

## Medicaid Value-Based Purchasing

The Missouri Department of Social Services is beginning a ‘Medicaid Transformation’ with an overarching objective to “build a best-in-class program that addresses the needs of Missouri’s most vulnerable population in a way that is financially sustainable.”<sup>1</sup> Director of MO HealthNet, Missouri’s Medicaid program, Todd Richardson has indicated that a primary undertaking will be to implement value-based care, although it is less clear how this goal will be translated into policies and programs. MO HealthNet should consider a variety of approaches along the continuum of value-based arrangements and learn from other states in designing its transformation projects.

### Overview

The health care system has traditionally reimbursed providers for each service provided through fee-for-service (FFS) payment. In a FFS system, providers have a financial incentive to deliver high volumes of profitable services while there is no reward for coordinating care or tracking patients’ outcomes. This payment structure is often cited as a cause for high costs and inefficient health care spending in the United States. An estimated 30 percent of all health care costs (\$3,000 per person) could be avoided by improving quality and efficiency.<sup>2</sup> Over 25 percent of inefficient spending is attributed to overtreatment (i.e., defensive medicine practices and high-priced services with limited supporting evidence). Another 5 percent of wasteful spending is linked to disjointed and fragmented care delivery (i.e., unnecessary hospital readmissions, avoidable complications, and duplicate lab/diagnostic tests.)<sup>3</sup>

Health care payers have been shifting to value-based payment (VBP) arrangements to reduce inefficiencies. VBP incentivizes quality over quantity by paying providers for the cost and quality of care instead of the number of services provided.<sup>4</sup> States are also adopting VBP for Medicaid to avoid wasteful spending and to improve population health. Over two-thirds of all Medicaid programs have at least one initiative to improve health outcomes and reduce cost growth.<sup>5</sup>

States are using VBP with varying degrees of financial risk for managed care as well as programs for traditional Medicaid beneficiaries. VBP models become more advanced as providers take on more financial responsibility for the cost and quality of care.<sup>6</sup> In models with upside or one-sided risk, providers share the savings if health care costs are lower than anticipated. In downside or two-sided risk models, providers share savings but also incur a penalty if health care costs are higher than expected. Many providers prefer upside risk arrangements, especially as they begin participating in APMs, although experts suggest that two-sided risk models may better motivate providers to generate cost savings.<sup>7</sup>

Alternative payment models increase in sophistication as they rely less on the FFS architecture. Supplemental payments, pay-for-performance (P4P), episode-based payments, and population-based payments progressively transition away from FFS. Examples of how these models have been implemented in other states can be used to better understand the landscape of VBP options and identify lessons for Missouri’s Medicaid Transformation.

## Supplemental Payments

One model used by Medicaid agencies is to supplement an existing form of payment to support a specific activity like care management. The additional payment is typically a per-member per-month payment that is often based on patient characteristics or enrollment.<sup>8</sup> This approach can be beneficial to support infrastructure, quality measurement, and reporting as well as fund services that are not otherwise reimbursable.<sup>9</sup> Since supplemental payments are not dependent on patient outcomes, they may have limited impact on improving health and decreasing costs.<sup>10</sup> Examples of this model include health homes and patient centered medical homes, which are widely used in Medicaid programs across the nation (in 29 and 20 states respectively).<sup>11</sup>

### ***Missouri's Primary Care Health Homes***

Missouri uses supplemental payments in its Primary Care Health Homes (PCHHs). PCHHs integrate primary and behavioral health services, provide care coordination, and address the social determinants of health for a medically complex patient population. MO HealthNet patients are eligible to participate if they have two or more chronic health conditions, including diabetes, asthma, cardiovascular disease, developmental disabilities, heart disease, obesity, and tobacco use. Providers at over 40 organizations in 160 locations throughout Missouri participate. In 2017, approximately 23,8000 people were enrolled in PCHHs.<sup>12</sup>

Since 2012, PCHHs have helped enrollees access preventive services and experience better health outcomes. Sixty percent of participants with diabetes and nearly 80 percent of participating children with asthma are better managing their chronic conditions. The program has also reduced enrollees' risk of cardiovascular disease and stroke. These results can be attributed in part to PCHHs' assistance with coordinating and accessing routine services. The program has reduced hospital admissions by nearly 90 percent among its highest utilizers. The quality improvements have also generated MO HealthNet savings of \$98 per member per month for individuals enrolled in a PCHH for at least 12 months.<sup>13</sup>

