

Out of the Spotlight, Medicaid Programs Tackle the Growth of Health Care Costs

By Lindsey Browning

In Washington, the philosophical and political questions about the future of health care in the U.S. are swirling. A House bill to repeal and replace the Affordable Care Act and change Medicaid financing was considered early in 2017 and failed. Notably absent from the debate surrounding this bill was how to fix the underlying cost drivers of health care. If and when other proposals are considered, the question of cost drivers will likely be absent from those debates as well. The action to tackle affordability is in the states. Medicaid directors are transforming the way health care is paid for and delivered to contain costs and improve health outcomes. This transformation is taking place in partnership with consumers, providers and other payers.

This article explores Medicaid's movement towards value-based purchasing—in particular, through the use of alternative payment models. It also offers a glimpse into the opportunities and challenges that lie ahead for states' work to drive value, especially in a dynamic federal policy environment.

What are “value-based purchasing” and “alternative payment models?”

Medicaid value-based purchasing is broadly any activity that a state Medicaid program undertakes to hold a provider or contracted managed care organization accountable for the costs and quality of the care they provide or pay for. Frequently, this refers to state Medicaid activities to implement alternative payment models. Alternative payment models change the way Medicaid programs pay providers; instead of reimbursing on a fee-for-service basis (which rewards the volume of care delivered), these models seek to incentivize value. Alternative payment models are being implemented in all types of Medicaid delivery systems, including fee-for-service Medicaid programs and in Medicaid managed care.

What is driving Medicaid programs to use alternative payment models?

There is an increasing recognition among payers, providers and consumers that the rising costs of health care in the United States are unsustainable. Health care accounts for nearly 20 percent of the gross domestic product, and these costs are growing faster than the rest of the economy. This is impacting the whole health care system, including state Medicaid programs, which serve the nation's most complex and high-need populations, such as

children and adults with disabilities, elderly, and those with serious and persistent mental illness. There is also recognition that longstanding fee-for-service payment to providers, which is used in commercial insurance, Medicare and Medicaid, has been responsible for a lack of coordination in the delivery system and poor health outcomes. It incentivizes providers to deliver a high volume of services, without financial rewards for coordinating a patient's care. This has resulted in duplication of services and fragmented care delivery.

Alternative payment models seek to realign financial incentives to reward providers for delivering coordinated, high-quality care. The financial incentives also seek to promote value, meaning payment is tied to improving performance and health outcomes while also containing cost growth.

What are the most common categories of Medicaid alternative payment models?

The National Association of Medicaid Directors, or NAMD, and Bailit Health Purchasing released a report in 2016 (with support from The Commonwealth Fund) to better understand the types of alternative payment models Medicaid programs are implementing. While models differ significantly by state, the study found that common types of approaches include:

- **Additional payments in support of delivery system reform.** An enhanced payment is made to a provider or group of providers for infrastructure, quality measurement and reporting. These programs most often support Health Home or Patient-centered Medical Home programs. They may also include a shared savings component, making providers eligible to receive a percent-

age of the net savings realized as a result of their efforts. Many state Medicaid programs are leveraging this type of model, such as Idaho, Michigan and Oklahoma.

- **Episode-based payment programs.** An identified provider or group of providers is held accountable for quality and total cost of care for specific procedures or events (such as asthma exacerbation or childbirth). There are opportunities for shared savings if the provider(s) achieves quality goals, while containing costs. Arkansas initially pioneered this approach, which has also been implemented in Ohio and Tennessee.
- **Population-based payment models.** A targeted expenditure is established for a population (total cost of care) and a provider or group of providers are held responsible for quality and cost based on that targeted expenditure. This model usually includes an opportunity for providers to earn shared savings and may also include shared financial risk. In some instances, this model is applied to entities that share health plan and provider characteristics. Massachusetts, Minnesota and Rhode Island are a just a few of the states using this type of approach.

What are some examples of alternative payment models?

- **Colorado's Accountable Care Collaborative, or ACC.** In this model, primary care providers receive an enhanced payment of \$4 per member per month, or PMPM, for managing patients' care, and Regional Care Coordination Organizations, or RCCOs, receive a PMPM payment of \$9.43-\$10 to provide care coordination services, network development, practice support and other functions on a regional basis. Both the primary care providers and the RCCOs have \$1 of the PMPM withheld and earned through performance on key indicators. Since implementing the ACC, Colorado has seen reduced readmissions, lower use of high-cost imaging and improvement in follow-up visits post-hospitalization. Moreover, Colorado reported net savings of \$139 million since the program's inception.¹
- **Rhode Island's Coordinated Care Pilot.** Through this pilot, which the state launched in spring 2016, the state has certified six Accountable Entities, or AEs, that are providing and coordinating a comprehensive set of services to attributed Medicaid beneficiaries. In this model, the state's two managed care plans contract with the AEs and

negotiate the total cost of care methodology, how savings are shared between the AE and the Managed Care Organizations, or MCOs, and set required quality performance targets. The state approves the MCOs' contracts with AEs. The state also anticipates that shared risk will eventually be incorporated into the pilot project.

What challenges and opportunities exist for Medicaid alternative payment models?

