CHCS
Center for Health Care Strategies, Inc.

Project ECHO: Policy Pathways for Sustainability

By:
Greg Howe and Allison Hamblin, MSHP,
Center for Health Care Strategies, Inc.

January 2019

Made possible by the Robert Wood Johnson Foundation, The Leona M. and Harry B. Helmsley Charitable Trust, and the GE Foundation.

Contents

I. Introduction

Project ECHO® is a telehealth mentoring model that enhances workforce capacity in underserved areas by providing community-based primary care teams with the evidence-based knowledge to manage patients with complex conditions. As of October 2018, it is operating from more than 130 hubs in 30-plus states and addressing some 65 complex conditions. As states and the federal government pursue health care transformation initiatives to achieve better outcomes, policymakers increasingly recognize the need to improve access to high-quality, cost-effective specialty care. By leveraging multi-disciplinary teams of experts at academic medical centers to permanently enhance primary care capacity in local communities, Project ECHO expands specialty care access in underserved areas, increasing the likelihood that patients get the care they need, when they need it, without having to rely on referrals and travelling long distances. Project ECHO enables more effective use of existing health care resources and can support states' efforts to achieve better outcomes and reduce costs in Medicaid.

Project ECHO is supported financially by a patchwork of federal and state grants, Medicaid funds in a few states, and grants from local and national foundations. Despite the array of financial support, there are no ongoing federal funding streams to help support Project ECHO's growth. In this context, with support from the Robert Wood Johnson Foundation, The Leona M. and Harry B. Helmsley Charitable Trust , and the GE Foundation, the Center for Health Care Strategies (CHCS) sought to explore the range of federal policy levers and funding streams that could support ECHO's long-term sustainability.

CHCS convened a group of individuals with deep expertise in Medicaid, Medicare, graduate medical education, and federally qualified health centers. The ensuing discussion led to additional conversations with subject matter experts, and further development and refinement of the options presented in this report. CHCS synthesized the feedback and independently developed the recommendations contained in this report. Although it has attempted to be comprehensive in its approach, CHCS recognizes that the recommendations included herein are not likely to be exhaustive and do not include detailed legal or regulatory analysis.

Glossary of Project ECHO Terms Used in this Report

Project ECHO: Used interchangeably with ECHO, refers to the larger ECHO movement, which is an international network of hubs implementing the four parts of the ECHO model: (1) use technology to leverage scarce resources; (2) share best practices to reduce disparities; (3) apply case-based learning to master complexity; and (4) evaluate and monitor outcomes. Project ECHO was launched by Sanjeev Arora, MD, at the University of New Mexico's School of Medicine, which provides training and support for replicating the ECHO model in communities around the world.

Hub: The team of specialty providers — typically located in an academic medical center — that mentors participating primary care teams to develop the competencies needed to effectively care for patients with complex needs independently and in their communities.

Spoke: A primary care practice or clinic that participates in ECHO to expand its capacity to deliver specialty care in its community.

This work was also undertaken in anticipation of a forthcoming report on Project ECHO by the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services (HHS), as required by the ECHO Act. The ECHO Act,[1] which was signed into federal law in

December 2016, requires HHS to report on the effectiveness of tele-mentoring models like ECHO and how they can be incorporated into HHS programs and the broader health care system.

This paper is intended to present a set of viable policy options at the state and federal level for how ECHO, as an evidence-based intervention, could be paid for through federal and state funding mechanisms. Each option includes: (1) a brief discussion of how it would work; (2) its rationale and potential impact; (3) the action steps required for implementation; and (4) CHCS' assessment of its feasibility. Some of these options would take significant time and effort to pursue and could involve considerable barriers to implementation, and none of them is a "slam dunk." Nevertheless, CHCS encourages policymakers and Project ECHO to consider all of the options included herein. The options are grouped in the following categories:

- ***Big Swings: High-Impact Policy Options for Advancing ECHO Funding Nationally:*** Large-scale, national opportunities that ease the way for states, hubs, and spokes to access federal funds;
- ***Promising Policy Options that Require Federal Action***: Policy options that require action at the federal level;
- ***Promising State-by-State Policy Options***: Policy options currently available to hubs and state policymakers; and
- ***High-Leverage Partnership Strategies***: High-leverage partnerships and enterprise activities that Project ECHO could initiate or develop as a pathway for sustainability.

Project ECHO in Action

For eight years, Renita Madu worked as a physician assistant at a community health center in Pearland, Texas, about 20 miles south of Houston. Her clinic days revolved around providing family medicine services. Then, through Project Echo, Madu learned how to treat and cure hepatitis C, a major health problem in her community. Every Monday afternoon, she logged onto the virtual ECHO clinic, along with other physician assistants, doctors, and nurses in communities from around the state. Two hepatologists from CHI Baylor St. Luke in Houston led the clinics, alongside a team of specialists that included a psychiatrist and pharmacist. During the virtual clinics, community providers made case presentations, discussed their progress with patients, and expressed concerns. The specialists paid close attention to what the community providers told them and asked questions. Together, they determined next steps for the group's patients. Through the community of collaborative learning and practice created by Project ECHO, Madu learned to successfully treat hepatitis C, curing more than a dozen patients. As Dr. Norman Sussman, one of the lead hepatologists in the collaboration, put it: "If we see [a patient], we manage one patient. If we educate Renita Madu, she can see 20 patients. We are training an army of people — it's a force multiplier."

II. Big Swings: High-Impact Policy Options for Advancing ECHO Funding Nationally

Policy options in this section include large scale, national opportunities that would ease the way for hubs and states to access federal funds. All of these options would require substantial effort to put into place, but if successful, would result in the largest impact in terms of advancing ECHO. Because Project ECHO is working towards a goal of reaching one billion people, this paper leads with the boldest initiatives for sustainability, followed by more incremental approaches.

Summary of Big Swing Policy Options

1. *Issue CMS Guidance on Medicaid Financing for ECHO*
2. *Add a New Enhanced Medicaid Match Rate for ECHO*
3. *Embed Funding for ECHO in HRSA Health Center Grants*

1. Issue CMS Guidance on Medicaid Financing for ECHO

The Centers for Medicare & Medicaid Services (CMS) issues guidance to state Medicaid programs through informational bulletins and State Medicaid Director Letters (SMDL) to announce new programs, help states understand how to leverage Medicaid funding through existing mechanisms and programs, and promote use of authorities that advance CMS' goals. Through the *Project ECHO Medicaid Learning Collaborative*, CHCS has identified a list of Medicaid financing strategies that states could pursue to secure funding for ECHO. An issue brief and financing matrix that describe these mechanisms are available on CHCS' website.