## Pay-for-Performance

In P4P models, providers receive a bonus in addition to their traditional reimbursement amount if they meet target cost and quality metrics. Some arrangements also include financial disincentives such as reducing or eliminating payments for poor performance. While the model rewards for value on specific metrics, the underlying FFS volume incentive still remains.<sup>14</sup> Research has found mixed results on the effectiveness of P4P in Medicaid. There is some evidence that P4P can improve provider performance on quality measures, but it is unclear whether the model is cost effective in the long term.<sup>15</sup>

### ***Massachusetts' MassHealth Hospital-Based Program***

In 2008, Massachusetts implemented a P4P program for all hospitals specific to surgical infection and pneumonia. The program has since expanded to include quality measures related to perinatal care, care coordination, health disparities, safety, and patient experience. The metrics were developed to complement the state's quality strategy for Accountable Care Organizations (ACOs).<sup>16</sup> Hospitals can receive bonus payments based on their performance metrics for each condition and can be penalized for preventable readmissions.

Researchers did not find a statistically significant improvement in quality after the first two years of MassHealth's program. Experts have raised several potential reasons that P4P programs can have limited results. The amount of financial incentives must be large enough to motivate providers to invest in quality improvements. Massachusetts provided sizeable bonus payments during the study period (\$40,000 per hospital on average) although still a small fraction of hospital revenues.<sup>17</sup> Confusion with reporting and payout requirements as well as delays in the receipt of bonus payments are also potential explanations that P4P initiatives might not create the desired improvements.<sup>18</sup> Researchers have suggested that providers with adequate quality performance experience diminishing returns for further improvements.<sup>19</sup> This challenge may be more prevalent when provider participation is voluntary and can be exacerbated by limited baseline performance data.<sup>20</sup>

## Episode-Based Payment

Episode-based models pay a fixed amount for services within a specified length of time or for all services related to an acute care episode (e.g., joint replacement and prenatal health services).<sup>21</sup> Providers are incentivized to create efficiencies and reduce unit costs since they receive a flat payment regardless of the actual costs incurred. Without proper model design, experts caution that providers may unnecessarily limit services that are delivered and raise prices for services that fall outside the episode to recuperate financial losses.<sup>22</sup>

### *Tennessee's Episodes of Care*

Tennessee uses episode-based payments for perinatal, asthma exacerbation, and total joint replacement. A retrospective payment covers all related services for a particular condition within a specified timeframe. The episode duration is based on a trigger event, such as when a physician claim is submitted, and includes pre and post-trigger services like imaging, medications, pathology, etc.<sup>23</sup> A Principle Accountable Provider (PAP) is designated as the provider with the greatest ability to impact outcomes (e.g., the provider who performs the delivery in the perinatal episode).<sup>24</sup> The PAP is responsible for all costs incurred for a patient, regardless of the provider who administers the services. PAPs are eligible for shared savings if costs are lower than expected and if quality metrics are met. They may also be liable for a penalty if high costs are incurred.

Between 2013 and 2018, Tennessee's payment model generated an estimated savings of \$38.3 million. Performance has also improved on most metrics, including increased perinatal HIV screenings and increased medication management for asthma.<sup>25</sup> Tennessee has expanded the model to include over 40 episodes that are in various stages of implementation. As a result of stakeholder feedback, the state recently removed the financial risk for low-volume providers and for services that are duplicated in overlapping episodes. The state also implemented an incentive to encourage providers to use medications on the preferred drug list.<sup>26</sup>

## Population-Based Payment

Population-based payments pay providers on a per-capita basis for a specified group of people. The provider assumes full responsibility for quality and cost in this model. Medicaid typically defines the payment based on the number of people enrolled, including a risk adjustment. A population-based model has the greatest value incentive, but it can be challenging for some providers, particularly

specialty providers who deliver high-cost services. Well-developed infrastructure is required for providers to be successful under this arrangement.<sup>27</sup>

### ***Minnesota's Integrated Health Partnerships***

Minnesota began contracting with delivery systems in 2013 to provide health care to Medicaid recipients through ACOs, referred to as Integrated Health Partnerships (IHPs). IHPs are required to deliver primary care and behavioral health services, coordinate specialty services, and partner with community organizations for social services; although, IHPs have flexibility to determine the best delivery method.<sup>28</sup> Aside from dually eligible beneficiaries, all Medicaid enrollees can be attributed to an IHP across the managed care and FFS delivery systems. IHPs' payment is based on expected costs for delivering a set of essential services to the assigned patient population. Most IHPs are required to take on two-sided risk with an exception for smaller providers who only have upside risk.<sup>29</sup>

