



Paying for Value in Medicaid:

A Synthesis of Advanced Payment Models in Four States

Final Report

Prepared for:

Medicaid and CHIP Payment and Access Commission (MACPAC)

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Project Summary

This report summarizes the work conducted under the project, “Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States.” The project was funded by the Medicaid and CHIP Payment and Access Commission (MACPAC) and conducted by both MACPAC staff and staff at the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health. The purpose of the project was to better understand specifics of different state approaches to Medicaid payment and delivery system reform (e.g., shared savings programs, episode-based payment initiatives, global budgeting), and to identify common themes across states.

The project involved site visits to four states (Arkansas, Minnesota, Oregon and Pennsylvania) in the fall of 2013. During the site visits, interviews were conducted with state officials and stakeholders to collect information on states’ Medicaid payment reform models, the factors that influenced state decisions, what was required to launch each of the models, the challenges and barriers states have experienced, how the models operate, and how the programs will be evaluated. This report summarizes the payment and delivery system approaches being used by these state Medicaid programs and discusses key themes that emerged from discussions within state.

The table below identifies the initiatives examined in each of the selected states.

Table 1. Summary of Implemented Medicaid Payment Initiatives in Selected States

| Model | Payer Participation* | Risk-Bearing Entities | Nature of Financial Risk |
|--|---|---|---|
| Arkansas’ Payment Improvement Initiative (APII) | | | |
| Episode-based payments | Medicaid and two commercial payers—Arkansas Blue Cross Blue Shield and QualChoice | Physician practices, hospitals, and other providers | Upside and downside risk. Shared savings bonus or payment back to state based on cost and quality thresholds designated for each type of episode. |
| Minnesota’s Health Care Delivery Systems (HCDS) Demonstration | | | |
| ACOs with shared savings/risk | Medicaid only (but modelled after the Medicare Shared Savings Program) | Integrated health care delivery systems; primary care or multi-specialty provider organizations | Upside and downside risk.** Shared savings bonus or payment back to state based on Total Cost of Care (TCOC) calculation for core set of Medicaid services. |

| Oregon's Coordinated Care Organization (CCO) Program | | | |
|---|---------------|--|--|
| Community-based approach with global budgeting | Medicaid only | Community-based organizations | Upside and downside risk based on covering comprehensive benefit set for defined population within specified budgets. |
| Pennsylvania's Payment Reform and Targeted Payment Adjustments | | | |
| Pay-for-performance program | Medicaid only | Managed Care Organizations (MCOs) and contracted providers | Mostly upside risk based on quality thresholds for certain health conditions/health care utilization. |
| Targeted payment adjustments | Medicaid only | MCOs and hospitals | Efficiency adjustments: Downside risk for MCOs based on calculation of potentially inefficient care in claims analysis. Hospital payment policies: Downside risk for readmissions within 30 days and for serious adverse events. |

* As of fall of 2013.

** Downside risk phased in for integrated delivery systems only.

Based on these site visits, we identified a number of themes in the areas of program design, administration, and expected outcomes. It is important to keep in mind, however, that these initiatives remain in their early stages. Results, therefore, are largely unavailable, and some of the more significant Medicaid cost drivers (e.g., behavioral health, long-term services and supports (LTSS)) have not yet been incorporated into these demonstrations.

Overview

The National Association of State Budget Officers (NASBO) reported that for FY 2012 Medicaid spending is estimated to account for 19.0 percent of state general fund expenditures.¹ The significant size of the Medicaid program, coupled with uncertainty over future health care trends, makes it one of the most challenging issues in state government finance.

Common state responses to Medicaid budget pressures have included program eligibility restrictions, payment reductions to providers and managed care organizations (MCOs), and benefit set limits. Despite these efforts, states continue to look for innovative ways to contain Medicaid cost growth. What is more, with full implementation of the Affordable Care Act (ACA) in 2014, certain cost containment tools used in the past will no longer be viable options for states. For example, states that face significant enrollment growth under the ACA may find that further across-the-board provider rate cuts are antithetical to attracting and maintaining the providers needed to serve a growing Medicaid population.

At the heart of the issue seems to be a growing recognition among state officials that under both Medicaid fee-for-service *and* traditional managed care delivery systems, incentives emphasizing service volume more than service quality persist in the delivery of Medicaid services. In response, several states have been on the forefront of testing new payment strategies to influence care delivery patterns at the provider level. These state Medicaid payment reforms, or “advanced payment models,” are intended to improve health outcomes for enrollees, increase the efficiency of care delivered, and achieve better value for taxpayers.

As the legislative branch agency charged with advising Congress on the Medicaid and CHIP programs, the Medicaid and CHIP Payment and Access Commission (MACPAC) is learning more about state payment and delivery system reforms, identifying promising approaches and lessons learned, and considering how policies might be structured to facilitate successful reform strategies across the states. In this context, MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota’s School of Public Health to assist them in conducting site visits to Arkansas, Minnesota, Oregon, and Pennsylvania in the fall of 2013 to learn about different value-based payment models such as shared savings programs, episode-based payment initiatives, and global budgeting approaches in Medicaid.

The following report:

- provides background on each state’s approach to Medicaid payment reform;

¹NASBO State Expenditure Report – Examining Fiscal 2011-2013 State Spending. Available at: www.nasbo.org.

- outlines the MACPAC/SHADAC project team's analysis approach and site selection criteria;
- presents payment reform case studies for Arkansas, Minnesota, Oregon, and Pennsylvania;
- synthesizes common themes across the four states; and
- looks ahead by raising broad policy questions about how to encourage value-based payment strategies in the states.

Medicaid Payment Reform in the States

In recent years much attention has focused on the need to reform health care payment and delivery systems in order to align financial incentives in ways that reward quality and reduce costs. Many payers—the federal government, states, and private payers—are concurrently pursuing initiatives that use payment reform to promote health system transformation. One example is Blue Cross Blue Shield of Massachusetts, which has experimented with an “Alternative Quality Contract” with global budgets for participating providers and bonuses for achieving quality benchmarks. Early evidence has suggested lower cost growth and improved quality among participating providers compared to a control group.²

Medicaid programs face several challenges in addition to those faced by private insurers. First, the population covered by Medicaid is significantly different from the privately insured population in terms of health and socioeconomic status. Having more enrollees with complex health conditions, higher medical costs, and economic and social challenges is likely to make cost containment efforts more challenging because these efforts will require more coordination between multiple health care providers and between health care providers and providers of other types of services. Second, Medicaid programs have a more limited ability to directly influence enrollee health care seeking behavior, due to strict limits on cost sharing for enrollees and other factors. Finally, lower payment rates within Medicaid make it more difficult for Medicaid to attract and engage health care providers in innovative reform efforts than it is for commercial payers.

Most state Medicaid payment reform efforts are in their infancy and vary significantly based on a state’s health care marketplace, Medicaid program history, political and executive leadership, and culture of stakeholder collaboration. Notable Medicaid payment reform initiatives have been implemented recently in Arkansas, Colorado, Minnesota, New Jersey, and Oregon, and several other states are deep in the planning and design stages of reform. Federal State Innovation Model (SIM) design and testing grants provided under the ACA, in particular, have been an important source of funding for many states to design and plan for the kind of payment reforms studied as part of this project. States have also developed a wide array of new care delivery structures and initiatives—ranging from patient-centered medical homes to health home programs to accountable care organization (ACO) models—alongside or in conjunction with state Medicaid payment changes. These broad categories of reforms are defined in the glossary below.

² Song Z, Safran DG, Landon BE, Landrum MB, He Y, Mechanic RE, Day MP, Chernew ME. The ‘Alternative Quality Contract,’ Based on a Global Budget, Lowered Medical Spending and Improved Quality. 2012. *Health Affairs* 31(8): 1885-1894.

Box 1. Glossary of Basic Terms Used to Describe State Medicaid Payment Reforms and Related Care Delivery Structures/Initiatives

Episode-based Payments: One payment to providers for multiple services associated with an episode of care. Episodes are typically associated with acute services or well-defined conditions or health care events such as upper respiratory infection or knee replacement.

Shared Savings/Risk: Approach that allows providers to retain a portion of savings generated from better managing care for a given population and set of services. Savings are calculated by assessing provider spending performance vis-à-vis established spending targets. Downside risk may also be incorporated by requiring providers to share in losses (i.e., make payments back to the state) if spending is higher than established targets.

Global Payments or Budgeting: One fixed payment for the total cost of care per member (global payment) or for the total cost of care for a population (global budget) over a defined time period. Also referred to as capitation, from a provider perspective this may be viewed as a more “extreme” form of shared savings/risk.

Pay-for-Performance (P4P): Enhanced payments and other financial incentives to providers linked to quality of care measures and reporting.

Targeted Payment Adjustment Policies: Denial of claims for preventable events/conditions and unnecessary services or reduced payments based on health care inefficiencies identified through claims analysis.