How it would work: CMS would issue guidance specific to ECHO, or an ECHO-like approach, that would describe available authorities that states could use to leverage Medicaid financing and/or managed care contracting parameters for Project ECHO, and clarify the actions that states would need to undertake for securing CMS approval, thereby streamlining the implementation process and encouraging states to consider pursuing these strategies. CMS would issue an informational bulletin or SMDL that could include the following topics:

- ***Approvable financing strategies available through existing authorities.*** Options could include those described in CHCS' financing matrix, such as: capitation payments (required or voluntary); in lieu of and value-added services; network adequacy; disease management programs; health homes; Delivery System Reform Incentive Payment (DSRIP) programs; care coordination payments; episodes of care; and shared savings arrangements through accountable care organizations.
- ***State-level Graduate Medical Education (GME) investment for ECHO.*** The state would designate a portion of its Medicaid GME funds to support existing or new ECHO hubs and spokes, either directly or as a qualifying entity that is part of a larger GME strategy for improving quality or transforming care delivery.
- ***Network adequacy.*** Primary care providers that participate in an ECHO clinic and develop expertise in a particular clinical area could be counted as offering specialty care within a health plan's network.

- ***In lieu of and value-added services***. The state could identify Project ECHO as a cost-effective service in lieu of other covered specialty care benefits, or could encourage its managed care organizations (MCOs) to finance Project ECHO as a value-added service to improve quality and reduce avoidable inpatient care.
- ***Opportunities for states to receive enhanced match.*** States would be able to claim Medicaid costs associated with supporting ECHO at an enhanced match rate, either through an existing authority, such as an investment in information technology or a new enhanced match rate specific to ECHO.

Rationale and impact: Several states are currently exploring ways to finance new and existing ECHO programs to advance their states' health and quality goals. While there are examples of Medicaid financing mechanisms for ECHO in practice, there are no clear federally approved templates for states to reference. States may be unwilling to consider supporting ECHO programs if the path for federal approval is unclear or uncertain. Having CMS guidance would confirm that there are approvable models and clarify the steps for securing that approval, opening a pathway for states. Guidance would also serve to promote the ECHO model as a way for states to address pressing health issues by providing expanded access to specialty care. This pathway would likely lead to greater spread of the ECHO model, particularly in states that are on the cusp of embracing ECHO.

Action steps and feasibility: Convincing CMS to issue guidance would likely not be a quick or easy undertaking. The internal approval and clearance process can be burdensome and time consuming. SMDLs are typically issued for new policies, while informational bulletins are used to clarify existing policies, although there is not always a clear divide between the two. An informational bulletin is faster to produce internally, as it can skip several layers in the internal approval process. But perhaps most challenging would be convincing CMS that guidance is necessary, and that ECHO is a model worthy of its investment of staff time and effort. It is unusual for CMS to single out one program for guidance, but ECHO has a national reach, a track record of expanding access to care and effectively addressing a range of diseases and conditions, and a good reputation among policymakers.

Evidence Supporting the Effectiveness of ECHO

Most of the 139 peer-reviewed publications on the ECHO model focus on self-reported changes in provider knowledge, attitude, and behavior resulting from ECHO program participation.[2] However, an increasing number of studies go beyond provider self-efficacy to examine impacts, such as changes in provider behavior and patient outcomes. For example, the ECHO model has been shown to: dramatically increase the number of buprenorphine-waivered physicians;[3] significantly reduce the number of patients treated with opioids for chronic pain for providers participating in ECHO relative to a control group,[4] as well as the number of opioid prescriptions per patient;[5] significantly increase treatment initiation rates for Hepatitis C patients with cases presented in ECHO and lower median time to treatment relative to control;[6] and to significantly reduce the use of physical restraints (by 75 percent) and anti-psychotic medications (by 17 percent) for nursing homes participating in ECHO.[7] The ECHO model has been used to: achieve Hepatitis C cure rates among primary care providers statistically equivalent to the cure rates of specialist providers;[8] to lower patients' length of stay, 30-day re-hospitalization rates, and 30-day healthcare costs at skilled nursing facilities participating in ECHO relative to a matched control;[9] and to significantly reduce the likelihood of death (by 46 percent) for patients whose providers participate in a liver disease ECHO program relative to a cohort of matched patients whose providers do not participate in ECHO.[10]

2. Add a New Enhanced Medicaid Match Rate for ECHO

The Federal Medical Assistance Percentage (FMAP) for Medicaid, or match rate, is the percentage that the federal government pays states for Medicaid services. FMAP varies among states and is determined by the federal government based on the per capita income of individual states. States can receive an enhanced match for certain services or populations, typically in areas that the federal government wants to encourage state investment. For example, a state can receive a 90 percent match for information technology expenditures related to upgrading its Medicaid Management and Information System.

How it would work: CMS would designate expenditures on ECHO, or on components thereof, as eligible for enhanced federal match. If enacted, states would be able to claim associated Medicaid costs at the enhanced match rate.

Rationale and impact: An enhanced match would provide states that want to invest in ECHO with additional federal resources to do so; for every state dollar invested in the program, a larger amount could be drawn down in federal support. Drawing down these funds would be optional, and anything less than a 100 percent match would require the investment of some additional measure of state resources. However, access to these additional federal dollars could provide a significant inducement for states to support ECHO.

Action steps and feasibility: An enhanced match would require a federal statutory change, which would require congressional action and presidential approval, most likely as part of a broader legislative action. Such an undertaking would likely require great effort and time, but if successful would give states access to substantial federal resources to advance ECHO.

3. Embed Funding for ECHO in HRSA Health Center Grants

Health centers are the foundation of the nation's health care safety net, providing primary care as well as behavioral health services, diagnostic lab services, radiologic services, preventive health services, cancer screening, family planning services, dental services, and patient case management. The Health Resources Services Administration (HRSA), which administers the federal Health Center Program, funds nearly 1,400 health centers operating more than 11,000 service delivery sites in the U.S. that serve more than 28 million patients,[11] including vulnerable populations in medically underserved communities, uninsured individuals, and the Medicaid population, among others. Access to specialty care is a critical and often unmet need for this population, as well as a barrier for health center providers striving to meet the full needs of their patients. Providers from federally qualified health centers (FQHCs) and rural health clinics represent a large number of the primary care providers that participate in ECHO across the country.

FQHCs, which include Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing, receive funding to cover their costs from several sources. Many FQHCs receive grant funds for infrastructure and operational costs through Section 330 of the Public Health Service Act. FQHC operating funds also come from Medicaid, Medicare, private insurance, patient fees, and other resources.[12] (*See page 15 for description of Medicaid funding for FQHCs.*)

How it would work: Congress would increase funding levels and designate a portion of Section 330 funding to cover start-up and operational costs for participating in ECHO, and require all health centers that draw down these funds to participate in ECHO.

Rationale and impact: FQHCs provide primary care to rural and underserved populations that the ECHO model targets. There is currently no mechanism for FQHCs to cover the costs of providers who participate in ECHO clinics, specifically to recoup the revenue they would alternatively generate by seeing patients during those times. By providing a guaranteed funding source to cover these costs, health centers would be made whole for efforts to provide patients access to a broader array of services in primary care settings. Requiring health centers to participate in ECHO would greatly enhance the ability of providers around the country to participate in ECHO programs, and would advance HRSA's interest in quality improvement in FQHCs.

