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Payment Reform: A Medicaid Overview

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The dramatic changes in health care delivery in the United States are providing most health actuaries with significant challenges that put our professional skills to the test, and there is no area where change is more extensive than Medicaid. The Affordable Care Act (ACA) extends Medicaid coverage to many more recipients, expands the coverage that recipients receive, and lays out a path for payment reform that is expected to increase quality of care and partially offset the increased costs of the expansion. This article focuses on the routes different states have taken to reform Medicaid, including payment reform and quality improvement initiatives.

The ACA has increased payment reform activity in a number of areas:

- There will be an increase in payments to primary care physicians, reflecting their expanded role in managing patient care. This increase will encourage providers to care for populations that have been historically underserved.
- The ACA funds studies, grants and demonstration programs focused on quality improvements and alternative payment and delivery methods.
- The ACA decreases Medicaid lump sum payments to disproportionate share hospitals—that is, those hospitals that deliver a higher proportion of care to low income patients who lack other insurance coverage (including Medicaid, Medicare and commercial insurance) in anticipation of fewer uninsured patients and less uncompensated care.

While these changes are federally mandated, it will be up to the states to implement them—or not. States can opt out of payment reform and Medicaid expansion, but those that do opt out will forgo all or part of federal funding. As of late January 2013, 10 states will definitely not implement ACA's Medicaid changes, five more states are unlikely to do so, five states are likely to participate, and 18 states plus the District of Columbia will definitely implement ACA's Medicaid payment reform and expansion measures. Twelve states are still undecided. Of the 18 states that are definitely participating, four states—Massachusetts, Kansas, Arkansas and Oregon—are far enough along to give us an idea of what the Medicaid reform will look like, though the presence of health care exchanges in 2014 will add an additional level of complexity.

Massachusetts

Massachusetts has new legislation to reduce costs based on alternative payment arrangements, and it will create new entities to oversee the change. Six years after Massachusetts' landmark legislation that reduced the commonwealth's rate of uninsured residents from 10.9 percent to 6.3 percent, Massachusetts introduced Health Care Reform 2.0. This bill, signed into law in August 2012, seeks to significantly curb the growth in health care spending while simultaneously increasing the quality of care. The legislation is far-reaching, impacting beneficiaries, providers, and public and private payors.

MassHealth, the state's Medicaid plan, is not exempt from the new requirements and responsibilities outlined by the law. The program will be accountable for achieving the spending growth targets applicable to the private sector (how the state will penalize itself is another question). Specifically, the legislation targets health care spending growth equivalent to the growth in gross state product (GSP) for the first five years, 0.5 percent below GSP for the following five years, and at a level equal to GSP thereafter.

The primary channel by which the state hopes to increase efficiency and lower Medicaid costs is through the transition from fee-for-service (FFS) payment arrangements to alternative payment methodologies (APMs). APMs may include shared-savings, bundled payments or global capitation arrangements. The legislation prescribes that MassHealth pays for 80 percent of its beneficiaries (excluding beneficiaries dually enrolled in Medicare) through an APM by July 2015.

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To ease the transition to the new payment system, the state has created two incentives for providers to participate in APMs. First, MassHealth will pay providers that demonstrate significant transition to APMs 2 percent higher rates (capped at $20 million) for the time period July 2013 through June 2014. Second, MassHealth will give priority to certified, "model" accountable care organizations (ACOs) in its contracting process.

The new legislation intends to increase access for MassHealth beneficiaries. Through the use of expanded "express-lane" eligibility renewals, the state hopes to decrease the enrollment churn associated with disenrollment due to administrative reasons. For qualified veterans, survivors or dependents currently enrolled in MassHealth, the state will investigate opportunities to improve access to the Department of Veterans Affairs' benefits.

To implement and operate the changes required by Health Reform 2.0, Massachusetts created two new entities: (1) the Health Policy Commission (HPC) and (2) the Center for Health Information and Analysis (CHIA). The HPC will essentially oversee the implementation of the new legislation, including APM development, ACO certification, the review of health care cost growth, and the creation of benchmarks. The CHIA will collect payor data, develop standardized quality reports, produce annual cost reports, and support the HPC with analytics.

More information is available at *http://masscare.org/about-mass-care/.*

Kansas

The Kansas Medicaid program implemented KanCare to encourage quality and innovation. The new program is intended to move Kansas toward a fiscally sustainable health care program providing quality care. The KanCare program includes a pay-for-performance (P4P) component that is designed to provide financial incentive to reward quality and withhold reimbursement if quality metrics are not achieved.

The state will withhold a portion of each health plan's monthly capitation for the health plan's year-end assessment. A number of quality metrics are considered, and each metric represents a portion of the rate that is withheld. During the first year, 3 percent of the capitation will be withheld from each plan. The amount withheld will increase to 5 percent in subsequent years. Under current law, 5 percent is the maximum allowable withhold to be at risk for managed care organizations (MCOs). During the first year, six performance measures will be monitored. The state will use 15 performance measures thereafter. Each measure holds equal weight; so during the first year, each measure will be worth 0.5 percent, and in subsequent years, each measure will be worth 0.33 percent. A health plan will not be able to make up for missing a threshold in one measure with excellent performance in other measures.