Medicaid programs are beginning to see early signs of success in their efforts to advance quality and sustainability goals through alternative payment models. But this work is still in its early stages, and there are numerous opportunities, as well as challenges, that lie ahead for this innovation. In many cases, overcoming these challenges will require a collaborative solution across health care payers, including Medicaid, state employees' plans, Medicare and commercial insurers.

Challenges

- **Federal uncertainty.** The change in federal policy leadership is creating significant uncertainty about the rules of the road for Medicaid payment reform efforts. In particular, federal policymakers are considering major changes to the financing structure of the Medicaid program. States are navigating this uncertainty while ensuring alternative payment models and other value-based purchasing efforts continue.
- **Staff and budget resources.** Medicaid directors face limited resources to sustain current Medicaid operations and drive new and innovative payment reform efforts. Staff recruitment and retention is particularly problematic as individuals with the skill sets to support innovation are highly sought after in the private sector. In NAMD's 2016 Operations Survey, 38 states identified staffing challenges as a major concern.² State Medicaid budgets are also under constant pressure, and budget shortfalls often result in cuts to Medicaid that potentially set back programmatic changes and stifle innovation.
- **Data.** Both payers and providers require a significant amount of data when operating alternative payment models. The Medicaid program needs to have and be able to share timely and accurate data to administer the models and hold providers accountable for performance measures in them. This often requires an investment to modernize legacy Medicaid IT systems.

- **Provider readiness.** Health care providers are at different points along a continuum of readiness to engage in alternative payment models. Providers must make financial, resource and systems investments to shift the way they practice medicine to achieve the goals of coordinated, high quality care. Some providers are well resourced to do this, while others operate slim or negative margins. Medicaid agencies are working to support providers along the spectrum of readiness.
- **The prospective payment system.** The statutorily-required prospective payment system for federally-qualified health centers and other safety-net providers limits states' ability to leverage the full range of alternative payment models with these providers. Specifically, it prevents the use of models that incorporate shared financial risk for poor performance. It also makes it difficult to deploy a comprehensive payment reform strategy across provider types.
- **Long-term services and supports, or LTSS.** Medicaid directors regularly identify LTSS as a next frontier for alternative payment models. As the major payer nationally of LTSS, there is a significant opportunity for Medicaid to improve value for this high-cost and high-need population. This opportunity may become even more prominent as the population over age 65 in the U.S. grows.
- **Social determinants of health.** Medicaid directors recognize that addressing the social determinants of health—such as food insecurity and homelessness—is one of the key ways to improve quality and contain costs. Because of this, alternative payment models often encourage providers to think more broadly about keeping their patients healthy. States are exploring how to deliver services not traditionally reimbursed by Medicaid and support innovative linkages between health care and non-health care services and supports.

Opportunities

- **Multi-payer alignment.** Medicaid agencies are not the only payers that are actively engaged in getting more value out of their health care purchase; Medicare and the commercial payers are as well. While multi-payer alignment is challenging, states recognize the opportunity to pursue broad alignment with other payers to minimize competing demands on providers and achieve the goals of payment reform. States and other payers have an opportunity to streamline quality and performance measures across markets and ensure payment incentives align.
- **Stakeholder engagement.** Medicaid directors regularly underscore that stakeholder engagement is key to advancing alternative payment models. Some of these key stakeholders include providers, sister state agencies, managed care organizations, counties, consumers and other payers. Engaging a diverse set of stakeholders early in the planning process facilitates the exchange of ideas and creates a shared commitment to see new initiatives succeed.
- **Behavioral health integration.** Medicaid is the largest payer of behavioral health services in the United States. As such, Medicaid has an opportunity to use alternative payment models to drive integrated physical and behavioral health care and remedy the historically poor health outcomes of individuals with these diagnoses.

Conclusion

In this period of great uncertainty and potential change in federal health policy, Medicaid directors are tackling the most complex issue facing the whole U.S. health care system: rising health care costs. They are leading innovations that link the health care dollar to the value of services delivered, while meeting the needs of their local communities. Though challenges lie ahead in this work, the opportunities—and the critical need—for states to leverage this innovation are too great. These value-based efforts, after all, are focused on ensuring the future of health care in this country.

Notes

¹Colorado Department of Health Care Policy and Financing. *Accountable Care Collaborative FY2015–2016*. November 1, 2016. <https://www.colorado.gov/pacific/sites/default/files/Health%20Care%20Policy%20and%20Financing%20FY%202016-17%20RFI%203.pdf>.

²National Association of Medicaid Directors. 2016 Medicaid Operations Survey. http://medicaiddirectors.org/wp-content/uploads/2016/12/5th-AnnualNAMD_OpsSurveyReport_DEC2016-FINAL.pdf.

About the Author

Lindsey Browning joined the National Association of Medicaid Directors in early 2014. In her role as program director, she leads various grant-funded projects to support Medicaid Directors and their senior staff in navigating the Medicaid program's most pressing policy issues. These projects focus on issues ranging from delivery system and payment reform to behavioral health integration and Medicaid managed care.

Before coming to NAMD, Lindsey worked at the Children's Hospital Association where she conducted research and analysis on state policy trends in Medicaid and CHIP. She also supported the association's work to analyze and respond to regulations implementing the Affordable Care Act.

Lindsey received her Master of Public Policy from George Mason University and graduated from McDaniel College with a Bachelor of Arts in political science and international studies.