Action steps and feasibility: This option would require congressional action, leveraging bipartisan congressional support for both FQHCs and the ECHO model. Policymakers would need to be sensitive to the impact on groups that may have concerns about altering the funding formula for finite resources for health centers.

III. Promising Policy Options that Require Federal Action

Policy options in this section require action at the federal level and are grouped in the following sub-sections: **Medicare**, **Health Centers**, and **Graduate Medical Education**.

Summary of Policy Options Requiring Federal Action

Medicare

1. *Include ECHO in the Merit-Based Incentive Payment System*
2. *Add ECHO to the Physician Fee Schedule*
3. *Build ECHO into a CMS Innovation Center Demonstration*

Health Centers

1. *Include ECHO Participation as a Factor in Determining HRSA Quality Awards*
2. *Award Targeted Grants for Health Center-Led ECHO Start-Ups*
3. *Offer Loan Forgiveness for Participating Providers at Health Centers*

Graduate Medical Education

1. *Tie New GME Slots to ECHO*
2. *Reallocate Existing Slots and Tie Them to ECHO Participation*

Medicare

1. Include ECHO in the Merit-Based Incentive Payment System

The Merit-based Incentive Payment System (MIPS) is one of the components of the Quality Payment Program, administered by CMS to measure performance of physicians who participate in the Medicare program and meet certain criteria related to number of patients and amount of billing. Under MIPS, physicians are required to report data in four categories: (1) quality; (2) improvement activities; (3) promoting interoperability; and (4) cost.[13] Physicians receive a payment adjustment based on their performance relative to the measures. Participation in ECHO could count for meeting the "Improvement Activity" thresholds. Activities in this category include: enhancing care coordination; patient and clinician shared decision-making; and expansion of practice access.

How it would work: CMS would explicitly name ECHO as an improvement activity that would be counted in MIPS.

Rationale and impact: ECHO's activities are consistent with the improvement activities under MIPS, and participation in such activities align with ECHO's and CMS' shared quality goals. Allowing physicians to count ECHO activities in this category would be received favorably by providers already participating in ECHO, and could encourage new providers to participate by offering an explicit financial incentive.

Action steps and feasibility: CMS, under existing administrative authority, would revise the criteria for MIPS to include ECHO.

2. Add ECHO to the Physician Fee Schedule

The Medicare Physician Fee Schedule establishes what services can be billed through Medicare, and is often the benchmark for reimbursement by other private and public payers. In 2015, under the Physician Fee Schedule, Medicare began paying for Chronic Care Management services provided to Medicare patients with multiple chronic conditions. Medicare recognizes these services as a critical component of primary care that contributes to better health and care for individuals.[14] Providers are able to bill for these services using one or more of three CPT billing codes. One of those codes (CPT

99487) covers "60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month."

How it would work: CMS would agree to pay for ECHO participation through a new or revised CPT billing code in the Physician Fee Schedule that covers the time that providers spend participating in an ECHO program, pending creation of the billing code by the American Medical Association (AMA).

Rationale and impact: While time for hub providers is often covered, spoke providers do not receive reimbursement for the time they invest in participating in ECHO. The availability of a CPT code might help these providers cover their time, and likely encourage greater participation in ECHO. Commensurately, participation in ECHO would support providers in their efforts to achieve better quality and health outcomes.

Action steps and feasibility: The AMA maintains the CPT code set and oversees a panel of physicians who update the codes. To add or change a code, ECHO would have to submit an application to the panel and follow the process for gaining approval. CMS would then add the code to the Physician Fee Schedule. This process could take up to several years and would likely require significant time and resources. This approach is also squarely in the realm of fee-for-service (FFS). While most health care systems are gradually moving away from FFS models, and Project ECHO has shied away from thinking of ECHO as a service or a billable action, this approach recognizes that FFS is likely to remain a fixture of the health care system for the foreseeable future. Establishing this billing code could provide substantive resources to participating ECHO providers, particularly those who are not currently being reimbursed for their participation, while Project ECHO concurrently continues to pursue strategies that fit in value-based payment systems.

3. Build ECHO into a CMS Innovation Center Demonstration

The CMS Innovation Center oversees initiatives testing various payment and service delivery models in Medicaid and Medicare that aim to achieve better care for patients, better health for our communities, and lower costs through improvement of the health care system.[15] Categories of models include: Accountable Care; Episode-Based Payment Initiatives; Primary Care Transformation; Initiatives Focused on the Medicaid and CHIP Population; Initiatives Focused on the Medicare Medicaid Enrollees; Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models; and Initiatives to Speed the Adoption of Best Practices.

How it would work: The Innovation Center could include ECHO in one of the existing models or propose a new innovation model specific to ECHO. There are several existing models that align with ECHO:

- **Medicare Shared Savings Program Accountable Care Organizations (ACOs)**: Participating ACOs could use savings to support ECHO for their providers, or ACOs could be encouraged to participate in ECHO or an ECHO-like model, perhaps with incentives to do so.
- **Medical home models, such as Comprehensive Primary Care Initiative Plus**: The program could be modified to include an enhanced payment to providers who participate in ECHO.

- **Bundled payment models, such as the Bundled Payments for Care Improvement Initiative**: The program could include an explicit payment within bundles to support providers' participation in ECHO.

Rationale and impact: The goal of the Innovation Center is to test promising approaches to improve quality, reduce cost, and improve the experience of care; ECHO is well-positioned to support this goal. Innovation Center programs create an opportunity for robust outcomes evaluations, and provide a pathway toward permanent authorization given the Center's statutory powers. Federal funding is authorized in the aggregate for the Innovation Center, so this option would neither entail a request for new money nor a reallocation from other priorities. Participation could have a large-scale impact on ECHO as many new providers would be induced to join. Likewise, participation in ECHO would enable providers to be successful in achieving the goals of the demonstration.

Action steps and feasibility: Adding ECHO to an existing demonstration, which would happen as an expansion of that program, would be difficult administratively. Likewise, approval of new demonstrations is a timely and uncertain proposition. However, given that the Center's role is to develop and test new programs, it is a logical target for policy efforts focused on Project ECHO.

Health Centers

1. Include ECHO Participation as a Factor in Determining HRSA Quality Awards

All health centers that receive funding from HRSA are required to report data annually on a prescribed set of performance measures through the Uniform Data System (UDS). Those health centers that meet or exceed quality improvement measures can receive quality improvement awards from HRSA. In 2018, HRSA awarded $125 million to health centers in categories like delivering quality care and improving access to care.

How it would work: HRSA would add participation in ECHO as a measure it uses in determining annual quality improvement awards. FQHCs would include reporting on this measure as part of the already established UDS reporting process.

Rationale and impact: HRSA has been ramping up efforts to recognize and reward high-quality care provided by FQHCs. ECHO is already recognized and utilized by many FQHCs as a model that improves both access and quality. Tying ECHO to this existing framework would not require a new program, and it naturally aligns with the goal of continuous quality improvement. Financial incentives for participating in ECHO would help offset costs for health centers already participating in ECHO, and could motivate new health centers to join.

