Medicaid

Shifting Payment and Delivery Models to Reward Quality and Outcomes

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INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Overview

Policymakers seeking to improve the quality of health care while controlling its costs are increasingly reforming how care is delivered and paid for. Traditionally, Medicaid providers have been reimbursed on a fee-for-service basis, which compensates for every service, test or procedure provided. Rather than reward volume, payment reform models seek to reward value and create financial incentives for health care providers to focus on primary and preventive care. Such models are designed to improve access to care and adopt more effective, efficient ways of delivering it.

Moving from volume-based to value-based care is a high priority for state Medicaid programs, according to a recent survey from the National Association of Medicaid Directors (NAMD). As a result, states are putting in place a wide array of delivery system and payment reforms, described below, that reward providers for delivering high-quality and cost-effective care to Medicaid beneficiaries. Despite their prevalence and potential to improve value and health outcomes, delivery system and payment reforms are complex and take time to develop, implement and show results.

The federal government has taken the lead in nudging the payment reform process along. In 2015, the U.S. Department of Health and Human Services (HHS) announced new goals to move Medicare away from paying for volume of services and instead paying for quality, patient-centered care through alternative payment models. HHS set new targets to shift 50 percent of fee-for-service Medicare payments to alternative quality or value payment models by 2018, and encouraged similar goals for the rest of the health care system.[1] That year, HHS launched the Health Care Payment Learning and Action Network, a public-private partnership involving public and private health plans, including fee-for-service Medicaid, to accelerate adoption of alternative payment models.

Overall, new payment approaches typically include financial incentives to encourage appropriate and timely care, reduce spending on unnecessary services, promote collaboration and care coordination among different providers, and reward providers for delivering high-quality care.[2] States can leverage their market power as large purchasers of health care to use new payment models that may simultaneously contain costs and improve care.[3]

Some legislatures have required state Medicaid programs to implement payment reform. For example, in 2012, Massachusetts lawmakers passed legislation to require the state Medicaid agency to move 80 percent of its provider payments into alternative payment models by 2015.[4] According to a March 2018 report by the Massachusetts Health Policy Commission, use of alternative payment methods among the state's three largest payers increased to 56 percent in 2016. Over one-third (36 percent) of Medicaid beneficiaries were enrolled in managed care plans (described below) as opposed to traditional fee-for-service models.[5] The report notes that federal approval of Massachusetts' waiver to adopt a statewide Accountable Care Organization (ACO) program in 2018 will increase alternative payment model coverage for MassHealth members. It anticipates that the "added incentives for controlling costs and improving care coordination could help reduce spending among those enrollees."

State Examples

A 2016 NAMD survey of state Medicaid programs found that states have invested significant resources to implement alternative payment models. They include additional payments for providers who meet performance expectations, bundled or episode-based payments, and population-based payments. These, and other state approaches for designing payment and delivery reforms that help improve the quality of care and reduce costs for people enrolled in Medicaid, are summarized below.

■ **Managed care** refers to health care plans that integrate financing and health care services to covered individuals by arrangements with selected providers. Such systems include a comprehensive set of services, standards for selecting health care providers, formal programs for ongoing quality assurance, and significant incentives for members to use providers and procedures associated with the plan. Despite the opportunities to deliver more efficient care, there are concerns that these "capitated" payment systems—which pay providers a set amount for each enrolled person assigned to them, whether or not the person seeks care—can have unintended consequences. They can reduce access to services or create incentives for health plans to discourage beneficiaries with complex health care needs from enrolling.[6] States have taken several steps—such as adopting provider network standards and care transition policies—to ensure uninterrupted access to necessary services.[7] As of 2017, 39 states and the District of Columbia had Medicaid contracts with managed care organizations (MCOs).[8] More than two-thirds of these states (27 and the District of Columbia) have enrolled 75 percent or more of Medicaid beneficiaries in MCOs.[9] Some states—including Arizona, California, Kentucky, New York and Tennessee—have enrolled more than 90 percent of beneficiaries in managed care plans.

■ **Performance-based reimbursements** are tied to quality and efficiency metrics, offer incentives for good health outcomes and pay

for coordination of a patient's care by a group of providers, such as physicians, nurses and social workers. According to a 2016 survey of state Medicaid directors, at least 12 states provided additional payments, usually in the form of a per-member, per-month payment, in exchange for meeting performance expectations. This model supports infrastructure for transformation efforts or for high-value services, such as care coordination, that typically are not reimbursed.