Patient-Centered Medical Homes (PCMHs) and Health Homes: Care delivery models designed to provide enrollees with greater access to primary care services, case management, and care coordination across a team of providers. Provider groups are often paid enhanced fees for these activities in addition to regular fee-for-service payments.

Accountable Care Organizations (ACOs): Typically defined as a provider-led organizations/entities comprised of different types of collaborating providers charged with managing care across multiple care settings for defined populations and directly contracting with payers (versus relying on health plans). The ACO structure often marries care delivery reforms with new provider payment strategies.

While definitions are helpful in describing basic concepts, these terms are not always used consistently. In addition, states have blended various components of the strategies defined above and adapted new models to local health care markets and political environments. This leads directly to the purpose of MACPAC’s site visit project, which was to look beyond commonly used terminology and summary-level program descriptions to gain an in-depth understanding of how states are changing their Medicaid payment strategies, and why.

MACPAC's Site Visit Project and Approach

The purpose of the site visit project was to enhance MACPAC's general understanding of how states approach Medicaid payment reform, not to conduct a formal, exhaustive research study or an evaluation of particular state reforms. Site visits were conducted in Arkansas, Minnesota, Oregon, and Pennsylvania to inform MACPAC on the following broad issues related to Medicaid payment reform:

- What key factors affected the state's choice of payment model? What local political and health care marketplace characteristics contributed to the decision?
- What activities and milestones were required to launch the initiative?
- What challenges and barriers has the state experienced implementing Medicaid payment reform, and what strategies has the state used to resolve issues?
- How does the program operate? What are the logistics? Who does what?
- How will the program be evaluated?

As an initial project activity, SHADAC and MACPAC selected project sites (i.e., state Medicaid programs with notable payment reforms). In determining potential sites, the project team considered the following: the degree to which initiatives had already been implemented (versus being designed or planned); the potential scope of reforms in terms of number of payers and providers participating, target populations, and expansion strategies; the diversity of Medicaid payment reform models across sites selected; and the diversity of geographic regions represented. In the end, MACPAC selected initiatives in Oregon, Minnesota, Arkansas, and Pennsylvania. The core components of the reforms in each state are summarized below in Table 2.

Several months prior to the site visits, SHADAC and MACPAC staff began working with officials from Arkansas, Minnesota, Oregon, and Pennsylvania—typically Medicaid directors or senior-level designees—to identify appropriate internal and external stakeholders to interview, develop comprehensive discussion guides for each interview, prepare site visit agendas, and coordinate logistics for the visits. While all of the site visits were very different depending on the reform model being discussed and the unique roles and perspectives of individuals participating, each of the discussions addressed the contributing factors and environment that led to the reform approach, implementation activities and challenges, and ongoing operations and program impacts.

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* As of fall of 2013.

** Downside risk phased in for integrated delivery systems only.

Two-day site visits to Arkansas (Little Rock), Minnesota (St. Paul), Oregon (Portland), and Pennsylvania (Harrisburg) were conducted in September and October of 2013. Five staff members from MACPAC and SHADAC participated in each of the site visits. In total, the team conducted 33 interviews across the four states, ranging from interviews with state officials, commercial payers, Medicaid MCOs, physician and hospital organizations, community organizations, and other key stakeholders. Please see the Appendix for a list of organizations participating in the interviews by state.

After returning from the visits, SHADAC and MACPAC staff jointly discussed the key themes of the site visits. Using the detailed notes from the interviews, SHADAC produced this report containing individual state case studies, a synthesis of findings across the four states, and relevant policy questions for MACPAC's consideration. In writing this report, SHADAC has not attributed any interview comments to specific individuals participating in the site visit discussions, although a few quotes are provided anonymously.

Four Case Studies in Medicaid Payment Reform

Arkansas' Payment Improvement Initiative (APII)

Beginning in 2012, the Arkansas Department of Human Services, Division of Medical Services (hereafter referred to as Arkansas Medicaid) and two commercial payers—Arkansas Blue Cross Blue Shield and QualChoice—launched retrospective, episode-based payments for several episodes of care on a statewide basis. The episode payments are part of a larger initiative called the Arkansas Payment Improvement Initiative (APII). Two other components of APII are patient-centered medical homes (PCMH) and Health Homes. The PCMH program focuses on preventive care and aims to coordinate care among health care providers as well as link patients to community resources. The Health Home component will focus on care communication specifically for individuals who have developmental disabilities (DD), needs for behavioral health (BH) services, and needs for long-term services and supports (LTSS). Our summary of Arkansas below focuses on the episode payments because enrollment for the PCMH and Home Health programs will begin in 2014.³

Under the APII, an episode is the collection of health care services provided to treat a particular condition for a given length of time.⁴ Providers who are the most “responsible” for the quality and cost of care provided to a patient for a particular episode of care share in the savings or excess costs of an episode. In Arkansas’ model, these responsible providers are called “Principal Accountable Providers,” or PAPs, and can be physician practices, hospitals, mental health providers, or other providers. The episode-based model was developed to provide financial incentives to PAPs to better coordinate services and ensure high quality care across providers for specific conditions and procedures. To date, the APII is the only statewide example of a multi-payer, episode-based payment system in the US.

Context and decision process

As is the case with many state reform efforts, Arkansas’ reform effort began with an impending state budget crisis. In 2010, anticipating the end of the enhanced Federal Medical Assistance Percentage (FMAP) provided to states under the American Recovery and Reinvestment Act (ARRA) and continued Medicaid cost growth, officials braced for a shortfall in the state’s Medicaid Trust Fund⁵ and considered policy options such as across-the-board provider rate cuts

³ For a useful summary of the APII, see Arkansas Center for Health Improvement’s website at <http://www.achi.net/Pages/OurWork/Project.aspx?ID=47>

⁴ State of Arkansas (2012). Health Care Payment Improvement Initiative: Episodes of Care. Available at: <http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx>

⁵ Arkansas Department of Human Services (2010). Arkansas Medicaid Program Overview SFY 2010. Available at: www.paymentinitiative.org

and the implementation of comprehensive risk-based managed care to reduce health care costs. These Medicaid cost control choices had become increasingly unpalatable to state officials, legislators, provider groups, and commercial payers alike, and a broad consensus began to emerge that a different vision and reform effort was needed to contain costs.

Spearheaded by Governor Mike Beebe's office and top officials within the Arkansas Department of Human Services, initial discussions about what shape reform would take focused on organizing care around central provider organizations that would assume *prospective* risk for providing a bundled set of Medicaid services. As more and more stakeholders were included in the discussions, however, it became clear that a bundled payment model was not going to be feasible in the state's current fee-for-service health care business environment. What ensued was an extensive, 18-month stakeholder input process with a wide array of consumers, providers, legislators, and other community and professional organizations, during which Arkansas' initial reform ideas evolved significantly.

At the heart of the debate was how to create meaningful incentives for providers to improve the quality, access, and efficiency of health care services without forcing the consolidation of provider groups, creating new fiscal intermediaries, or upending the fee-for-service delivery system. This was especially important to Arkansas' provider community, which is dispersed, due in part to the state's large rural population.⁶ Arkansas also has a higher poverty rate and lower access to health care (as defined by the number of physicians per population and by reported health case use) than the U.S. overall.⁷

Both provider dispersion and access limitations in Arkansas contribute to difficulties in clinical integration as providers, specialists, and hospitals are challenged to communicate and coordinate care effectively. There are also inconsistencies across providers in how evidence-based clinical guidelines are integrated into standard practice. From a state payment reform perspective, this lack of provider integration posed additional challenges, in that it meant that the state was *not ready* to create or encourage new "layers" of ACO-like entities that would be prospectively accountable for managing a set of services for Medicaid enrollees.

Working in the state's favor, on the other hand, was a relatively consolidated payer market and a history of collaboration between Medicaid and private payers, Arkansas Blue Cross Blue Shield (the largest in the state) and QualChoice, which together represent 80 percent of the commercial

⁶ The 2010 Census notes that 56.2% of the Arkansas' population lives in urban areas, whereas 44% live in rural areas (see 2010 US Census at <http://www.census.gov/geo/reference/ua/urban-rural-2010.html>). The proportion living in urban areas within Arkansas is lower than the US average, which the 2010 Census reports to be 80.7% (see <http://www.census.gov/geo/reference/ua/uafacts.html>).

⁷ Kaiser State Health Facts at <http://kff.org/statedata/>

market.⁸ A strong multi-payer partnership allowed the state to design a common approach to payment reform across payers that would yield consistent incentives, standardized data and reporting, and importantly, generate a critical mass in terms of patient volume that would be critical for providers to begin changing clinical practices and bolstering investments in information technology (IT) and other infrastructure to support more coordinated and cost-effective care.