Action steps and feasibility: HRSA would include participation in ECHO as a factor in how the quality awards are determined and add measures related to ECHO to its UDS reporting requirements.

2. Award Targeted Grants for Health Center-Led ECHO Start-Ups

On occasion, HRSA awards grants to health centers to support the implementation of programs that address specific health concerns. For example, in June, HRSA awarded $350 million in new funding to expand access to substance use disorder and mental health services, including medication-assisted treatment services.

How it would work: HRSA would develop a grant program that would provide start-up or short-term operational funds for health centers to participate in ECHO and cover the costs associated with participation. Grants could be for ECHO hubs or spokes, or targeted to address a specific disease or condition, and could be time-limited.

Rationale and impact: Most health centers do not have the resources to launch ECHO, and health centers are financially impacted under current payment models when their providers are participating in an ECHO clinic and not seeing patients. The availability of new funding could lead to increased participation of FQHC providers in ECHO. New hubs would also serve to demonstrate the value of ECHO in improving access and quality, and could lead to additional investments by health plans and state Medicaid agencies.

Action steps and feasibility: Grants could be funded through redirecting funds through existing appropriations or a new congressional appropriation. New funding would require Congressional action, which would be a significant undertaking. However, ECHO enjoys bipartisan support, and is recognized as a model for improving access and quality that aligns with the populations that are served by FQHCs — another health care delivery model supported widely in Congress.

3. Offer Loan Forgiveness for Participating Providers at Health Centers

The National Health Service Corps (NHSC), administered by HRSA, offers a loan repayment program for primary care providers who commit to working in areas with limited access to care. Eligible sites include any FQHC and other primary care sites that meet HRSA criteria. Many states also offer loan repayment programs for service in underserved areas.

How it would work: HRSA, or individual states, could designate additional funds to reduce educational loans for primary care practitioners that work in underserved areas and also participate in ECHO. HRSA could alternatively make ECHO participation a requirement for loan forgiveness.

Rationale and impact: Reducing debt could be an incentive for individual practitioners to participate in ECHO and lead to greater interest in ECHO at those sites.

Action steps and feasibility: HRSA would make changes to the NHSC program, and individual states would factor ECHO participation into their relevant loan forgiveness programs.

Graduate Medical Education

ECHO is in large part a workforce development program that expands the knowledge and expertise of health care providers, and is at the forefront of innovation around lifelong learning. From that perspective, ECHO fits naturally in the GME field, and GME represents perhaps the area of greatest long-term potential for advancing ECHO. However, the graduate medical education landscape is very

complicated, particularly at the federal level, where funds are allocated throughout a far-reaching web of programs and institutions across the country. There are also significant political pressures brought to bear on the allocation of existing resources, with substantial vested interest in the status quo across a range of constituencies.

While there should be opportunities for leveraging the vast resources currently being directed by the federal government to GME *(see sidebar below)*, more work needs to be done to fully understand this landscape and how the goals of ECHO and GME can be optimally aligned. For this reason, this report is not presenting options to tap into Direct or Indirect Graduate Medical Education payments. Instead, there are several entry points into this landscape and potential near term opportunities that are worthy of greater exploration. Two options are described in this section, and a third in the section on state-level initiatives.

About Graduate Medical Education

Graduate medical education (GME) refers to the training that physicians receive immediately after completing medical school. GME, also referred to as residency or fellowship training, lasts between 3-9 years and allows physicians to specialize and practice independently.[16]

The Accreditation Council for Graduate Medical Education (ACGME) sets the standards for and accredits GME programs in the United States and the institutions that sponsor them. There are approximately 830 ACGME-accredited institutions sponsoring approximately 11,200 residency and fellowship programs in 180 specialties and subspecialties.[17]

GME is funded at the federal level primarily through payments by the Medicare program and by matching Medicaid payments to states that choose to support GME *(see discussion below)* with state dollars. Additional federal sources of funding include: the Department of Defense; Veteran's Affairs; and HRSA through the Children's Hospitals GME program that supplements GME payments from Medicare to Children's Hospitals.

There are two forms of payments by Medicare: Direct Graduate Medical Education (DGME) and Indirect Graduate Medical Education (IGME). DGME payments are designed to cover the direct costs related to educating residents, such as compensation and benefits for students and faculty. IGME payments are intended to cover the indirect costs, or additional costs accrued by hospitals that have a GME program. DGME payments are based on the number of residents at an institution, whereas IGME payments are based on the number of residents, number of beds, and other related factors. However, institutions are capped in the number of residents that can be counted for determining funding. In 2016, total GME payments made by Medicare alone were about $9 billion.[18]

1. Tie New GME Slots to ECHO

Institutions receiving GME payments through Medicare are capped at the number of residents that can be counted in funding determinations. There are currently efforts in Congress to increase residency caps to allow more funding for GME programs, and therefore more residents to be trained.

How it would work: Institutions that receive additional funding for new "slots" for residents would be required to use a portion of those funds to invest in ECHO programs at the institution. Legislation could be limited to Medicare funding, or could include any federal program that supports GME.

Rationale and impact: The goals of ECHO and GME are closely aligned. Because of this alignment, GME funding represents a promising avenue for advancing both Project ECHO and medical education. *(See page 19 for a discussion on reimagining medical education and lifelong learning.)*

Action steps and feasibility: Increasing the resident caps in GME (allocation of new "slots") would require congressional action.

2. Reallocate Existing Slots and Tie Them to ECHO Participation

CMS has the authority to reduce residency slots from certain hospitals and redistribute the slots resulting from those reductions. Federal law stipulates how those slots are reallocated. For example, hospitals with proximity to where the slots are being reduced would be given priority for the redistributed slots.[19]

How it would work: CMS would increase residency caps for designated institutions. These institutions would be required to use a portion of those funds to invest in ECHO programs.

Rationale and impact: The goals of ECHO and GME are closely aligned. Because of this alignment, GME funding represents a promising avenue for advancing both Project ECHO and medical education. *(See page 19 for a discussion on reimagining medical education and lifelong learning.)*

Action steps and feasibility: Redistributing slots in GME would require CMS action, and would likely be politically challenging.

IV. Promising State-by-State Policy Options

Policy options in this section include existing, workable opportunities that are currently available to hubs and state policymakers. These options are grouped in the following subsections: **Medicaid**, **Health Centers**, and **Other**.

