Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States

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Project Objectives

- To better understand the range of state approaches to Medicaid payment reform
- To identify promising practices and lessons learned
- To identify common themes across states

Background

Policymakers seek value from Medicaid program

- Improving outcomes
- Containing cost growth

States exploring a variety of approaches to achieve these goals

Challenges in Medicaid payment reform

- More enrollees with complex conditions, higher medical costs, and economic and social challenges
- Limited ability to influence enrollee health care seeking behavior through cost sharing
- Lower payment rates make it difficult to attract and engage providers

Project Approach

Site visits to AR, MN, OR, and PA in the fall of 2013 to understand:

- What key factors affected model choice and design?
- What was required to launch and implement the initiatives?
- How does the program operate and how will it be evaluated?

Interviews with state officials and stakeholder groups over 2 days in each state

Not a formal research study or evaluation

Project Sponsor

This project was sponsored by the **Medicaid and CHIP Payment and Access Commission (MACPAC)**. MACPAC staff members James Teisl and Moira Forbes participated in and collaborated on this effort.

Arkansas: Payment Improvement Initiative (API)

Context

- No comprehensive Medicaid managed care
- Little provider integration

Episode-based payment system

- Statewide and multi-payer, with standard and flexible components across payers
- Eight episodes launched during 2012-13; plans to launch six additional episodes beginning in 2014
- Couples acute care payment strategies with initiatives to address population health (PCMH, health home)

Retrospective

- Payments made using fee for service schedule, with "settle-up" after performance period
- Claims data used to identify "principal accountable provider" (PAP) for each episode

PAP performance is compared to cost and quality benchmarks

- Providers meeting both cost and quality benchmarks are eligible to share in savings
- Providers with costs that are "not acceptable" return a portion of excess costs

Minnesota: Health Care Delivery Systems Demonstration (HCDS)

Context

- History of integrated health care systems
- Medicaid managed care
- ACO initiatives involving Medicare and commercial payers

Modeled on Medicare Shared Savings Program

- Encourages voluntary creation of Accountable Care Organizations (ACOs)
- Piggybacks on Medicare shared savings methodology to lessen provider burdens and encourage provider participation

Providers are responsible for the total cost of care for their attributed patient populations

- "Virtual" model for smaller providers: upside shared risk only
- Integrated model for larger providers: upside and downside shared risk
- Allows significant provider flexibility

Opens up new avenues for testing provider reform and innovation in the context of an existing Medicaid managed care delivery system

Oregon: Coordinated Care Organizations (CCOs)

Context

- History of Medicaid managed care
- Growing frustration with cost growth and lack of accountability for quality/cost

CCOs are community-based organizations governed by local partnerships among providers, community members, and stakeholders that assume financial risk

- Provide integrated physical, behavioral, and other covered services
- Accountable for outcomes – cost (global budget) and quality

State negotiated agreement with CMS that committed to reducing annual per capita cost growth, increasing quality of care, and improving population health

- In return, Oregon gained federal approval to claim Medicaid matching funds for certain health-related services that have not traditionally been reimbursable

Replaced MCO contracting and uncoordinated funding streams for physical and behavioral health

- However, many former Medicaid MCOs contract with the CCOs or directly own them

Pennsylvania: Medicaid Payment Incentives and Policies

Context

- Long history of Medicaid managed care
- Program administrators have significant flexibility

Pay for performance

- MCOs: bonuses incorporated into MCO contracts for meeting quality measures (mostly HEDIS)
- Providers: Separate provider P4P program incorporated into MCO contracts (must be passed through to providers)

Targeted payment adjustments

- Efficiency adjustments reduce base MCO rates for inefficient care determined through Medicaid claims analyses
- Hospital readmissions and preventable severe adverse events policies: affect payment for acute care general hospitals

Reforms largely implemented within existing Medicaid managed care program

Targets both MCOs and providers and addresses a variety of areas of health care

Allows for significant control at the state agency level

Themes Across States

1. State budget conditions often provided initial impetus for Medicaid payment reform, but savings are not the only goal
2. States are taking an active role in payment and care delivery reform beyond traditional Medicaid managed care, but changes in roles for MCOs vary by state
3. State Medicaid payment reforms intended to influence provider behavior directly
4. Data are important for facilitating improved care delivery downstream
5. One payment reform model will not fit all states
6. States have balanced flexibility with accountability in securing stakeholder buy-in
7. Current federal authorizing tools appear to be sufficiently flexible for the states we visited
8. Designing and implementing payment reform require investments in state staff time and resources
9. States continue to grapple with targeting Medicaid cost drivers within payment reform models
10. Results of Medicaid payment reforms are largely unavailable

Looking Forward

- What policy levers can be used to spur innovation?
- How can CMS encourage states to use flexibility while ensuring transparency and accountability?
- What is federal government role in aligning objectives across payers and programs?
- How should value be defined and measured to assure consistency in evaluation?
- How is the role of managed care organizations evolving?
- How can goals of payment reform be applied to other (non-acute) services with the Medicaid program?