The payment reform compromise that emerged after lengthy and extensive input from stakeholders was a statewide, multi-payer, retrospective episode-based payment system. Key lynchpins of the compromise included:

- An approach that was not predicated on the “uprooting” of the current delivery system—clinical integration could be encouraged over time but was not mandated by the state through the creation of new legal/fiscal intermediaries like ACOs,
- Shared savings/payments calculated and applied retrospectively, an approach that makes an important shift away from pure fee-for-service without upending the basic payment system for providers, and
- Multi-payer collaboration and standardization on key components of the model, but independence on others.

Program summary

As illustrated in Table 3 below, during 2012-13, payers participating in the APII—Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice—launched a total of eight episodes of care on a statewide basis. Private payers participated in five of the episodes. For some episodes, the volume of patients or of the spending within the privately insured population may not be as high as in the Medicaid population, resulting in private payers opting out. Arkansas plans to launch an additional six episodes beginning in 2014.

⁸ Kaiser State Health Facts at <http://kff.org/statedata/>

Table 3. Summary of Arkansas' Episodes and Implementation Schedule

| Episode | Payers Participating | | | First PAP Performance Period |
|--|----------------------|---------|------------|------------------------------|
| | Medicaid | AR BCBS | QualChoice | |
| 1. Upper respiratory infection (URI) | ✓ | | | Oct 2012 – Sep 2013 |
| 2. Perinatal care | ✓ | ✓ | ✓ | Oct 2012 – Sep 2013 |
| 3. Attention deficit/hyperactivity disorder (ADHD) | ✓ | | | Oct 2012 – Dec 2013 |
| 4. Congestive heart failure (CHF) | ✓ | ✓ | | Jan – Dec 2013 |
| 5. Total hip and knee replacement | ✓ | ✓ | ✓ | Jan – Dec 2013 |
| 6. Cholecystectomy (gall bladder removal) | ✓ | ✓ | ✓ | Oct 2013 – Sep 2014 |
| 7. Colonoscopy | ✓ | ✓ | ✓ | Oct 2013 – Sep 2014 |
| 8. Tonsillectomy | ✓ | ✓ | | Oct 2013 – Sep 2014 |

Future plans include implementing the following additional episodes, beginning in 2014:

Oppositional defiance disorder (ODD), Coronary artery bypass grafting (CABG), Percutaneous coronary intervention (PCI), Chronic obstructive pulmonary disease (COPD), Asthma, Attention deficit hyperactivity disorder/ Oppositional defiance disorder (ADHD/ODD) comorbidity, Neonatal

Through the APII, Arkansas Medicaid and private payers attempt to identify and define episodes of care associated with an acute procedure or defined conditions that have the best chance of encouraging more effective and efficient care and controlling costs. For example, as shown above, all payers participating in the APII chose to implement the *perinatal episode of care*. This was due to the sheer volume of services provided to 40,000 pregnant women in Arkansas each year. This episode, as defined under the APII, encompasses the full spectrum of services provided by providers and hospitals during the perinatal period, including prenatal care, labor and delivery, as well as postpartum maternal care.

By grouping all care for a pregnant woman under one episode and holding one provider accountable for quality and costs, the theory is that service delivery will change such that the whole care experience becomes more focused on quality outcomes, more patient-centered, and more efficient and cost-effective. Providers designated as PAPs are expected to serve as “quarterbacks” for all health care services delivered by providers that are associated with a particular episode of care. In the case of the *perinatal episode of care*, for example, PAPs are typically the physicians or nurse midwives who perform deliveries. Other providers who are likely to participate in a woman’s care during this time include obstetricians, family practice physicians, emergency room physicians, specialists, and others.

With respect to payment, all providers delivering services associated with an episode of care submit claims on a fee-for-service basis using existing payer fee schedules and are paid on a fee-for-service basis, just as in the past. However, after the close of a defined performance period (typically one year in length), payers utilize claims data to identify PAPs: the physician

practices, hospitals, or other providers who are most accountable for the quality and cost of care provided to individuals for particular episodes. Then, using quality metrics and average costs per episode for each PAP, payers compare PAP performance to predetermined thresholds (i.e., benchmarks) to determine whether shared savings or excess cost recoupments are warranted for the PAP.

Two types of quality metrics are identified through claims data or collected from PAPs via a payer provider portal: quality measures that are directly linked to episode-based payments, and quality metrics that are tracked and monitored but not linked to episode-based payments. On the quality side, payers determine whether a PAP has met (or not met) minimum quality requirements for those quality metrics linked to gain sharing. With respect to the *perinatal episode of care*, for example, six quality metrics are tracked, but only three are linked to gain sharing: HIV screening rate, Group B strep screening rate, and chlamydia screening rate.

On the cost side, payers determine whether a PAP's average cost for an episode (across all patients) is considered "commendable," "acceptable," or "not acceptable" based on the overall distribution of average episode costs for all PAPs. Based on this analysis, Medicaid and private payers determine whether PAPs will share in savings, share in paying for excess costs, or see no change in their payment for the episode.

A high-level example of Arkansas' shared savings/risk methodology based on the *perinatal episode* for a hypothetical "Provider A" is provided in Table 4 below.

Table 4. Summary of Methodology for Determining Shared Savings/Risk for Provider A: Perinatal Episode of Care

| Cost and Quality Performance | | Financial Outcomes |
|---|--|---|
| Average cost “commendable” (< \$3,400) | Quality requirements met <ul style="list-style-type: none"> • HIV screening rate of 80% • Group B strep screening rate of 80% • Chlamydia screening rate of 80% | Shared savings payment |
| Average cost “acceptable” (\$3,400 to \$3,900) | Quality requirements met or unmet <ul style="list-style-type: none"> • See above | No change in reimbursement |
| Average cost “not acceptable” (> \$3,900) | Quality requirements met or unmet <ul style="list-style-type: none"> • See above | Payment to relevant payers to share in excess costs |

Quality measures tracked but not linked to payment:

Ultrasound screening, Gestational Diabetes screening, Asymptomatic Bacteriuria screening, Hepatitis B specific antigen screening, C-section rate

Source: Arkansas Payment Improvement Initiative (APII). Perinatal Episode Statewide Webinar. January 14, 2013.

Available at: <http://www.paymentinitiative.org/episodesOfCare/Pages/Perinatal-.aspx>

Note: Based on cost and quality thresholds for perinatal episode of care as of January 2013.

PAPs receive regular reports and data from payers outlining their performance on quality metrics and costs to support their decision-making. PAP performance reports are available online and contain summary results as well as detailed analyses showing episode costs, quality, and utilization statistics over the performance period.

As mentioned earlier, Arkansas’ approach is the only statewide example of multi-payer, episode-based payments in the country, and as such, the model is unique in its own right. However, the APII also stands out as a Medicaid payment reform model for several other key reasons in that it:

- *Allows for payer flexibility.* Core components of episode-based model are standard across payers, others are flexible. For example, the quality metrics for an episode are similar across payers, and there is a single portal for all providers to access. The algorithm used to define and identify an episode and final payment determinations can vary, however, by payer.
- *Encourages the future addition of other payers and employer groups to episode-based payments.* The existing ‘base’ of payers will likely interest and attract others.
- *Couples acute care payment strategies with complementary initiatives to address population health.* The state is integrating its episode-based payment strategy for acute care with the rollout of a population-based health strategies including: a PCMH program for preventive care, and health homes for individuals who have developmental disabilities (DD), needs for behavioral health (BH) services, and needs for long-term services and supports (LTSS).

Minnesota's Health Care Delivery Systems (HCDS) Demonstration

Minnesota's HCDS demonstration project encourages the creation of ACOs within the state's Medical Assistance (i.e., Medicaid) and MinnesotaCare programs (hereafter referred to as Minnesota Health Care Programs, or MHCP). The Minnesota Department of Human Services (DHS) currently contracts with six HCDS providers that participate in a shared savings/risk program based on a total cost of care (TCOC) calculation and other quality metrics. Developed to operate alongside the well-established, long-standing participation of managed care organizations in Minnesota's public programs, the HCDS demonstration project is one of only a few state efforts to incorporate shared savings directly into Medicaid provider contracts.

Context and decision process

In 2010, the Minnesota Legislature mandated DHS to develop a demonstration project to “test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.”⁹ The intent was to improve the quality of health care services and lower costs in publicly-funded health care programs in Minnesota as well as to align with new opportunities available to states under the newly-enacted ACA. In early 2011, the HCDS demonstration became an important component of a push to challenge existing managed care and fee-for-service delivery systems to deliver more cost-effective care in the context of a looming state budget deficit.

While the HCDS demonstration was never a budget initiative per se, it was well-aligned with the health and human services reform agenda developed as part of Governor Mark Dayton's first biennial budget, submitted to the Minnesota Legislature shortly after taking office in January 2011. Prompted by an historic \$6.2 billion general fund budget deficit, the proposed initiatives included placing stricter limits on managed care administrative costs, launching a competitive price bidding pilot among health plans in the Twin Cities metropolitan area for the first time in the state's long history of contracting with MCOs for MHCP, and identifying “other payment and care delivery reforms” to achieve meaningful reductions in non-administrative managed care payments.