The performance measures used for the first year are related to operations and put an emphasis on the transition to managed care. This focus will alleviate concerns about credible data not being available to measure quality in the first year. The performance criteria include claims processing measures, data submission compliance, grievances and other operational measures.

Quality measurement in subsequent years will include metrics intended to improve physical health (for example, certain HEDIS metrics), metrics relating to provider access and life outcomes for those

with physical or mental disabilities as well as those receiving substance abuse services, and metrics relating to how long-term care patients use skilled nursing facilities and home and community-based services (HCBS) versus hospitals. Performance targets are more rigorous than the standard contract requirements, and in general, the performance targets will increase by 5 percent per year. A list of the 15 measures can be found on the KanCare website.

More information can be found at http://www.kancare.ks.gov/quality_measurement.htm#pay.

Arkansas

Arkansas has ranked near the bottom of measures of health outcomes and is a state with severe budget challenges. Medicaid beneficiaries have received care from a system that is fragmented and rewarded for volume rather than quality. Arkansas felt that small changes to payment were not sufficient enough to address the needs of the Medicaid population, and thus, embarked on a payment improvement initiative.

Arkansas worked with a broad range of payers, state agencies and providers to develop a payment method that will retain many fee-for-service (FFS) payment methods and also incorporate episode-based payments intended to incent and reward providers that deliver quality care. An "episode of care" is defined as the collection of all services and care to treat a medical condition for a given period of time.

The goal is to forestall payment rate cuts to providers by reaping the savings due to better coordination of care. The state will develop an average episode cost and measures for the quality of delivery during a set study period. Patient treatments will be clustered to an episode. Each episode will be attributed to a Principal Accountable Provider (PAP), who is deemed to have the most responsibility for each episode. At the end of a reporting period, the PAP will be rewarded or penalized depending on the cost of the episode relative to the benchmark for that episode. Providers who save money will be rewarded. PAPs whose episodes cost more than the benchmarks will pay for part of the excess.

This program went into effect in the summer of 2012, but it will take three to five years to fully develop the episode model. The first episodes measured are Upper Respiratory Infection, Perinatal, Attention Deficit Hyperactivity Disorder, Congestive Heart Failure, and Total Joint Replacement (Knee and Hip).

Arkansas is also embracing the concept of medical homes for coordinated care, emphasizing preventive care and the health of the patient based on a holistic view of a patient's health care needs. Arkansas reform also addresses the need for better coordination of care for patients with mental health illnesses, developmental disabilities, and those with long-term-care needs.

More information can be found at *http://www.paymentinitiative.org/Pages/default.aspx.*

Oregon

Oregon has a history of Medicaid innovation. For example, in 1993, Oregon adopted the concept of the Prioritized List, which ranked care by effectiveness and need, and then covered services as far down on the ranked list as budgets would allow. Also, when the Medicaid budget allowed for expansion in 2008, the state used a lottery method to choose 10,000 new beneficiaries out of 90,000 applicants for the pool. This method of expansion provides valuable early information and research opportunities on the impact that Medicaid expansion under the ACA may have across the country.

The state has had a large penetration of managed care organizations in the Medicaid population and had used a network of mental health organizations (MHOs) to administer mental health care. With a history of progressive changes to the delivery system, it is not surprising that the next phase of payment reform in Oregon would be dramatic and comprehensive.

In 2012, Oregon consolidated managed care plans into a network of 15 coordinated care organizations (CCOs) based on the medical home concept. The CCOs are local and community based, patient-cen-

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tered and team focused. They integrate community, county, MCOs and providers into an organized system of care. CCOs receive a risk-adjusted budget for each member, and while they must offer the basic benefit plan, it is expected that they will provide other community-based services to provide better access to care, coordinate care for members with chronic physical conditions, integrate mental and physical health care, and reduce disparities in access to care. CCOs are accountable for the outcomes of their member populations. The state reiterates that the desired outcome is to achieve what the Institute for Healthcare Improvement (IHI) has coined as the "Triple Aim": improved patient experience (including quality and satisfaction), improved health of populations and reduced per capita cost.

While the CCOs are operational and most Oregon Medicaid members are now enrolled in a CCO, there is still work to be done to finalize how high-risk patients are integrated into the system, as well as how to better coordinate care for those with dual eligibility (that is, those with Medicare and Medicaid coverage). In an expectation of cost savings due to the new model, the initial budgets for the CCOs reflected a 2 percent reduction in payments so the organizations will need to show improvements in costs from the inception of the program.

More information can be found at *http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx.*

These four states have responded to the challenge of payment reform in different ways, but they are all trying to achieve cost containment through an emphasis on quality, an expectation of improved performance, and some form of transfer of responsibility to the delivery system. States that have just begun the payment reform process are watching these efforts to see which are workable and effective. Some states have moved beyond these four states, while others are trying to build a consensus of what their future in Medicaid looks like. Each state has a different starting point for Medicaid transformation, and each state will implement reform slightly differently. Differing versions of the health care exchanges will complicate any changes to programs. At the end of the process of reform, Medicaid programs will still vary from state to state, and there will be disparities.