For example, **Colorado's** Accountable Care Collaborative program has seven organizations known as Regional Accountable Entities (RAEs) that are responsible for coordinating care and connecting members to primary and behavioral health care services. They are eligible to receive higher per-member per-month payments for meeting specific performance targets, such as increased well visits or reduced emergency room visits. In addition, RAEs are eligible to receive up to 5 percent of their annual behavioral health capitation rate for reaching certain goals, such as increased enrollee follow-up with a mental health provider after an inpatient hospital discharge for a mental health condition. The state's approach includes three core components: primary care medical providers (PCMPs), which serve as medical homes; regional accountable entities (RAEs) that develop networks of primary care medical providers; and a statewide data analytics portal. The portal supports providers and regional entities by providing information about key performance indicators and other performance measures.[10] A 2016 evaluation of a prior iteration of the program found that Colorado's Accountable Care Collaborative reduced expenditures by $60 per member per month for adults and $20 for children while maintaining quality of care.

■ **Delivery System Reform Waivers.** According to NAMD, several states have used a Section 1115 Medicaid waiver to create Delivery System Reform Incentive Payment (DSRIP) programs. These allow the state to reward providers for implementing successful delivery system and payment reform initiatives. Although the future of the Centers for Medicare & Medicaid Services (CMS) approval for DSRIP waivers is uncertain, several states operate a DSRIP or DSRIP-like program, including California, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Texas and Washington. For example:

- In 2011, **Texas** received federal approval for a Section 1115 waiver to increase access to health care, improve well-being and reduce costs. In addition to expanding Medicaid managed care statewide, the waiver created a DSRIP program, through which providers could earn payments for meeting approved reporting and performance metrics.[11] Providers implemented approximately 1,500 DSRIP projects to improve behavioral health, access to primary and specialty care, chronic care management, and health promotion and disease prevention.[12] A 2017 evaluation of Texas' 1115 waiver found that Texas' DSRIP projects have increased access to primary and preventive care, emergency department (ED) diversion, and attention to people with behavioral health needs.

- In January 2017, **Washington state** received federal approval of its request for a Section 1115 waiver. The Medicaid Transformation Project waiver uses DSRIP to fund projects that show measurable improvements in Medicaid clients' health outcomes.[13] Under the DSRIP program, regional organizations known as Accountable Communities of Health (ACHs) and Medicaid MCOs must demonstrate improvement toward and attainment of transformation targets. These include value-based purchasing and performance in clinical quality and outcome metrics.[14] A 2017 participant survey found high levels of member satisfaction and a perception that ACHs are achieving positive effects on health system transformation, cross-sector collaboration and regional health outcomes.[15]

Delivery Models and Quality Outcomes: State Policy Options and Considerations

- Explore payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs.
- Examine the current payment and delivery system and identify opportunities for improving access, quality and efficiency. Some states have appointed commissions or task forces to make recommendations and guide implementation of new payment systems.
- Examine state oversight of accountable care organizations (ACOs) that accept risk. Some states require licensure for health maintenance organizations (HMOs), while others require a special license or certificate.

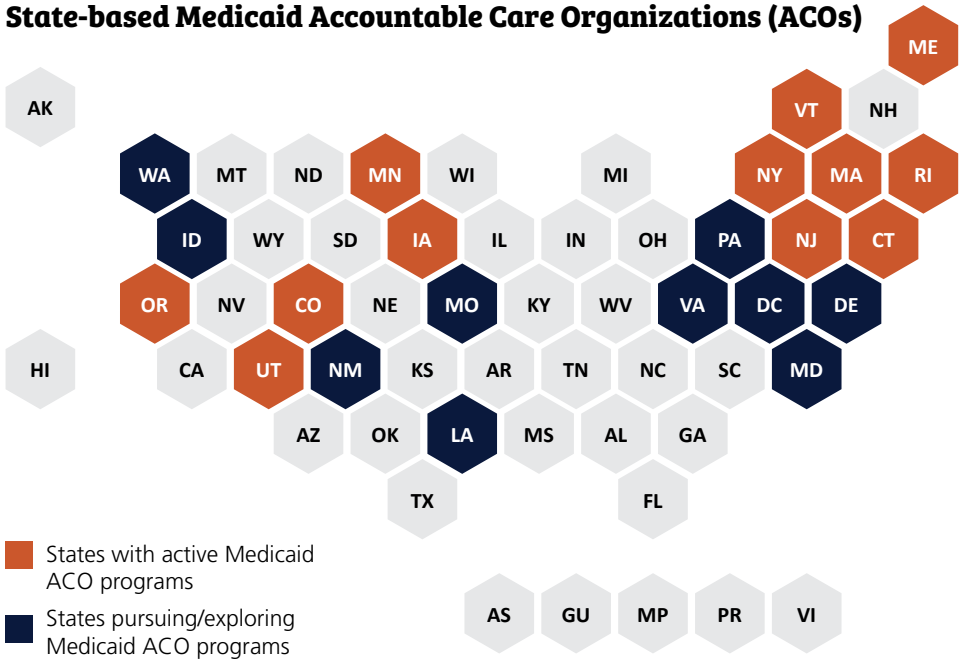
■ **Bundled payments**, also known as **episodes of care (EOC)**, provide a lump sum to a group of providers functioning as a team to divide among themselves for all services related to a patient's specific illness. Bundled payments are increasingly used for high-cost procedures, such as cardiac bypass surgery, diabetes or maternity care. Such models provide an incentive to maintain quality without overtreating patients, since only a certain amount of money is allocated to meet patients' needs, based on practice standards and other factors. Medicare is partnering with more than 500 hospitals and related health care organizations to make bundled payments for all the care associated with four dozen conditions and procedures, such as strokes and joint replacements.[16]