In addition to achieving more cost-effective care, interviews with executive leadership from DHS suggested that the HCDS demonstration project was designed to create new options for providers to directly share in the gains and risks of developing clinical models that would improve quality for MHCP enrollees and to test payment models that would increase provider

⁹ Minnesota Statutes §256B.0755.

accountability for these improved outcomes. Although there were differences in opinion among individuals interviewed as part of this project, some noted that for a variety of reasons, opportunities for provider organizations to enter risk-based or other innovative payment arrangements with health plans in Medicaid (versus commercial business) had been relatively limited until state HCDS discussions began.

Minnesota's health care delivery system has a high concentration of large, multi-specialty provider organizations that include hospitals, primary and specialty care clinics, mental health and other ancillary services. Several mature, vertically integrated health care systems in the Minnesota market were not only interested in demonstrating their value to the state, but were already participating in Medicare Pioneer ACO/Shared Savings programs and well-poised to provide the infrastructure necessary to jumpstart the state's initiative. The state aligned its own initiative with these existing initiatives in order to reduce the burden on participating providers and encourage greater participation.

By the spring of 2011, DHS began gathering targeted input on the HCDS initiative from stakeholders through a Request for Information (RFI) process and several stakeholder input sessions. By the end of 2011, DHS had utilized this input to develop and issue a Request for Proposals (RFP) for HCDS demonstration providers, received and competitively scored nine HCDS proposals from a diverse set of provider organizations from different parts of the state, and had formally sought federal authority for the demonstration. Actuarial, data analysis, and systems work occurred throughout 2011 and 2012, as did in-depth program discussions and contract negotiations with prospective HCDS providers. By all accounts, DHS allowed ample time in the design process to incorporate feedback from a wide variety of provider delivery systems. For example, HCDS providers reported that there were lengthy and meaningful discussions between the state and HCDS providers on technical topics such as risk adjustment and patient attribution that resulted in provider concerns being addressed.

High-level requirements for participating HCDS providers include developing new care models and strategies to provide comprehensive and coordinated services, engaging and partnering with patients and families, and instituting formal partnerships with community organizations to encourage the integration of social services into clinical care. However, participating delivery systems have significant flexibility to design, develop, and refine their own clinical models and innovations. The state's goal was not to create one model, but to encourage the creation of many. To that end, the state provided flexibility for either small or large organizations to participate as HCDS providers; integrated provider systems take on both upside and downside financial risk, while non-integrated providers can participate as "virtual" HCDS's with upside risk only.

To include as many patients in each HCDS provider delivery system as possible, the demonstration includes MHCP enrollees in both fee-for-service and managed care systems. MCOs are contractually required to participate in the shared savings aspect of the HCDS initiative. MCOs continue to perform customer service, claims payment, network management, transportation coordination, and certain quality improvement functions, and also continue to hold financial reserves and take on financial risk as they have done in the past. HCDS providers are responsible for providing direct care and care coordination services to MHCP enrollees.

Program summary

In January 2013, the state entered into contracts with five HCDS providers in the Minneapolis/St. Paul metropolitan area -- (Children's Hospitals and Clinics of Minnesota, CentraCare Health System, Federally Qualified Health Center Urban Health Network (FUHN), North Memorial Health Care, and Northwest Metro Alliance (a partnership between Allina Health and HealthPartners) --and one provider organization in northern Minnesota (Essentia Health). These provider organizations are charged with delivering the full scope of MHCP-covered primary care services, and directly delivering or coordinating core services provided by specialty clinics and hospitals to the populations covered by the HCDS demonstration.

DHS “assigns” MHCP enrollees to HCDS demonstration sites according to a complex methodology (described below) for the purpose of tracking provider performance on cost and quality metrics. All MHCP enrollees—other than those who are dually eligible for Medicare and Medicaid or those enrolled in the separate Hennepin Health demonstration—can be potentially assigned to HCDS demonstration providers. However, it is very important to note that individuals are not enrolled in the HCDS demonstration as they are in MHCP or as they are in MHCP MCOs. In fact, MHCP enrollees do not necessarily know they are assigned to one HCDS provider or another. In this sense, the HCDS demonstration should be thought of as initiative tracking the performance of care delivery organizations based on a “rolling group of patients” that move in and out by performance period, rather than a care management program into which MHCP-eligible individuals enroll.

TCOC calculation and shared savings/risk payment model. An HCDS provider's TCOC target for a given performance period is based on the expected costs of delivering a subset of core Medicaid services, similar to the at-risk services included in the state's MCO contracts, to an attributed patient population. It is important to note that approximately 35-45 percent of the Medicaid claims incurred for individuals are generally excluded from the TCOC calculation: at present, excluded costs include dental care, supplies, transportation, long-term services and supports, and intensive or residential mental health and chemical dependency services. These exclusions reflect the fact that (at least in the current environment), HCDS providers have less opportunity to control or coordinate the delivery of these services, and as such, are not currently

held accountable for their use. HCDS providers may propose to add excluded services, and DHS is actively seeking to collaborate with providers to bring greater accountability around these excluded services.

Through Minnesota's shared savings/risk model,¹⁰ HCDS providers are held accountable for the TCOC of their patients for a core set of services, regardless of where these services are ultimately delivered. The state or appropriate MCO distributes to the HCDS provider a negotiated percentage of the difference between a provider's calculated "TCOC target" and "TCOC performance" for an attributed patient population and performance period, contingent on quality and patient experience metrics, as described in Box 2 below.

Box 2. Simplified Example of HCDS Payment Methodology for 2013

1. An HCDS provider's assigned patients, population risk score, and average per member per month costs are determined for the base year using retrospective fee-for-service claims and MCO encounter data for 2012.
2. Base year average per member per month costs are adjusted for expected cost trends between 2012 and 2013, as well as changes in the HCDS provider's population risk score for 2013, to determine a "Target TCOC" for 2013.
3. A "Performance Period TCOC" is determined by calculating average per member per month costs for the HCDS provider's assigned patients in 2013.
4. The HCDS provider's Target TCOC and Performance Period TCOC for 2013 are compared for purposes of determining performance results and shared savings/risk payments. DHS will make interim payments in the spring of 2014, with final payments made in spring 2015.

Patient assignment process. For a TCOC methodology to be credible and equitable, patients need to be "assigned" to HCDS providers that play a large role in the care they receive. To assign patients to HCDS providers for the purposes of calculating TCOC targets and performance period results, Minnesota uses a three-step attribution methodology that incorporates whether and where patients were provided care coordination services; primary care evaluation or management visits such as preventive or well child services; or relevant specialist visits. In the end, approximately 60 percent of patients associated with HCDS provider organizations are assigned to an HCDS organization because a large proportion of members are removed from the assignment process due to enrollment characteristics (e.g., Medicare eligibility), limited enrollment continuity or duration (less than six months of continuous

¹⁰ For integrated provider delivery systems with both inpatient and ambulatory care, the model starts with shared savings and phases in downside risk by year three. Primary care providers who are not part of an integrated delivery system can also participate in a shared savings program.

enrollment or nine months of non-continuous enrollment), or because the state's patient assignment methodology does not yield a provider who can be assigned credibly.¹¹

Quality measurement. Potential financial gains for HCDS providers will be increasingly dependent on performance on 36 clinical quality and patient experience measures, scored and weighted as 10 measures after measure aggregation.¹² All quality metrics required of HCDS providers are part of an existing state measurement initiative—the Statewide Quality Reporting and Measurement System administered by the Minnesota Department of Health. Therefore, there are no new reporting burdens for HCDS providers. The measures required are standard across HCDS providers, but there is some leeway for individual providers to negotiate changes to measure sets or methodologies based on populations served.

Data feedback to providers. HCDS providers receive monthly patient-level data on emergency department admissions, hospital admissions, readmission counts, and other care management flags for all patients assigned to an HCDS provider. HCDS providers also receive quarterly reports on TCOC performance, including population risk profiles and aggregate costs by category of service, monthly line level detail on claims for the most recent 12-month period, and pharmacy utilization for all assigned patients (note that this does not include paid amounts for MCO enrollees). While the data are not perfect and do not meet all provider needs—especially with respect to real-time care management—gaining access to these data for the first time was one of the key reasons several provider organizations made the decision to participate in the demonstration.

Minnesota's HCDS approach also stands out as a Medicaid payment reform model in that it:

- *Allows significant provider flexibility in care delivery innovations, rather than specifying how HCDS's should achieve savings and quality improvements.* For example, one HCDS might choose to place a priority on increased use of telehealth services, while another might choose to partner with community organizations to meet patients' social service needs.
- *Piggybacks on the Medicare shared savings methodology to lessen provider burdens and encourage provider participation.* Of the nine provider organizations participating as HCDS providers, three are also participating in Medicare Pioneer ACO/Shared Savings programs.
- *Opens up new avenues for testing provider reform and innovation in the context of an existing Medicaid managed care delivery system.* The HCDS model aligns payment levels for HCDS providers across fee-for-service and managed care delivery systems.