Summary of State-by-State Policy Options

Medicaid

1. *Pursue Financing Mechanisms that Leverage Medicaid Funding*
2. *Encourage State Medicaid Investments in Graduate Medical Education*
3. *Utilize Civil Money Penalty Funds for ECHO*
4. *Allocate Disproportionate Share Hospital (DSH) Payments for ECHO*

Health Centers

1. *Update FQHC Rates at the Health Center Level to Cover ECHO Participation*

Other

1. *Leverage Tobacco Settlement Funds*

Medicaid

1. Pursue Financing Mechanisms that Leverage Medicaid Funding

Through the *Project ECHO Medicaid Learning Collaborative*, CHCS has identified a set of strategies for state Medicaid agencies to use Medicaid funds to support ECHO (*see Financing Project ECHO: Options for State Medicaid Programs*). These financing strategies include: capitation payments (required or voluntary); in lieu of and value-added services; network adequacy; disease management programs; health homes; Delivery System Reform Incentive Payment (DSRIP) programs; care coordination payments; episodes of care; and shared savings arrangements through accountable care organizations.

How it would work: State Medicaid agencies, in partnership with Project ECHO, would identify and pursue one of the above financing mechanisms, or a feasible alternative identified by the state, for approval by CMS.

Rationale and impact: Use of 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 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 experience significant waiting times before getting access to needed specialty care. Second, 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.

Action steps and feasibility: Each option requires a different set of actions. An issue brief developed by CHCS is available for both state policymakers and hub leaders, *Financing Project ECHO: Options for State Medicaid*. The CHCS resource, *Medicaid Financing for Project ECHO: Strategies for Engaging State Medicaid Officials*, is designed for ECHO hub leaders who are interested in building the case for Medicaid financing with their state policymakers.

2. Encourage State Medicaid Investments in Graduate Medical Education

States may choose to use Medicaid dollars to support GME. States appropriate general fund dollars that are then matched by federal funds through Medicaid at the FMAP matching rate. In 2015, 43 states and the District of Columbia made Medicaid GME payments, totaling over $4 billion.[20] A 2017 study by the University of North Carolina[21] identified 10 states that are actively engaged in examining the way that state GME funds are distributed to better address health care needs, including expanding access to care.

How it would work: The state would designate a portion of its Medicaid GME funds to support existing or new ECHO clinics, either directly or as a qualifying entity that is part of a larger GME strategy for improving quality or transforming care delivery, e.g., through an emphasis on team-based care.

Rationale and impact: States recognize the value of medical education and voluntarily devote significant resources for GME. Many states are considering changing the way those resources are distributed. The ECHO model is inherently designed to effectively disseminate knowledge, and therefore well-positioned to help states maximize their investments in medical education.

Action steps and feasibility: States use various approaches with differing levels of stakeholder involvement in determining how state GME investments are made. Interest by policymakers would depend in part on competing priorities for those dollars.

3. Utilize Civil Money Penalty Funds for ECHO

CMS imposes a civil money penalty (CMP) against nursing facilities that are not in compliance with Medicare or Medicaid participation requirements for long-term care facilities.[22] A portion of CMPs collected from facilities are returned to states in which the CMPs are imposed, and these funds may be reinvested to support activities that benefit nursing facility residents, specifically to protect or improve their quality of care or quality of life. States determine the process by which these funds are distributed to entities that are interested in implementing allowable activities.

How it would work: Hubs and spokes would apply for CMP funds to support new or existing ECHO clinics that benefit nursing home residents.

Rationale and impact: There are a number of existing ECHO clinics, and more under development, designed to improve care for nursing home residents. These funds could help bolster those efforts.

Action steps and feasibility: Interested hubs and spokes would apply for CMP funds. This is a promising source of funds for a subset of the nursing home population.

4. Allocate Disproportionate Share Hospital (DSH) Payments for ECHO

State Medicaid agencies are required by federal law to make an annual payment to qualifying hospitals to cover the uncompensated costs that they incur by caring for a disproportionate number of low-income patients. These are patients that are not otherwise covered by Medicare, Medicaid, CHIP, or private insurance.[23] States receive an allotment from the federal government based on a formula that ensures that the allotment does not exceed the actual uncompensated costs. In 2017,

U.S. hospitals received over $12 billion in DSH payments.[24] States have some flexibility in determining the amount of the payment to individual hospitals and how the payments are distributed among hospitals.

How it would work: States could require hospitals that receive DSH funding to use a portion of those funds to support primary care practices and health centers that are participating in ECHO, or allocate DSH funds to support ECHO hubs in their own hospitals.

Rationale and impact: Low-income, uninsured patients who are served by hospitals receiving DSH payments are often sicker and have more complex health needs than those served by other hospitals. These patients, who may also be seen at primary care practices in these communities, may not have access to the specialty care that they need to stay healthy and out of the hospital.

Action steps and feasibility: States could build the ECHO model into their DSH strategy. Because of competing hospital budget priorities and the large amount of funding involved, hospitals would likely resist changes to how DSH funds are distributed.

Health Centers

1. Update FQHC Rates at the Health Center Level to Cover ECHO Participation

Federal law requires that FQHCs be reimbursed through a Prospective Payment System (PPS) or Alternative Payment Methodology (APM), based on a health center's historical costs of providing comprehensive care to Medicaid patients. Each center has its own PPS or APM rate, which is updated annually for inflation. States also are required to have a change in scope policy in place and to update a health center's rate if there is a change in scope of services that are provided to health center patients. If a state has chosen to reimburse health centers via an APM, two statutory requirements must be met: (1) that each health center agrees to the APM; and (2) that any payment be no less than what a health center would have received via the PPS rate.

How it would work: States would factor the costs of participating in ECHO into the rates that are paid to participating clinics by adding ECHO to the scope of services. HRSA could issue guidance to states about this action.

The Need to Support Spokes

Spokes, the primary care providers that are expanding their specialty knowledge at their practice sites, typically receive no compensation for participating in ECHO activities. While participating providers are able to receive valuable continued medical education credits, they are largely motivated by learning how to provide better care to their patients. For the primary care practices, particularly FQHCs, participating in ECHO is uncompensated time spent away from seeing patients and represents a loss of revenue, thereby essentially acting as a disincentive for participating in ECHO. Whereas many funding mechanisms are focused on supporting operations within hubs, financial incentives to enable greater participation among spokes are equally important. This report seeks to reinforce that objective by recognizing the need for greater spoke funding, and by identifying policy options that support all of those who participate in the ECHO model.

Rationale and impact: FQHC participation in ECHO would likely increase to the extent there were a designated funding source to cover the associated time spent in ECHO activities. Addressing this issue would remove a major barrier to FQHC participation in ECHO.

Action steps and feasibility: FQHCs and ECHO hubs would engage state policymakers in the rate setting process. Rate setting is complicated and costly — most states contract with actuarial firms to support this activity. Budget constraints and competing priorities may affect state interest in funding ECHO this way.

Other

1. Leverage Tobacco Settlement Funds

In 1998, four of the largest tobacco companies entered into a master settlement agreement (MSA) with 46 states, in perpetuity, to help states cover their tobacco-related health costs, guaranteeing $246 billion over the first 25 years. States passed legislation stipulating how those funds were to be used, generally requiring that they be used for health-related purposes, including activities to curtail the use of tobacco.

How it would work: States would allocate MSA funds to support existing or new ECHO hubs.