Three states—Arkansas, Ohio and Tennessee—have implemented episode of care payments in Medicaid for a wide range of procedures (e.g., bypass surgery or joint replacement), medical conditions, and/or perinatal and behavioral health care.[17] The Arkansas Payment Improvement Initiative, the only state with published results on episode of care payments, did not significantly affect screening rates for pregnant Medicaid beneficiaries. However, the study found a slight decrease in the rate of cesarean section deliveries and length of inpatient stays for C-section births.[18]

■ **Global payments** pay a health care organization to provide all

needed care for a specific population, such as a large company's employees or people living in a certain geographic area. Health care providers must meet certain quality criteria, such as offering timely preventive screenings and promptly following up on test results with patients. They receive bonuses if their patients stay healthy and avoid costly hospitalizations.[19] For example, Oregon's Coordinated Care Organizations (CCOs) are reimbursed for services by a global payment that includes physical health services, such as primary care visits and medical tests, as well as mental health and substance abuse treatment, oral health care, and some long-term services and supports. CCOs can also receive bonus payments for specific outcomes, such as reduced emergency department visits among CCO members and increased developmental screenings for enrolled children. A December 2017 program evaluation found that financial incentives were "strongly associated with improvements in performance," with two-thirds of CCO incentive measures showing improvement in at least two of three years between 2013 and 2015.[20]

State-based Medicaid Accountable Care Organizations (ACOs)



Source: Center for Health Care Strategies

■ **Accountable Care Organizations (ACOs)** offer a way of both delivering and paying for patient care. Typically, ACOs are a partnership between a payer, such as a private or government insurer, and a network of doctors, hospitals and other providers that share responsibility for providing care to patients. ACOs create savings incentives by offering providers bonuses for efficiencies and quality care that results in keeping their patients healthy and out of the hospital, including focusing on prevention and managing patients with chronic diseases.[21]

According to the Center for Health Care Strategies, "State-based Medicaid accountable care organizations (ACOs) are becoming increasingly prevalent, with more states pursuing this model as a way to align provider and payer incentives to focus on value instead of volume."[22] As shown in the map, 12 states had implemented Medicaid ACOs as of February 2018 and 10 states were considering ACO adoption. For example:

- In 2010, the **Minnesota** Legislature passed legislation that directed the commissioner of human services to develop and implement a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations. Minnesota established a statewide Medicaid ACO program known as Integrated Health Partnerships (IHPs) in 2013. Through it, the state's Department of Human Services contracts with provider organizations, or IHPs, to provide primary care and other covered services to Medicaid enrollees.[23] Under the model, participating health care providers work together across specialties and service settings to deliver efficient and effective care for more than 460,000 Medicaid enrollees.[24] The Minnesota Department of Human Services estimates that the program saved over $200 million between 2013 and 2016 through decreased use of emergency rooms and shorter hospital stays. About $70 million of these savings were returned to IHPs as shared savings.[25]
- In 2011, **Utah's** Senate Bill 180 required the Department of Health to amend the Medicaid state plan to replace the fee-for-service model with one or more risk-based delivery models. The legislation directed the department to restructure Medicaid's provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves enrollees' health status. To achieve these goals, Utah Medicaid began contracting with ACOs to provide medical services to Medicaid members in 2013.[26] Most of the state's Medicaid enrollees who are not elderly or disabled are currently enrolled in one of the state's Medicaid ACOs.[27] A 2018 quality review report found that all of Utah's Medicaid and Children's Health Insurance Program (CHIP) ACOs exceeded national averages on several measures. They topped the average number of adolescents being immunized and children being treated appropriately for upper respiratory infection. Most of the state's ACOs exceeded national performance rates for a wide range of other measures, such as comprehensive diabetes care, managing antidepressant medication and controlling high blood pressure. The report noted opportunities for improvement, for example, in the rates of well-child visits and breast cancer screening.

Notes

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