence to evidence-based guidelines and improve provider-patient communication skills. The latter, which Colorado had pursued, allows states to claim administrative match for disease management activities and does not require a State Plan Amendment. To operate the program, Colorado paid CHC a lump sum based on the number of participating Colorado physicians.

In anticipation of the program end date in March 2017, in 2016, Colorado requested CMS approval to expand the disease management program to cover additional diseases under this same authority, leveraging a new appropriation of state funds for the expanded program. The proposed program would be based in the University of Colorado, which has developed a robust continuum of clinical and population-based ECHO programs in recent years with support from the Colorado Health Foundation. Although at this time CMS is not allowing Colorado to operate an expanded program with the previously implemented financing mechanism, Colorado is exploring other options with CMS to advance the ECHO model under a new financing mechanism that would optimize the new program design.

Additional Medicaid Opportunities to Support Project ECHO

In addition to the financing approaches used in the four states described above, several other models could conceivably be used by state Medicaid agencies to support Project ECHO. These

models, developed through the *Project ECHO Medicaid Learning Collaborative*, have been discussed with state and federal Medicaid partners, but have not yet been submitted for CMS approval nor put into practice. The models are organized in three groupings: (1) managed care; (2) care management programs; and (3) value-based payment strategies and integrated care programs. These options represent financing strategies that align with a range of Medicaid delivery system environments, and also provide mechanisms for evolving financing of Project ECHO over time within payment systems that are increasingly focused on outcomes.

1. Managed Care

"In Lieu Of" and "Value-Added" Services: *In lieu of* services refer to services or settings not covered in a Medicaid state plan or MCO contract, but that are identified by the state as medically appropriate, cost-effective alternatives 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.

Similarly, *value-added* services are similarly services outside 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.[5] 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.

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. 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. 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 ECHO hubs to help build a case for this investment.

Access Requirements and Network Adequacy: States are required by federal law (42 CFR §438) and standards set forth in the Medicaid and Children's Health Insurance Program Managed Care Final Rule (effective July 5, 2016) to include access and network adequacy standards in their contracts with MCOs.[6] An MCO must ensure the availability of health care services as well as the adequacy of the supply of those service providers to all of its members. 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.[7]

Project ECHO is a potentially powerful platform for helping Medicaid managed care plans meet network adequacy requirements for specialty care – and thus states could adapt such requirements to provide incentives for their MCOs to directly invest in Project ECHO. Specifically, primary care providers who 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. To ensure that these

providers have sufficient expertise, states (or other delegates) could certify them as an "ECHO provider," requiring them to meet a set of education and training standards developed by the state. These standards 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.

2. Care Management Programs

Health Homes: Medicaid health homes, made possible through Section 2703 of the Affordable Care Act, provide states with a mechanism to support care management and care coordination activities for people with chronic conditions, with the goal of improving health outcomes and reducing costs. States receive an enhanced federal match during the initial phase of the program. States have considerable flexibility in designing their health home models, including defining the necessary qualifications for providers to be eligible to deliver health home services. Accordingly, states could include participation in Project ECHO among other health home provider qualifications, and/or could pay an enhanced rate to health home providers that participate in Project ECHO.

This ECHO financing approach may fit particularly well for states that define health homes as networks of providers, including hospitals and ambulatory settings that represent both the hub and spokes of the ECHO model. It also presents one of the more explicit pathways for providing incentive payments to primary care providers to participate in Project ECHO – in contrast or in addition to approaches that finance only the hub.

3. Value-Based Payment Strategies and Integrated Care Models

Delivery System Reform Incentive Program: In recent years, many states have included Delivery System Reform Incentive Programs (DSRIP) as part of 1115 waivers, which enable states broad flexibility to experiment with new delivery system innovations on a budget neutral basis. DSRIP allows states to reward eligible provider entities – usually, but not always, led by hospitals – for meeting performance milestones linked to care delivery improvements or payment reforms.

States can choose to explicitly identify Project ECHO for funding through DSRIP; alternatively, they can more generally encourage participating providers to pursue projects that, for example, increase access to care, improve coordination among primary care and specialty providers, and drive better outcomes for individuals with chronic conditions. In turn, participating providers may select to implement ECHO as a mechanism for delivering outcomes that are directly incentivized through DSRIP.

Because funding through DSRIP projects is time-limited (generally five years), it should not be considered a permanent financing vehicle for Project ECHO. Rather, DSRIP can provide transitional funding to support initial infrastructure building, and can serve as a pathway to the establishment of a more permanent, outcomes-based financing model.

Care Coordination Payments: 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. Similar to the proposed approach under Medicaid health homes, states could design tiering criteria that specify higher

payments for providers who participate in Project ECHO, given the expected increase in provider capacity to treat complex conditions.

This approach would reward eligible providers for Project ECHO participation through a higher care coordination payment. Similar to the health home model, this approach presents an explicit opportunity to provide incentives for spoke participation. In addition, a portion of the enhanced payment could potentially be remitted to the hub to fund administrative costs (e.g., a subscription model). The payment to the hub could be an explicit program component or a separate agreement between the spoke and the hub.

Episodes of Care: Provider organizations that enter into bundled payment arrangements are responsible for the financial and performance outcomes for defined episodes of care. Bundled payments reimburse for a discrete course of treatment (e.g., a joint replacement procedure, diabetes-related care) rather than paying individually for each clinical interaction and procedure. Bundled payments usually occur in the form of a lump sum payment for all professional and facility-based services that are projected to be medically necessary for treatment of an illness episode or chronic condition for a fixed time period.