Rationale and impact: Tobacco settlement funds continue to be a significant source of funding for addressing state health care needs. These funds could support ECHO programs that address tobacco-related diseases, such as asthma, hypertension, and cancer.

Action steps and feasibility: State policymakers would allocate MSA funds to support ECHO. Although states have designated MSA funds for health-related purposes, many states use these funds to cover funding gaps in their Medicaid and other health programs. These funds are often targeted by other health-related programs, both internal and external to state government.

V. High-Leverage Partnership Strategies

During the course of exploring policy options for this report, several compelling ideas surfaced that would not require policy change at the federal or state level. Described further below, these opportunities, which exist within current policy frameworks, include potentially high-leverage partnerships that ECHO should consider exploring to support continued growth and sustainability.

Summary of High-Leverage Partnership Strategies

1. *Reimagine Medical Education and Lifelong Learning in the United States*
2. *Leverage Opportunities in Medicare's Quality Programs: IDIQ Contracts*
3. *Use the STARS Rating Program to Engage Medicare Advantage Plans*
4. *Embed ECHO in FQHC Alternative Payment Models*
5. *Support Maintenance of Certification Activities*
6. *Leverage Community Benefit Requirements*

1. Reimagine Medical Education and Lifelong Learning in the United States

ECHO, as a proven workforce development model, can play a key role in shaping the future of medical education and ongoing learning. Because patterns of lifelong learning are established in residency, graduate medical education could be a springboard to reimagining and advancing medical education beyond initial clinical training. As discussed earlier, GME represents an area of enormous long-term potential for advancing ECHO. Likewise, ECHO is a model that could enable a major transformation for continuing medical education, effectively blending practice and education.

Key entities in the health care system, such as hospitals and health systems, also have a stake in ensuring the ongoing development and continuing education of the health care workforce. Investments in learning by hospitals and health systems are typically limited to helping providers meet continued education requirements, or involve activities related to human resources functions. ECHO offers key lessons for changing how learning is supported and advanced in those institutions.

***How it would work**:* ECHO could design a strategy for reaching multiple hospitals and health systems to present its vision for how the model fits into a culture of learning and how a reimagining of lifelong learning is a mutually beneficial endeavor. ECHO could potentially partner with organizations or individual entities to launch enterprise-wide pilot projects that demonstrate the value of ECHO as a learning model.

***Rationale and impact**:* Individual partnerships with pre-eminent institutions could go a long way toward building a case for others to follow. Generating interest across a spectrum of organizations and building a network to support a common vision would strongly position ECHO in future efforts of advancing lifelong learning.

***Action steps and feasibility**:* ECHO could engage key medical education organizations, such as:

- Alliance for Independent Medical Centers
- Association of Academic Health Centers
- Association for Medical Educators
- Association of American Medical Colleges
- American Hospital Association
- America's Essential Hospitals
- Council of Teaching Hospitals and Health Systems

Outreach in this area could include identifying national health system networks to serve as a multisite learning infrastructure, similar to how ECHO is implemented within the Department of Defense and the Department of Veteran's Affairs.

Federal support is also critical to driving greater investment in lifelong learning. Efforts to engage hospitals and institutions would be bolstered by federal guidance or legal requirements in this area. This is a policy option that could be pursued in coordination with efforts to engage hospitals, as described above. CMS could issue a guidance statement that would signal its vision for greater investment in lifelong learning. The guidance could include concrete direction in selected areas or indicate its intentions to make changes. Alternatively, laws could be enacted to require institutions to make investments or implement prescribed learning activities.

Institutions would benefit from a clear vision by the largest health care payer, and may not otherwise take independent action.

2. Leverage Opportunities in Medicare's Quality Programs: IDIQ Contracts

Quality of care continues to be a major focus of the Medicare program, and this goal has been advanced through a number of programs such as the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) program and the Hospital Improvement Innovation Networks (HIINs) program. There are 14 QIN-QIOs that work with providers, stakeholders, and Medicare beneficiaries to improve the quality of health care for targeted health conditions.[25] QIN-QIOs lead initiatives focus on increasing patient safety, making communities healthier, better coordinating post-hospital care, and improving clinical quality. These initiatives include opportunities for providers to learn from each other and implement best practices. Under the HIIN program, groups of hospitals at a regional, state, or national level join together to develop strategies focused on harm reduction in their hospitals, often in partnership with QIN-QIOs. Integral to the HIIN program is the creation of learning opportunities and disseminating proven solutions.[26]

These two programs, along with other related quality initiatives, are currently being consolidated in 2018 under one federal Indefinite Delivery/Indefinite Quantity (IDIQ) contract: the "Network of Quality Improvement and Innovation Contractors." Under this contract, individual task orders will be awarded to quality improvement contractors that "have the capability to achieve large scale improvement results using effective and innovative quality improvement strategies that are data driven, transparent, and empower patients, families, and clinicians to make decisions about their healthcare."[27] CMS anticipates awarding multiple IDIQ contract awards that will have a 10-year ordering period, with awards totaling up to $25 billion over the life of the contract.[28]

How it would work: ECHO would identify prime contractors with whom to partner as a subcontractor. ECHO could potentially join more than one bidder on a non-exclusive basis in order to be positioned to bid on future task orders. ECHO, along with the prime contractors, would monitor task orders that align with ECHO. ECHO is already in contact with HIINs that have an interest in using ECHO, and could build upon those contacts to identify additional contractors.

Rationale and impact: There are multiple potential initiatives under this contract for which ECHO would be well-positioned to help established federal contractors address ongoing Medicare quality

improvement objectives. Participating in this large IDIQ would help spread the ECHO model nationally, and position ECHO to participate in future opportunities.

Action steps and feasibility: Project ECHO and potentially local hubs would monitor the timing and rollout of this IDIQ, identify the universe of potential prime contractors, and engage a targeted subset for partnership opportunities.

3. Use the STARS Rating Program to Engage Medicare Advantage Plans

Medicare Advantage plans are rated annually by Medicare based on various quality and performance metrics though the STARS program.[29] Plans receive an overall rating as well as ratings in several categories, with all ratings on a scale of one to five stars. Consumers consider these ratings when comparing and deciding on a plan, and the ratings have bearing on the payments the plans receive from Medicare.

How it would work: A plan would contract with an ECHO hub to support its provider network to improve on a specific measure or set of measures included in the STARS ratings, such as medication adherence for a particular disease. Plans, which rebid annually, could also use ECHO to drive quality in a particular category, such as Managing Chronic (Long-Term) Conditions.

Rationale and impact: Plans have an interest in achieving the highest rating to both attract customers and to strengthen their bids in the competitive bidding process with Medicare. There are more than 2,000 Medicare Advantage Plans across the country that could serve as potential partners with ECHO. [30]

Action steps and feasibility: Project ECHO would develop a strategy to engage Medicare Advantage plans. Based on ongoing interest in ECHO demonstrated by Medicaid health plans, it is reasonable to think that Medicare Advantage plans would be receptive to the ECHO model.