¹¹ An intentional feature of the model in Minnesota is that provider stakeholders feel comfortable that the patients attributed to them are actually theirs; a trade-off of this model feature is a lower overall attribution rate.

¹² In year one of the demonstration, 25 percent of an HCDS' potential shared savings is contingent upon reporting required measures; in year two, 25 percent of potential shared savings is contingent on performance scores; in year three and beyond, 50 percent of potential shared savings is contingent on performance scores.

Oregon's Coordinated Care Organizations

Oregon's Coordinated Care Organizations (CCOs), launched in the fall of 2012, are community-based organizations governed by local partnerships among health care providers, community members, and stakeholders that assume financial risk. CCOs are responsible for providing integrated physical, behavioral, and other covered health care services to a defined group of Oregon Health Plan (OHP, Oregon's Medicaid program) enrollees within a specified budget and are also accountable for the health outcomes of the populations they serve.

Context and decision process

Two factors played critical roles in the establishment of CCOs in Oregon: first, state policymakers' longstanding interest in health system reforms to improve health care, population health, and contain health care costs; and second, a state budget shortfall that created what some have called a "burning platform" for action.

Oregon has a long history and tradition of extensive stakeholder participation in health policy development. The CCO payment model was the product of several years of policy development and stakeholder consultation. In 2009, the Oregon Legislature created the Oregon Health Authority (OHA) and the Oregon Health Policy Board to oversee health policy, coordinate health reform and health-related activities, and improve health and health care for residents of Oregon. After extensive stakeholder consultation and public meetings, in late 2010 the Board produced a comprehensive action plan for reforming health care in Oregon. In its 2011 session, the Legislature charged the Health Policy Board with crafting a specific proposal for how CCOs should be established, governed, and held accountable for health care cost and quality; in 2012, the Legislature approved a bill formally establishing the CCO payment model.

In addition to Oregon policymakers' longstanding interest in health reforms to improve quality and contain costs, a significant budget shortfall in Oregon created even more urgency to act. Stakeholders were looking for solutions other than simply cutting payment rates or eligibility. Leading up to the 2012 legislation, state leaders convened weekly stakeholder meetings with the goal of reaching agreement on the CCO authorizing legislation. Many stakeholders that were interviewed indicated that this level of intensive and urgent focus was a key reason why Oregon was able to achieve agreement on the CCO model. The budget shortfall also contributed to stakeholders' being more willing to take action and to take risk than they might otherwise have been.

Oregon implemented its CCO model through an amendment to an existing Medicaid Section 1115 research and demonstration project waiver, described in more detail below. Oregon

submitted its waiver amendment in March 2012 and, after an intensive negotiation process with the Centers for Medicare & Medicaid Services (CMS), received approval in July 2012. On a parallel track with the federal negotiations, the state solicited applications from organizations interested in becoming CCOs, in order to ensure that the tight timeline for rollout could be met. The first CCOs began serving OHP enrollees in August 2012, and by November 2012 there were 15 CCOs in operation, serving about 90 percent of OHP members.

Prior to the launch of CCOs in Oregon, about 80 percent of the Medicaid population was served through state contracts with MCOs for physical health, and the state contracted separately with other MCOs for mental health and dental services. CCOs represent a departure from Oregon's prior managed care approach in several ways. First, an important part of the CCO vision is to better integrate and coordinate care by removing the barriers to coordination caused by having separate contracts for physical, behavioral, and oral health. Second, CCOs are held accountable for cost growth in a way that is different from prior managed care contracts. Prior to the CCO model, managed care capitation rates were set based on historical costs and projected future trends, which, according to state officials, perpetuated existing system inefficiencies and did not provide incentives for improvement. Third, CCOs are held accountable through a quality incentive pool that provides incentives for meeting quality benchmarks or making specified progress toward benchmarks. Finally, the CCOs differ from traditional Medicaid managed care in the degree to which they are required to include community and consumer representation in their governing boards.

Program summary

The scope of Oregon's CCO model includes nearly all OHP beneficiaries¹³ and most services except long-term care (dental services were optional when the program launched, but are scheduled to be integrated in all CCOs by mid-2014). As part of its federal waiver, Oregon committed to reducing annual per capita cost growth in OHP, increasing quality of care, and improving population health.

Oregon's commitment to reduce costs requires the state to reduce annual per capita medical expenditure growth, in comparison to a 2011 calendar year baseline and an assumed baseline growth rate of 5.4 percent.¹⁴ The required cost reductions are one percentage point in the second year of the demonstration, and two percentage points thereafter.

¹³ Dual eligibles and Native Americans are not required to participate (although they may do so voluntarily); people with other major medical health insurance are excluded from coverage through a CCO.

¹⁴ Oregon Health Authority, July 6 2012. Summary of 1115 Medicaid Demonstration, accessed at <http://www.oregon.gov/oha/OHPB/Documents/cms-waiver-brief.pdf>, November 18, 2013.

Box 3. Summary of Oregon CCO Model Cost and Quality Incentives

1. Negotiations between the state and CCOs established baseline costs, with aggregate cost growth over time limited to the levels specified in the state's Medicaid waiver.
2. CCOs may earn bonus payments for achieving specified levels of quality or improvement toward quality targets.
3. CCOs have flexibility on provider payment methodologies and other provider-level incentives.

In return for these commitments, Oregon gained federal approval to claim Medicaid matching funds for certain health-related services that have not traditionally been reimbursable services. The goal of these “flexible services payments” is to invest in things that improve health and reduce costs overall; for example, providing an air conditioner to a congestive heart failure patient may reduce emergency room visits and inpatient admissions, potentially saving significant amounts of money for the Medicaid program. These flexible services payments can either be individual-based or population-based, but must be health-related. One issue that has slowed implementation of this component of Oregon's reform model is figuring out how to adequately account for these payments (e.g., whether they are medical costs or administrative costs, and at what level of detail to categorize and track the payments).

In addition to approval to claim federal matching funds for the flexible services payments, Oregon also gained federal approval for other expenses to support health system transformation in the state. This investment is expected to total about \$1.9 billion over five years, and funds a quality incentive pool for the CCOs, establishment of a Health Care Transformation Center to accelerate health care providers' transition to a more coordinated care model, and workforce development programs.

The Health Care Transformation Center provides support for CCOs to adapt to the opportunities and challenges that they face along with their increased flexibility and accountability for results. The Transformation Center provides support to individual CCOs through “Innovator Agents” embedded in CCO communities who work with them to implement transformation plans and strengthen the partnership between the CCO and OHA. In addition, the Transformation Center sponsors a statewide learning collaborative to help CCOs learn from each other.

Because the CCOs are taking financial risk, they must meet solvency requirements established by OHA. In most cases, the “start-up” capital to establish the necessary reserves for CCOs came from partner organizations (e.g., local governments, health care providers and/or MCOs that previously contracted with the state to provide care to OHP members). A majority of governing board members must represent the persons or organizations that share financial risk, but providers and communities must be represented on the governing board as well. Each CCO must have a Community Advisory Council (CAC) that includes representatives from the community

and county governments, as well as consumers; at least one CAC member must be included on the CCO governing board.

Although the ownership structure of CCOs varies, many have contracts with the MCOs that formerly contracted with OHA. Leveraging the existing MCO infrastructure (e.g., claims processing capability, provider contracts, and other back-office functions) was viewed as essential to successfully launching a CCO within the tight timeframes demanded by the state. Every county in the state is served by at least one CCO, with multiple CCOs available in a few areas (including the Portland metropolitan area).

Quality measurement. With regard to accountability for quality and access to care, the agreement between the state and CMS includes a set of 33 quality and access metrics that are compared against a 2011 baseline; for the first two years of the demonstration, performance on these metrics must not decline, and for the remainder of the demonstration it must improve. If the quality goals are not achieved, there are significant financial penalties to the state.

Individual CCOs are held accountable for quality through a set of 17 metrics (16 of which are included in the statewide set of 33 metrics that are part of the Oregon's waiver agreement with CMS). The state publishes quarterly reports showing the performance of each CCO against target levels, as well as statewide performance and progress toward quality goals.¹⁵

Data feedback to providers. Data for the quarterly reports on quality measures come primarily from existing state Medicaid claims data systems. The state is investing in enhancing its capacity for monitoring and public reporting in this area.