To the extent that states promote bundled payments for illnesses and chronic conditions that are well served by the ECHO model, such payments could create inherent incentives and flexibility for health systems to invest in Project ECHO as a means to deliver cost-effective care.

Shared Savings: In shared savings models, providers receive retrospective payments based upon a portion of savings achieved for an attributed population, relative to the projected total cost of care. These models typically allow significant flexibility regarding service delivery approaches, and often entail new relationships between hospitals and community providers. Shared savings are an increasingly common payment mechanism for accountable care organizations (ACOs), which align provider and payer incentives to focus on quality and cost of care. Currently, 10 states have active Medicaid ACO programs, and at least 13 more are pursuing them.[8]

Given that the ECHO model could be a significant tool to help ACOs accelerate the outcomes and shared savings that they are aiming to achieve, ACOs could choose to embed Project ECHO within a provider network, internally funded through shared savings. ACOs would have the flexibility to define how payments are allocated between the hub and spokes. States could also encourage the use of Project ECHO in ACO qualifications.

Pursuing Medicaid Financing for ECHO: Design Considerations

There is no “one size fits all” approach to Medicaid financing for Project ECHO. States and other stakeholders looking to build support for Medicaid financing of ECHO models are encouraged to keep the following considerations in mind:

1. ***States (and other ECHO stakeholders) must consider how various financing strategies align with their delivery system and payment environment.*** Some of the models described in this brief only work in a managed care environment, while others are best suited for fee-for-service settings. States with both types of arrangements may want to address a particular health need or target a

specific population that is found primarily in one of those systems. States with large-scale investments in delivery system reforms such as health homes, patient-centered medical homes, DSRIP, or ACOs may view ECHO as an opportunity to further leverage these platforms.

2. ***States can choose to provide explicit or implicit support for Project ECHO.*** Several state Medicaid agencies have sought and received federal approval for an explicit ECHO financing model. In other states, health systems are implementing Project ECHO with Medicaid funds earned through more broadly defined performance or value-based incentive programs. States looking to ensure investment in Project ECHO may prefer the explicit approach, whereas others that are seeking to provide the flexibility for MCO and health care system partners to deliver outcomes and control costs may prefer more implicit pathways.

3. ***States may be able to leverage external resources to support Project ECHO.*** States are increasingly partnering with philanthropy and commercial payers to support their ECHO programs. For example, in Montana, two commercial health plans, Blue Cross Blue Shield Montana and PacificSource, are contributing to the mental health and addictions ECHO pilot offered by Billings Clinic, the local ECHO hub. Many ECHO programs use some form of upfront philanthropic support for their programs, but such support may be limited to start-up costs, may not cover all expenses, and is not likely to be sustainable over time. As ECHO continues to be evaluated and evidence of cost savings is documented, ECHO may be more likely to attract the interest of commercial payers and Medicare, and form multi-payer partnerships.

4. ***An evaluation is helpful to demonstrating a return on investment.*** While not required for launching an ECHO program, states are encouraged to consider how an evaluation could bolster financing opportunities. Collecting data and conducting an evaluation that can demonstrate improved health outcomes and reduced costs could be helpful for securing ongoing state funding. The New York Academy of Medicine recently released an evaluation toolkit that can assist in these efforts.[9] Colorado, for example, is conducting its own analysis using claims data to evaluate its program. The evaluation will compare data for patients with chronic pain in participating primary care practices during the first 12 months of the program with data from a baseline period. Outcome measures include: inpatient hospitalization for pain/prescription opioid-related issues; opioid prescription utilization and cost; high-cost imaging; and behavioral health utilization. For Colorado, this analysis will be critical to receiving future support from the state legislature and approval from CMS to expand the program. A library of peer-reviewed studies is available on the Project ECHO web site.[10]

Conclusion

Project ECHO offers a compelling solution for states seeking to broaden access to specialty services for high-need Medicaid populations in underserved communities. A variety of financing strategies are emerging to support state efforts in leveraging Medicaid resources to pursue Project ECHO programs. Identifying a financing strategy that matches a state's unique delivery system environment as well as an ongoing evaluation mechanism to demonstrate the value of Project ECHO in improving outcomes and reducing costs are critical factors for effective implementation.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It 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

- **Medicaid Financing Models for Project ECHO** - 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.
- **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.

ENDNOTES

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

[2] S. Arora, et al. "Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers." *New England Journal of Medicine*, June 2011; 364(23):2199-207. Available at: http://www.nejm.org/doi/full/10.1056/NEJMoa1009370#t=article.

[3] For information about Oregon's Coordinated Care Model: http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx.

[4] State Medicaid Director Letter #04-002. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations. Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd022504.pdf.

[5] D. Bachrach, J. Guyer, and A. Levin. *Medicaid Coverage of Social Interventions: A Road Map for States*. Milbank Foundation, July 2016. Available at: http://www.milbank.org/uploads/documents/medicaid_coverage_of_social_interventions_a_road_map_for_states.pdf.

[6] 42 CFR §438—Managed Care. U.S. Government Publishing Office. Available at: https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-part438.pdf.

[7] *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval*, Department of Health & Human Services, Centers for Medicare & Medicaid Services, January 20, 2017. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf.

[8] *Medicaid Accountable Care Organizations: State Update*, Center for Health Care Strategies, July 2017. Available at: https://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/.

[9] *Project ECHO Evaluation 101: A Practical Guide for Evaluating Your Program*. New York Academy of Medicine. April 2017. Available at: http://nyshealthfoundation.org/uploads/resources/project-echo-evaluation-guide.pdf.

[10] For the Project ECHO library of peer-reviewed studies, see http://echo.unm.edu/about-echo/research/.