4. Embed ECHO in FQHC Alternative Payment Models

States are required by federal law to reimburse FQHCs through a Prospective Payment System (PPS) based on a health center's historical, reasonable costs *(see above description on FQHC payment*). In reimbursing FQHCs, states are permitted to use an alternative payment methodology (FQHC APM), provided each health center agrees to the APM and the APM amount is no less than what a health center received under the PPS. States and FQHCs across the country are increasingly looking for opportunities to adopt FQHC APMs that delink payment from the face-to-face visit, converting the existing FQHC PPS/APM to a capitated per member per month payment. The capitated FQHC APMs are typically designed to give states and health centers more flexibility in how they deliver care, and often include incentives for improving quality. These arrangements allow FQHCs to offer services, such as group visits and care management, which are not paid for under the existing per-visit system.

How it would work: An FQHC that is participating in a capitated FQHC APM would have the flexibility afforded by a capitated payment methodology to invest in provider participation in ECHO. In some FQHC APMs, the costs of delivering care through alternative services — like ECHO — may be factored into the rate-setting process for future years.

Rationale and impact: FQHCs that participate in ECHO need a designated funding source to cover the costs of their providers *(see discussion above on spoke funding)*. Capitated FQHC APMs are currently only implemented in two states (Oregon and Washington), but interest and implementation is growing. Because ECHO can help health centers meet quality goals that may be tied to financial incentives under FQHC APMs, participating in these arrangements should have greater incentives to participate in Project ECHO.

Action steps and feasibility: Connect local hubs and FQHCs that are participating in capitated FQHC APMs or are involved in efforts to develop capitated FQHC APMs to recruit spoke providers.

5. Support Maintenance of Certification Activities

The American Board of Medical Specialties (ABMS), through its 24 certifying boards, limits board certification to 10 years. In order to maintain board certification, physicians must undergo a rigorous maintenance of certification (MOC) process. The MOC programs, provided by the respective specialty boards, are based on a framework of enhancing patient care and improving patient outcomes.[31]

How it would work: ECHO would work with ABMS and other related partners to develop programs related to MOC process. ECHO could leverage the MOC requirement as an incentive for specialists to participate in local ECHO hubs.

Rationale and impact: The MOC is an arduous process for specialists. ECHO's experience in specialty care education would be an asset to the ABMS and the specialists undertaking MOC. This role would expand ECHO's reach and serve as a valuable recruiting tool for specialists currently not involved in ECHO.

Action steps and feasibility: Project ECHO is currently involved in pilot programs to support MOC activities, and would build on its work in this area.

6. Leverage Community Benefit Requirements

The majority of U.S. hospitals operate as non-profits, which affords them tax and other favorable financial benefits.[32] Federal tax rules require that non-profit hospitals, as a condition for maintaining their non-profit status, engage in activities that benefit their communities. Many states also have laws that stipulate requirements related to community benefits. In 2012, an estimated $37 billion was spent on community benefit contributions.[33] Although federal and state rules require hospitals to undertake community needs assessments and meet some reporting requirements, there are no minimum thresholds for spending, and there is a lack of clarity on what counts as a community benefit.

How it would work: The ECHO model could be used to leverage community benefit dollars to improve patient care. ECHO hubs would work with their affiliated hospitals to encourage them to invest community benefit dollars in their programs.

Rationale and impact: Most community benefit expenditures are devoted to services related to patient care.[34] This is an existing mechanism that is designed to address community needs, including expanding access to care and addressing quality gaps.

Action steps and feasibility: Local hubs would work within their hospital systems to use community benefit dollars for ECHO. ECHO could support these local efforts by advocating for allocation of community benefit funds at state and federal policy levels, and by supporting local hubs with tools to make the return on investment case for these allocations.

VI. Recommendations and Next Steps

The following recommendations are for near-term action to move the ECHO movement along the path toward long-term sustainability:

1. Develop a strategy to advance the "Big Swing" policy initiatives.

Enactment of any of these policy changes would move the needle significantly toward sustainability. CMS guidance on approvable Medicaid financing strategies would ease the way for states to use Medicaid dollars and could serve as a tipping point for states contemplating the ECHO model. An enhanced rate for ECHO would allow states to implement ECHO with a relatively small state investment that would be supported by an infusion of federal dollars. Building ECHO into the HRSA health center grants would unlock a dependable source of funding available to all FQHCs. All of these changes would require action at the federal level.

2. Continue efforts to support ECHO hubs in pursuing state-level strategies to secure financing.

Project ECHO is already providing technical assistance to states and hubs around state-level Medicaid strategies. ECHO should continue these efforts, while also exploring the "Promising Strategies" presented in this report in the areas of Medicaid, FQHCs, and graduate medical education.

3. Bolster efforts to support hubs in advocating for ECHO to be built into Medicaid managed care capitation payments, and support efforts to engage Medicaid managed care organizations to voluntarily support ECHO.

One of the most promising Medicaid financing strategies for ECHO is building support for ECHO into capitation payments made to a state's managed care organizations. Such payments provide a dependable funding stream for ECHO hubs and impact the entire Medicaid population served by managed care in the state. States may not be willing or able to commit state resources to support rate-based capitation payments due to budget constraints. In these states, ECHO should work with hubs to engage Medicaid managed care plans around the benefits of voluntarily supporting ECHO hubs through their Medicaid capitation payments. For Medicaid MCOs involved in value-based payment arrangements, ECHO could be promoted as a mechanism for delivering on quality and cost targets.

4. Explore graduate medical education as an area of natural alignment with ECHO and as a significant source of financial support.

ECHO, as a proven workforce development model, sits squarely in this space and needs to be involved in shaping the future of learning. Because patterns of lifelong learning are established in residency, graduate medical education could be a springboard to reimagining and advancing medical education beyond initial clinical training — a conceptual adjustment to doing education differently. Concurrent with the broader efforts to reimagine the larger learning system, existing funding for Direct and Indirect GME payments from Medicare deserve further exploration.

5. Focus on disease-specific initiatives that align with current health needs.

Policy initiatives are often driven by the need to address pressing health concerns. ECHO is widely recognized as an effective model for quickly responding to those needs across a spectrum of diseases and conditions. The opioid crisis, for example, is currently one of the most visible health concerns among the public and policymakers, and one in which ECHO is already extensively involved. ECHO should look for opportunities to address pressing health concerns among all of the policy options, as it successfully did by securing CURES Act and HRSA funding for opioids, as well as keep proven results in these areas at the forefront of discussions about policy changes that advance ECHO.

6. Step-up efforts to engage HRSA and advance options to encourage FQHC involvement.

The population served by FQHCs have a great need for access to specialty care. HRSA's goals for supporting FQHCs and vulnerable populations can be well served by ECHO's potential to expand access to care. FQHCs also enjoy bipartisan support from policymakers, which opens up even greater opportunities for expanding ECHO's reach.