Oregon's CCO model stands out as a Medicaid payment reform model for several other key reasons in that it:

- *Commits the state to a limited level of cost growth in its Medicaid program, while also holding the state accountable for improvements in quality.*
- *Allows the state to claim federal payments for services that cannot otherwise be matched with federal dollars.*
- *Replaces MCO contracting and uncoordinated funding streams for physical and behavioral health with an integrated funding model that is more directly accountable to communities, while continuing to leverage the administrative infrastructures (enrollment, claims payment, etc.) traditionally provided by MCOs.*

¹⁵ See, for example, the November 2013 report available at <http://www.oregon.gov/oha/Metrics/Documents/report-november-2013.pdf> (accessed November 20, 2013).

- *Provides for significant flexibility in the models used by individual communities, with variation across CCOs in ownership/management structures as well as approaches to improving quality and containing cost growth.*
- *Dedicates significant resources to directly supporting health care providers in making the types of practice changes that will be needed to accomplish the desired transformation.*

Pennsylvania's Medicaid Payment Programs/Policies

At the outset of this project, the payment reform initiative in Pennsylvania of greatest interest to the project team was the Chronic Care Initiative (CCI), a multi-payer program aimed at improving health while reducing health care costs through a primary care transformation initiative initially targeted at diabetes and pediatric asthma.¹⁶ From our early discussions with Pennsylvania, however, we learned that other Medicaid value-based payment reform approaches have been implemented by the state, some of which have been in place dating back to the mid to late 2000s. Since CCI's initial rollout in one region of the state in 2008, CCI expanded into additional state regions and then later waned, and components of the program are currently being integrated into the Innovation Plan the state has developed in relation to their CMS SIM design grant.¹⁷

At this time, Pennsylvania considers its key Medicaid payment reform initiatives to be:

- *Pay for Performance (P4P) programs for Medicaid MCOs and providers:* P4P requirements are incorporated into MCO contracts, and the state pays bonuses to MCOs that achieve performance goals relative to a set of Health Effectiveness Data and Information Set (HEDIS) quality measures. Through a separate *provider* P4P program, the state issues funding to the MCOs, which in turn establish P4P goals for and pay bonuses to providers.
- *Efficiency adjustments:* As an important part of the annual Medicaid MCO rating setting process, the state makes reductions to the base MCO rate for unnecessary health care/costs identified through Medicaid claims analyses for a prior year.
- *Hospital readmission policy:* This policy affects acute care general hospitals enrolled in the state's Medicaid program and stipulates reimbursement rules for readmissions occurring within 30 days of a hospital discharge for Medicaid beneficiaries.
- *Preventable severe adverse event (PSAE) policy:* This policy affects the same hospitals and stipulates reimbursement rules for serious events that are determined to have been preventable among Medicaid beneficiaries.

¹⁶ For a description, see <http://nashp.org/med-home-states/Pennsylvania>

¹⁷ The Pennsylvania Innovation Plan may be accessed at:

[http://www.portal.state.pa.us/portal/server.pt/community/department_of_health_information/10674/center_for_medical_care_and_medicaid_innovation_\(cmmi\)/1535774](http://www.portal.state.pa.us/portal/server.pt/community/department_of_health_information/10674/center_for_medical_care_and_medicaid_innovation_(cmmi)/1535774)

Context and decision process

Like Minnesota, Pennsylvania has a long history of managed care in Medicaid, dating back to the 1980s. Pennsylvania's current Medicaid managed care program, HealthChoices, was initiated in 1997 in the Southeast region (Philadelphia) and later expanded to the Southwest (Pittsburgh) and South Central (Lehigh/Capital Zone) regions. As of 2011, 81.5 percent of the state's Medicaid enrollees were enrolled in some form of managed care arrangement.¹⁸ Between 2012 and 2013, the remaining, primarily rural, regions also transitioned to the managed care program. Today, there are nine Medicaid MCOs in the state serving Medicaid beneficiaries in five regions across the state: Southeast (Philadelphia area), Southwest (Pittsburgh area) Lehigh/Capital (south central), New East (central/northeast) and New West (northwest).¹⁹ The Department of Public Welfare (DPW), Office of Medical Assistance Programs oversees and administers the state's Medicaid program.

In talking to state leadership and staff, a recurring theme was that the predominant motivations behind both its MCO and provider payment initiatives were to foster improvements in the quality of health care delivery and to use taxpayer dollars wisely. From the Governor to DPW leadership and staff, the state has supported these goals and has "tried to be a good steward of dollars, improve quality, [and] improve access."

Pennsylvania's P4P programs, efficiency adjustments, and hospital policies were all established and are all maintained without state legislative involvement. This is an important aspect of the Pennsylvania context. State department leaders and staff are appreciative of the flexibility to assess what works and make mid-course adjustments and corrections as needed. There is the "perspective of allowing the department to make these changes knowing there is federal oversight, [we are] required to do state amendments, have a waiver to participate..."

The histories behind each of the PA's five programs/policies vary and involved different levels of stakeholder involvement. Two of them in particular were initially defined with much input from and collaboration with external stakeholders: MCOs contributed to key design decisions for the MCO P4P program, and hospitals actively participated in the design of the final PSAE policy.

¹⁸ See June 2013 MACPAC MACStats Table 15 at <http://www.macpac.gov/macstats>

¹⁹ See http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002108.pdf

And

<http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/statewidemanagedcaremap/index.htm>

Program summary

P4P:

As mentioned above, Pennsylvania currently has two P4P programs: 1) the MCO P4P program initiated in 2005 and 2) a relatively new provider P4P program that is executed as a pass-through to the MCOs. Medicaid MCOs are required to participate in both programs.

Under the MCO P4P program, MCOs are eligible for bonus payments based on their performance on a set of 12 quality measures, 11 of which are currently HEDIS measures. The state incorporates P4P requirements and MCO-specific goals into each MCO contract. Payments are made based on a MCO's ranking in comparison to national Medicaid HEDIS benchmarks and to the MCO's own performance in the previous year. A bonus payment is made for each measure, and payments are prorated based on the actual rate achieved by the health plan. Currently, the core HEDIS measures pertain to: high blood pressure, comprehensive diabetes care (two measures), cholesterol management for patients with cardiovascular conditions, prenatal care in the first trimester, ongoing prenatal care, breast cancer screening, cervical cancer screening, emergency department utilization, adolescent well-care visits, and annual dental visits. A non-HEDIS measure on preventable hospital admissions also is currently in place.

The maximum earning potential for MCOs from P4P bonuses is 1.5 percent of their annual per member per month (PMPM) revenue. One percent of the incentive pool is for the MCOs' performance in comparison to national benchmarks, and the remaining half percent is for the MCO's year-over-year improvement on each measure (i.e., the MCOs' comparison to their individual previous year performance). Table 5 below summarizes the available bonus payments by performance level. It is important to note that since 2008, a penalty was incorporated for MCO performance below 50 percent of a national Medicaid benchmark. In doing so, the state incorporated downside risk into its MCO P4P program.

Table 5. Summary of Pennsylvania’s P4P Payment Methodology

| MCO Performance Level | Percentage of Relevant Incentive Pool per P4P Measure |
|------------------------------------|--|
| Benchmark Comparisons: | |
| 90 th + percentile | 125% |
| 75-89 percentile | 100% |
| 50-74 percentile | 25.0% |
| <50 percentile | -25.0% |
| Year over Year Comparisons: | |
| ≥ 5 percentage points | 100% |
| ≥ 4 and < 5 percentage points | 80.0% |
| ≥ 3 and < 4 percentage points | 60.0% |
| ≥ 2 and < 3 percentage points | 40.0% |
| ≥ 1 and < 2 percentage points | 20.0% |
| < 1 percentage point | 0.0% |

Source: Pennsylvania Department of Public Welfare. Health Choices MCO Pay for Performance (P4P) Program: Seven Year Progress Review (June 2005 – December 2011). Prepared June 2013.

DPW makes bonus payments to MCOs in August for their performance two calendar years earlier (e.g., in August 2014, payments will be made to MCOs based on care delivered during CY 2012). The state provides MCOs with an estimate of their potential payout in the November before payments are issued and informs them of the final number by January each year. Much of the delay in bonus payments to MCOs is because HEDIS benchmarks usually are not made public until October of the year after clinical care is rendered.

In prior years, MCOs have earned about half of the total 1.5 percent earning potential, and the proportion earned has been slightly lower in recent years. Several potential reasons for this decrease have been suggested. One potential explanation is that early payment levels may have been a function of MCOs addressing “low hanging fruit.” Another is that performance may simply be levelling off in some performance areas. The program is not designed to award status quo performance, so with MCO input, the state has worked to incorporate new areas of performance (e.g., a new diabetes bundle) into their P4P program.

In addition to the mandatory participation in the MCO P4P program, each MCO is required to operate a provider P4P program to incentivize and reward provider performance related to the same set of HEDIS measures. The state funds this program (equivalent to \$1.00 PMPM), and MCOs are required to pass through all of the state payments to providers as appropriate or return the funds to the state. No payments may be retained by the MCOs for administrative purposes. MCOs build required measures into provider contracts as well as specify which providers are eligible to participate for each measure. The state dictates a set of mandatory performance measures (in line with the MCO P4P measures), but MCOs can elect to include optional measures as well and shape other areas of the program. The provider P4P program is run on a

calendar basis with disbursements made on a quarterly basis or at the end of the year. Effective in January 2014, each MCO will be required to conduct a more thorough evaluation of its provider P4P program.