The number of participating providers has quadrupled since the beginning of the program. The state currently contracts with 24 IHPs and covers more than 460,000 people. The program has realized \$276 million in cost savings, a 7 percent decline in emergency department visits, and a 14 percent decrease in hospital admissions.<sup>30</sup> Minnesota launched IHP 2.0 in 2013 to encourage broader provider participation by eliminating the risk-bearing requirement. The new version also realigns quality measures with federal payment policies and encourages more community provider collaboration to address the social determinants of health.<sup>31</sup>

## **Policy Recommendations**

MO HealthNet officials will need to be cognizant of the unique challenges associated with implementing VBP in Medicaid due to patient demographics and program requirements. Many Medicaid enrollees have complex health issues, such as functional limitations, behavioral health needs, and chronic conditions. An enrollee's health is also likely to be impacted by social and economic conditions.<sup>32</sup> Factors such as these require more coordination between health and social service providers and make it more challenging to impact health outcomes. Medicaid's ability to encourage appropriate utilization of care is also constrained by the federal government's limitations on cost-sharing, a mechanism often used in private insurance. Further, the program's traditionally low reimbursement rates may discourage some providers from participating in payment reforms.<sup>33</sup>

Perhaps the most important finding from other states' VBP implementations is the need to gather stakeholders' perspectives. States have engaged providers, community organizations, and Medicaid enrollees to inform model development, communicate implementation plans and updates, gather feedback, and share best practices.<sup>34,35</sup> Bringing a variety of providers together can also help create new partnerships. Collaborations between medical and social service providers may be particularly beneficial given the needs of Medicaid population.<sup>36</sup>

A complete transition to value-based care is a long-term strategy, and the impact of reform will take several years to measure. States frequently issue updates and multiple iterations of models after several years of experience and feedback. MO HealthNet should account for the current state of Medicaid payment and also assess department and provider readiness for payment reforms.

Education, technical assistance, and transition periods can be used to support providers. Moreover, state officials should communicate the long-term vision for VBP to allow providers time to prepare.<sup>37</sup>

Evaluations in other states emphasize the importance of supporting data analytic capabilities and streamlining providers' reporting requirements. States have invested in data analytics within their Medicaid agencies to determine payment rates; attribute patients to providers; and analyze health outcomes, utilization, and cost.<sup>38</sup> Timely data reports are also necessary to ensure that providers are receiving regular performance feedback. If multiple payment models are being used, policymakers should try to align the goals, definitions, quality metrics, and reporting requirements where possible.<sup>39</sup> Stakeholders could also be engaged to develop a common set of quality measures.<sup>40</sup> Notably, in Missouri, new data systems will likely be needed for the state to have these capabilities.

Several states are encouraging providers to address health disparities through VBP. Some states stratify performance measures based on race, ethnicity, geographic location, disability status, and other factors. Others add specific measures related to equity, such as an enrollees' ability to meet basic needs like food and housing.<sup>41</sup> States are also taking steps to avoid penalizing providers who help underserved enrollees by adjusting for individual and community-level social risk factors (e.g., poverty and rurality) as well as tracking quality improvements based on a provider's own historical performance.<sup>42</sup>

Provider flexibility can be a selling point to encourage participation and foster innovation. Unlike FFS, reimbursement is not based on the patient's location or the clinician who administers the service.<sup>43</sup> This flexibility allows for telehealth utilization and care managers or community health workers to be added to the care team. VBP also creates the incentive to coordinate care across all providers, including behavioral health, primary care, and community-based services. States have supported care coordination by funding community health worker pilots, building health information exchanges, and offering technical assistance.<sup>44</sup>

## Conclusion

Missouri has achieved positive results through the PCHHs; however, the scope is limited to a small percentage of Medicaid enrollees and provider incentives still supplement traditional payments. Lessons should be gathered from the initiative in addition to other states before implementing more advanced VBP models. The state can use these learnings to develop a comprehensive plan that contains tailored payment arrangements and metrics to specific geographic regions and populations.

A successful Medicaid Transformation and value-based care implementation will require MO HealthNet to lead an entire field through transformation. As such, the administration will need to involve consumers, health care providers, and community organizations throughout the process. A long-term commitment to engage stakeholders, provide transparent data, and educate the field will help ensure a successful implementation.



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