7. Consider payment models that support spokes.

In deciding which policy options to advance, consider how policy changes will impact the spoke provider and, more importantly, advance models that incent greater participation.

8. Develop a targeted strategy for leveraging new partnership opportunities that align with ECHO's mission and sustainability goals.

Identifying and leveraging business opportunities requires a strong and dedicated team, discreet marketing messages, and strategy organized around this goal. In addition to the federal and organizational opportunities described above, there are myriad other business opportunities that could prove promising for ECHO.

VII. Conclusion

The options and recommendations described in this report cover a wide range of policy areas. All of the options are ripe for further exploration and development, and serve as an entry point for discussions with state and federal policymakers. Those efforts involve engaging the growing ECHO community as well as new stakeholders across the health care spectrum. Project ECHO is well-positioned to advance these promising opportunities to sustain and expand the ECHO movement and to monitor ongoing policy developments that can be leveraged for this purpose.

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 community-based organizations 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 Robert Wood Johnson Foundation, The 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 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.
- 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 in states as well as strategies that are not yet operational.

VIII. Appendix: Summary of Options

	OPTION	BRIEF DESCRIPTION
Big Swings: High-Impact Policy Options for Advancing ECHO Funding Nationally		
1.	Issue CMS Guidance on Medicaid Financing for ECHO	CMS would issue guidance specific to ECHO, or an ECHO-like approach, that would describe available authorities that states could use to leverage Medicaid financing and/or managed care contracting parameters for Project ECHO, and clarify the actions that states would need to undertake for securing CMS approval, thereby streamlining the implementation process and encouraging states to consider pursuing these strategies.
2.	Add a New Enhanced Medicaid Match Rate for ECHO	CMS would designate ECHO as a program for which states would receive an enhanced match. If enacted, states would be able to claim Medicaid costs associated with supporting ECHO at the enhanced match rate.
3.	Embed Funding for ECHO in HRSA Health Center Grants	Congress would increase funding levels and designate a portion of the Community Health Center Fund to cover start-up and operational costs for participating in ECHO, and require all health centers that draw down these funds to participate in ECHO.
Promising Policy Options that Require Federal Action		
Medicare		
1.	Include ECHO in the Merit-based Incentive Payment System (MIPS)	CMS would add ECHO as an improvement activity that would be counted in MIPS.
2.	Add ECHO to the Physician Fee Schedule	CMS would agree to pay for ECHO participation through a new or revised CPT billing code in the Physician Fee Schedule that covers the time that providers spend participating in an ECHO clinic, pending creation of the billing code by the American Medical Association.
3.	Build ECHO into a CMS Innovation Center Demonstration	CMS would include ECHO in one of the existing models or propose a new innovation model specific to ECHO.
Health Centers		
1.	Include ECHO Participation as a Factor in Determining HRSA Quality Awards	HRSA would add participation in ECHO as a measure it uses in determining annual quality improvement awards. FQHCs would include reporting on this measure as part of the already established UDS reporting process.
2.	Award Targeted Grants for Health Center-led ECHO Start-ups	HRSA would develop a grant program that would provide start-up or short-term operational funds for ECHO or funds to cover the costs of providers who participate in ECHO. Grants could be for any ECHO hub, or targeted to address a specific disease or condition, and could be time-limited.
3.	Offer Loan Forgiveness for Participating Providers at Health Centers	HRSA, or individual states, could designate additional funds to reduce educational loans for primary care practitioners that work in underserved areas and also participate in ECHO, or make ECHO participation a requirement for loan forgiveness.
Graduate Medical Education		
1.	Tie New GME Slots to ECHO	Institutions that receive additional funding for new "slots" for residents would be required to use a portion of those funds to invest in ECHO programs at the institution. Legislation could be limited to Medicare funding, or could include any federal program that supports GME.
2.	Reallocate Existing Slots and Tie Them to ECHO Participation	CMS would increase residency caps for designated institutions. These institutions would be required to use a portion of those funds to invest in ECHO programs.

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OPTION		BRIEF DESCRIPTION
Promising State-by-State Policy Options		
Medicaid		
1.	Pursue Financing Mechanisms that Leverage Medicaid Funding	State Medicaid agencies, in partnership with Project ECHO, would identify and pursue one of the financing mechanisms strategies for approval by CMS.
2.	Encourage State Medicaid Investments in Graduate Medical Education	A state would designate a portion of its Medicaid GME funds to support existing or new ECHO clinics, either directly or as a qualifying entity that is part of a larger GME strategy for improving quality or transforming care delivery, e.g., through an emphasis on team-based care.
3.	Utilize Civil Money Penalty (CMP) Funds for ECHO	Hubs and spokes would apply for CMP funds to support new or existing ECHO clinics that benefit nursing home residents.
4.	Allocate Disproportionate Share Hospital (DSH) Payments for ECHO	States could require hospitals that receive DSH funding to use a portion of those funds to support FQHCs that are participating in ECHO, or allocate DSH funds to support ECHO clinics in their own hospitals.
Health Centers		
1.	Update FQHC Rates at the Health Center Level to Cover ECHO Participation	States would factor the costs of participating in ECHO into the rates that are paid to participating clinics by adding ECHO to the scope of services. HRSA could issue guidance to states about this action.
Other		
1.	Leverage Tobacco Settlement Funds	States would allocate Master Settlement Agreement funds to support existing or new ECHO hubs.
High-Leverage Partnership Strategies		
1.	Reimagine Medical Education and Lifelong Learning in the United States	ECHO would design a strategy for reaching multiple hospitals and health systems to present a vision for how ECHO fits into a culture of learning and how a reimagining of lifelong learning is a mutually beneficial endeavor.
2.	Leverage Opportunities in Medicare's Quality Programs: IDIQ Contracts	ECHO would identify prime contractors with whom to partner as a subcontractor. ECHO could potentially join more than one bidder on a non-exclusive basis in order to be positioned to bid on future task orders. ECHO, along with the prime contractors, would monitor task orders that align with ECHO.
3.	Leverage the STARS Rating Program to Engage Medicare Advantage Plans	A plan would contract with an ECHO hub to target one or more disease areas to improve on a specific measure or set of measures to impact the plan's STAR ratings, such as medication adherence for a particular disease. Plans, which rebid annually, could also use ECHO to drive quality in a particular category, such as Managing Chronic (long-term) Conditions.
4.	Embed ECHO in Federally Qualified Health Center Alternative Payment Models	ECHO hubs would engage FQHCs that are participating in APMs or are involved in efforts to develop APMs to recruit spoke providers. An FQHC that is participating in an APM would have the flexibility to use capitated payments under the APM to cover the costs of ECHO for its participating providers.
5.	Support Maintenance of Certification Activities	ECHO would work with ABMS and other related partners to develop programs related to MOC process. ECHO could leverage the MOC requirement as an incentive for specialists to participate in local ECHO hubs.
6.	Leverage Community Benefit Requirements	ECHO hubs would work with their affiliated hospitals to encourage them to invest community benefit dollars in their programs.

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