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STATE HEALTH ACCESS DATA ASSISTANCE CENTER

PAYING FOR VALUE IN MEDICAID:
A SYNTHESIS OF ADVANCED PAYMENT MODELS IN FOUR STATES

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Introduction

- Policy makers seek value from the Medicaid program
  - Containing cost growth
  - Improving outcomes
- States taking a variety of approaches to achieve this common goal
- This project was intended to:
  - Better understand specifics of different state approaches
  - Identify common themes across states

Challenges in Medicaid Payment Reform

- Compared to most private payers, more enrollees with complex conditions, higher medical costs, and economic and social challenges
- More limited ability to directly influence enrollee health care seeking behavior (limits on cost sharing)
- Lower provider payment rates may make it difficult to attract and engage providers

Project Approach

- Site visits to AR, MN, OR, and PA 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

Arkansas: Payment Improvement Initiative (APII)

- Context
  - No comprehensive Medicaid managed care
  - Little provider integration
- Episode-based payment system
  - Statewide
  - Multi-payer (2 commercial payers participating)
  - Eight episodes launched during 2012-13; plans to launch six additional episodes beginning in 2014

Arkansas: Payment Improvement Initiative (APII)

- 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

Arkansas: Payment Improvement Initiative (APII)

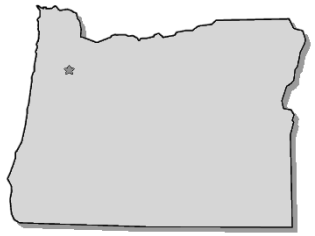
- Other notable features:
  - Multipayer, with both standard and flexible components across payers
  - Can expand over time to additional payers and health conditions
  - Couples acute care payment strategies with initiatives to address population health (PCMH and health home)

Minnesota: Health Care Delivery Systems Demonstration (HCDS)

- Context
  - History of integrated health care systems
  - Medicaid managed care
  - ACO initiatives involving Medicare and commercial payers
- Encourages voluntary creation of Accountable Care Organizations (ACOs)
- Modeled on Medicare Shared Savings Program
  - Piggybacks on the Medicare shared savings methodology to lessen provider burdens and encourage provider participation

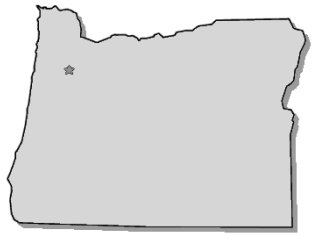
Minnesota: Health Care Delivery Systems Demonstration (HCDS)

- 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
- Implemented alongside the state's existing Medicaid managed care program
  - Populations include both FFS and managed care enrollees
  - All MCOs must participate in shared savings component
- Opens up new avenues for testing provider reform and innovation in the context of an existing Medicaid managed care delivery system



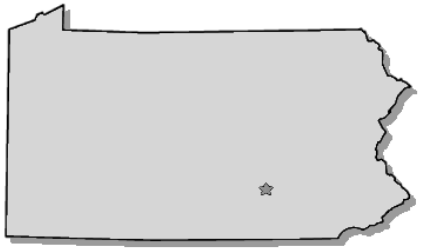
Oregon: Coordinated Care Organizations (CCOs)

- 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



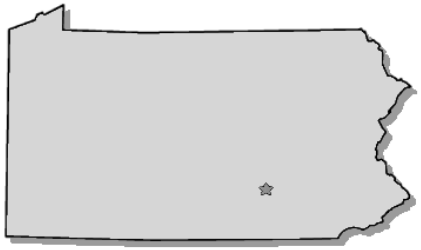
Oregon: Coordinated Care Organizations (CCOs)

- 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
- Launched in August 2012; by November 2012 there were 15 CCOs in operation serving about 90% of OHP members
- 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/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)



Pennsylvania: Medicaid Payment Incentives/Policies

- 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
- Other notable features:
  - Reforms largely implemented within existing Medicaid managed care program
  - Allows for significant control at the state agency level, allowing the program to be responsive to stakeholder input, changes in the health care environment, and other factors over time
  - Targets both MCOs and providers and addresses a variety of areas of health care

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
    - States using financial incentives that directly reach providers with goal of improved health outcomes, more cost-effective care delivery, and better value for taxpayers

Themes Across States (continued)

4. Data are important for facilitating improved care delivery downstream
   - Analytics are essential to helping providers understand their performance and identify opportunities to improve, and states are taking action to make data available
   - However, it is unclear at this point whether and how this information is being used
5. One payment reform model will not fit all states:
   - State health care business environment, Medicaid program histories, and cultures important to shaping reform efforts

Themes Across States (continued)

6. States have balanced flexibility with accountability in securing stakeholder buy-in
   - Accountability for total costs in Minnesota, Oregon with provider flexibility in how to achieve savings
   - In Arkansas, standard core components for episodes with flexibility across payers in episode and payment determination

Themes Across States (continued)

7. Current federal authorizing tools appear to be sufficiently flexible for the states we visited
   - State officials viewed CMS as a helpful partner
   - Waivers and SPAs were adequate for these states
8. Designing and implementing payment reform require investments in state staff time and resources
   - States often require significant start-up and ongoing funding
   - Limited staff resources pulled from other projects
   - Variation in reliance on in-house capacity vs. consultants

Themes Across States (continued)

9. States continue to grapple with targeting Medicaid cost drivers within payment reform models
    - Many of the most significant cost drivers (behavioral health, long-term services) have not yet been incorporated into the payment reform models, but states are moving in this direction
10. Results of Medicaid payment reforms are largely unavailable
    - Still early in implementation stages
    - Data infrastructure and reporting processes are important to actively monitor change in quality and outcomes

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?

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