Efficiency Adjustments

Not commonly used in other states, Pennsylvania's efficiency adjustments are a mechanism the state uses to address concerns about cost efficiency and care quality (specifically, unnecessary care) through its annual MCO rate setting process. Essentially, the adjustments are a reduction to the regional base payment rates for MCOs in a given year based on health care inefficiencies identified in Medicaid managed care claims analyses. Whereas the P4P programs are intended to be a "carrot," the efficiency adjustments, involving downside risk only, were described as the "stick." The adjustments were first implemented in 2005, and to date, adjustments have been made in the following care areas: ambulatory care-sensitive conditions among adults and children, hospital readmissions, emergency care use, cesarean sections, overuse of high-tech radiology, and pharmacy management (e.g., antipsychotic medication use in children). Pennsylvania's goals for these adjustments are to "quantify [inefficient care], put a dollar value on it, and not pay for it," and in the process, encourage more proactive care management. As in other states, MCO rate setting in Pennsylvania takes into account many factors, and efficiency adjustments are one of many considerations.

To calculate the adjustment for a particular area of care, a state contractor conducts claims analyses to identify health care costs associated with potential inefficiencies. Claims data from two years prior are used in the analysis (e.g., for 2013 rates, claims data for 2011 were analyzed). Costs associated with unnecessary or inefficient health care are identified on a plan level and then aggregated to the regional level and trended to the current year. The identification of inefficient health care costs is based on claims algorithms including diagnosis codes, billing levels and other specifications informed by consultants, the state's Medicaid Medical Director, other medical consultants and MCOs. Once an initial base total for inefficient health care cost is determined, several exclusions and assumptions are implemented to reduce the cost calculation to rule out factors such as high risk patients who may be cost outliers, patient scenarios that the health plan cannot control, or double counting. As an example, for hospital readmissions one year, the state identified from the claims analysis an initial total of approximately \$100 million in potential inefficiencies. After implementing the exclusions, the total base adjustment for the year amounted to \$13 million. While the state has provided some information about the adjustment methodology to MCOs (for example, DPW provided a 78-page PowerPoint document and a 4-hour session with all MCOs to address questions), detailed data and specifications about the claims analyses and cost determinations have not been shared.

The care areas of focus and the algorithms used in the claims analyses are not necessarily the same each year and evolve based on the state's response to MCO input and other factors. Although the state indicated it does not have a target efficiency adjustment amount, the MCO base rate reduction each year has been about three to four percent of the MCO base rate. In total, since 2005, approximately \$900 million has been pulled out of the base rates through the efficiency adjustment program.

Hospital Readmission Payment Policy

Originally implemented in 1988, the hospital readmission policy was revised most recently in 2011. The policy applies to acute care general hospitals participating in Pennsylvania's Medicaid program and outlines payment rules for short turn-around hospital readmissions of Medicaid fee-for-service enrollees. The policy is written for fee-for-service beneficiaries but MCOs are expected to operationalize the policy as well. The 2011 amendment²⁰ extended the readmission period from 14 to 30 days. The shift to a longer time window was one of several Medicaid cost savings included in the state budget at a time when the state was facing the loss of enhanced FMAP dollars.

For each readmission occurring within 30 days, DPW conducts a review and makes a final payment determination (see Box 4).

Box 4. Pennsylvania's Hospital 30-Day Readmission Payment Policy

1. If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the Department shall make no payment in addition to the hospital's original DRG payment. If the combined hospital stay qualifies as an outlier, an outlier payment shall be made.
2. If the readmission is due to complications of the original diagnosis and the result is a different DRG with a higher payment, the Department shall pay the higher DRG payment rather than the original DRG payment.
3. If the readmission is due to conditions unrelated to the previous admission, the Department shall consider the readmission as a new admission for payment purposes.

Source: Pennsylvania Medical Assistance Bulletin #01-11-44. Issue Date: October 3, 2011.

Preventable Severe Adverse Event (PSAE) Policy

Separate from the state's adverse event reporting system (to which hospitals in the state report directly and which is monitored by an independent Patient Safety Authority), the preventable severe adverse event (PSAE) policy impacts the general acute hospitals enrolled in the Medicaid program and stipulates payment rules for serious events that are determined to have been

²⁰ Pennsylvania Medical Assistance Bulletin 01-11-44. Available at: <http://www.dpw.state.pa.us/publications/index.htm>

preventable among fee-for-service Medicaid beneficiaries.²¹ As with the readmission policy, the PSAE policy is written for fee-for-service beneficiaries but MCOs are expected to operationalize the policy as well. Per the policy, PSAEs result in a denial or a reduction in payment, depending on whether the PSAE is the reason for payment or caused a higher payment. Our interviews revealed that Pennsylvania was the first state to adopt such a Medicaid policy.

In order for the PSAE policy to apply, the event must be preventable; be within the control of a hospital; have occurred during an inpatient hospital admission; and have resulted in significant harm to the patient. The policy includes definitions of critical terms, and the naming of the policy and the definitions within the PSAE policy were a result of much hospital engagement on the topic and collaboration between the state and hospitals.

Multiple approaches are taken by the state to identify and review PSAE cases. In the course of completing retrospective reviews of medical records for other reasons (e.g., for outlier payments or quality reviews), the Medicaid program may flag PSAE cases. In addition, on a monthly basis, Pennsylvania uses claims data to generate a report of potential PSAE cases, identified via ICD-9 diagnosis codes and external cause of injury (E) codes. For these potential cases, the state also requests from hospitals the patient's complete inpatient medical record and conducts a medical/quality review. A final determination as to whether the case meets the PSAE definition and a final payment decision are made by the state within 90 days of the initial claim.

Compared to the other states discussed in this report, Pennsylvania has relied on more Medicaid-focused (i.e., not multi-payer) and incremental approaches to advance value-based purchasing within its Medicaid program. Pennsylvania's programs and policies stand out in that they:

- *While incremental, have resulted in noticeable changes in the ways in which the Medicaid program, health plans, and providers do business with each other.*
- *Allow for significant control at the state agency level, enabling the Medicaid program to be malleable to stakeholder input, changes in the health care environment, and other factors over time.*
- *Target both MCOs and providers and address a variety of areas of health care.*

²¹Pennsylvania Medical Assistance Bulletin 01-08-11. Available at: <http://www.dpw.state.pa.us/publications/index.htm>

Synthesis of Themes across States

Budget pressures provided impetus for Medicaid payment reform in the states we visited, but reforms serve broader purposes and do not necessarily lead to immediate savings

While state budget conditions provided an initial impetus or context for Medicaid payment reforms in three of the four states we visited, it was clear from interviews with state officials and stakeholders alike that broader goals for improving care delivery and outcomes also provided momentum for change. In two of the states (Arkansas, Minnesota) savings were not immediately assumed for budget planning purposes, and in a third (Oregon), budget savings were to phase in beginning in year two.

According to state officials in Minnesota, the decision to make the HCDS demonstration a budget neutral initiative at the time of an unprecedented state budget shortfall was extremely important in securing provider buy-in. While the HCDS demonstration was well aligned with the intent of many of the health care budget initiatives proposed by the administration at the time, DHS focused this initiative on improving quality and developing new care delivery models within the system. The HCDS providers we interviewed cited many reasons for their decision to participate in the initiative including: new data provided by the state that allows providers to analyze patient utilization patterns, prioritize care management interventions, and better coordinate care; the chance to have input at an early stage in what they view as a clear future direction for health care payment policies; and the chance to align payment for their Medicaid populations with existing Medicare and commercial payment reform arrangements.

Although the short-term impetus for Oregon's CCO model came from a state budget crisis that was driven in part by rising Medicaid costs, both the state and stakeholders recognize that extending the model beyond Medicaid will help it be a more powerful force for health care system transformation. The state has plans to extend the principles of CCOs into its purchasing for state employees and other public employee groups, and some CCOs told us that this prospect is part of what drove their decision to participate as Medicaid CCOs.

With the exception of the sunset of enhanced FMAP payments, Pennsylvania officials had less to say about budget concerns and fiscal motivations for its payment programs and policies. As described above, the predominant motivations communicated by Pennsylvania were to foster improvements in health care quality and to use taxpayer dollars responsibly.

These states continue to grapple with how to target Medicaid cost drivers within payment reform models

Our interviews confirmed that the biggest cost drivers within the Medicaid program are the hardest to target, but the payment reform models being used in these four states incorporate some steps to address these drivers. For example, these drivers include the prevalence of high-cost, chronic medical conditions among Medicaid beneficiaries and financial and regulatory barriers to integration of physical and behavioral health care delivery systems.

Additional work to integrate the highest cost populations in Medicaid—individuals with BH and LTSS needs—and the non-medical provider groups that serve these populations will take time and innovation on the part of states. Linking new payment models to community health strategies and social service systems is another aspiration of many states engaged in payment reform. Minnesota’s federal SIM testing award is directed at broadening its HCDS demonstration initiative to incorporate higher cost populations, services, and community health infrastructure.

While Arkansas’ episode-based payment system tends to garner much interest and attention in the health care community, it is actually just one component of a broader set of complementary initiatives within the APII to address population health outcomes, care delivery, as well as payment. While the episode-based payment model is designed to encourage more effective and efficient care associated with acute procedures and specialized health needs, federal SIM testing grant funds have afforded the state the opportunity to integrate its episode-based payment strategy with the rollout of a population-based health strategies including: a PCMH program for preventive care, and health homes for individuals who have DD, needs for BH services, and LTSS needs. These complementary components of Arkansas’ reform initiative are either in the very early stages of implementation or are being designed alongside the development of new episodes.

In Oregon, one of the primary goals of the CCO model was to streamline and integrate funding for physical health, behavioral health, and oral health that had previously been separated and in many cases contracted out to different managed care entities. Integrating the funding streams through the CCOs is only the first step in what is likely to be a longer transition to more integrated care. Some interviewees acknowledged that these services remain largely siloed, in part because the CCOs were brought on-line quickly and, at least in the short term, some of the CCOs are subcontracting separately for behavioral and physical health care for their populations, due to the historically distinct roles of mental health providers (especially counties) and physical health providers. In other words, changing the financing streams for important cost drivers may enable greater integration but are not a guarantee that this integration will happen. Over time, it

is expected that the CCOs will take steps to establish more integration between the providers of different types of services – with financial accountability (the global cap) as a key motivator for the CCOs.

Results of these states' Medicaid payment reforms are largely unavailable at this point

All of the payment reform models we studied will be closely watched over time to see what lessons and results could be adapted for other states. At this time, however, results from Arkansas, Minnesota, Oregon, and Pennsylvania related to care delivery processes, service utilization, cost containment and other goals are largely unavailable or anecdotal.

One reason is that most Medicaid payment reform models are in the very early stages of implementation. In Arkansas and Minnesota, for example, the first provider performance periods related to their payment models have just closed or are drawing to a close. Arkansas officials hope to have their first credible data available related to provider cost and quality performance on episodes in early 2014, and Minnesota should have preliminary HCDS performance data by the spring of 2014.

Although Oregon's CCOs were officially launched in the fall of 2012, the full impact will be phased in over time as the state and CCOs take time to develop and implement strategies for integrating physical and behavioral health care, changing provider reimbursement methodologies, and implementing flexible services payments. Further, because there are many CCOs, it is likely that the impacts will vary across the state. Although policy officials and stakeholders in Oregon and elsewhere are eager to see how well the model is working, it will be important to keep these factors in mind when reviewing the early results. One of the conditions of the state's federal waiver is that it conducts a robust evaluation of the demonstration project in order to determine its impacts. With all this in mind, early reports from Oregon show some encouraging changes. Compared to the baseline year (2011), emergency department visits and potentially avoidable hospitalizations for chronic conditions were lower in the first half of 2013; outpatient primary care visits for CCO members have increased (and spending for primary care has also increased), and enrollment in patient-centered primary care homes has also increased.²²

Pennsylvania's example illustrates the importance of investing up-front in data infrastructure and analytics. The Pennsylvania initiatives described in this report have been in place for a number of years, yet a recurring theme during our visit was that empirical data on affiliated cost and care delivery outcomes are lacking. While the state is able to quantify the reductions in MCO base

²² Oregon Health Authority, Oregon's Health System Transformation Quarterly Progress Report, November 2013. Accessed at <http://www.oregon.gov/oha/Metrics/Documents/report-november-2013.pdf>.

payments and hospital payments, to calculate the paid P4P bonuses, and to monitor MCO performance on HEDIS measures annually, the state, MCOs, and provider representatives expressed difficulty in otherwise objectively understanding the changes that have occurred downstream in the delivery system and the additional cost implications of these changes. Even so, state officials are confident that they have gotten MCO/provider attention, and they communicated noteworthy qualitative impacts: “In the first few years, MCOs would come to the table and tell us why all these things were not possible, not possible to save any money....Now for rate discussions, they come with a laundry list of all the innovations they are doing to address care.”

If one of the goals associated with Medicaid payment reform is to change the way services are delivered to enrollees, it is important for states to put in place the data infrastructure and processes to actively monitor changes in quality and outcomes.

Current federal authorities appear to be sufficiently flexible for the states we visited

State officials in Arkansas, Minnesota, and Oregon who were directly involved in seeking and obtaining federal authorization to move forward with their respective Medicaid payment reforms all viewed CMS as a helpful partner during the process.²³ Several state officials cited that their many conversations with CMS were substantive and collaborative, that state needs for flexibility were reasonably accommodated, and that the process of obtaining federal approval for reform was relatively smooth and timely. Our key takeaway across these states is that waivers and State Plan Amendments (SPAs) appear to be adequate tools for the federal government to use in approving state payment reforms, particularly when state needs for flexibility and turnaround are balanced with CMS needs for state transparency and reporting.

This point is underscored by Oregon’s experience in obtaining federal approval for its CCO model. Even though the model that Oregon pursued is without precedent in terms of its scope and ambition, the state successfully negotiated with CMS and gained initial approval of the model within just a few months. The success of the Oregon model requires significant flexibility on the part of the federal government, in terms of willingness to consider and invest in new approaches such as the flexible services payments in exchange for accountability on overall cost and quality. For example, Oregon’s waiver includes substantial commitments to transparency,

²³ It should be noted that in Pennsylvania, efficiency adjustments, and P4P programs have not required significant additional CMS involvement. Efficiency adjustments are part of the state’s rate setting process and additional federal authority is not needed as long as the state actuary certifies the rates. At the P4P program’s initiation, CMS reviewed program components and provided feedback; now, CMS reviews any P4P changes as part of their normal managed care contract review process.

with quarterly reports to CMS on 33 performance metrics for which the state is held accountable under its waiver.

Officials from Arkansas were also pleased with how quickly they were able to negotiate SPAs related to episode-based payments with CMS. They emphasized that rolling out an episode-based payment model and addressing the many implementation challenges would require significant room to make changes to episode definitions, payment methodologies, and operational processes on a timely basis. The SPAs negotiated with CMS allow for this kind of flexibility, but also require Arkansas to provide detailed reporting at regular intervals to keep CMS apprised if and when plans change.

Similarly, Minnesota highlighted its need for flexibility in crafting federal agreements because the goal was to provide participating delivery systems with significant leeway to design, develop, and refine their own clinical models and innovations. In addition, timing concerns with respect to CMS approval played a significant role in determining the payment reform approach Minnesota would ultimately pursue. According to interviews with DHS' executive leadership, officials were concerned that a more ambitious project than a pilot would require a new CMS waiver or amending the current waiver, which would take time and cause a loss of momentum toward change. Because the state could operationalize most of the HCDS program changes through MHCP MCO contracts, and obtain federal authority for changing fee-for-service payment methods through a SPA, DHS could obtain CMS approval for the HCDS demonstration on a relatively short timeline.

These four states are taking an active role in payment and care delivery reform beyond traditional Medicaid managed care, but changes in roles for MCOs vary

Three of the four states we visited – Minnesota, Oregon, and Pennsylvania – have historically relied to a significant degree on MCOs to manage care for their Medicaid populations. Our study states viewed MCOs as important stakeholders and partners in ensuring access to health care for Medicaid enrollees. However, these states are also focusing on strategies to create value and accelerate delivery system change that change the traditional role of Medicaid MCOs.

In Oregon, the state no longer contracts directly with MCOs for the populations included in its CCO initiative. However, many MCOs that formerly contracted with the state now contract with the CCOs to provide some of the same services that they previously performed (e.g., claims processing, provider contracts). Some CCOs are directly owned by former Medicaid MCOs.

Minnesota's approach is more incremental than Oregon's, in the sense that existing MCO contracts continue to be in place alongside the HCDS contracts. Minnesota includes MCO enrollees in the HCDS patient attribution and cost calculations in order to increase the total scale of the HCDS demonstration, and requires MCOs to participate in the shared savings components of the HCDS model.

Finally, Pennsylvania is continuing to use a traditional MCO model, but using its MCO contracts to more directly incentivize quality improvement at the provider level. The state uses P4P incentives at both the MCO and the provider levels in its Medicaid managed care program. The provider incentives are incorporated into the state's contracts with MCOs, which in turn pass the incentives through to individual providers.

These states' Medicaid payment reforms aim to directly influence provider behavior

One perspective shared by most of the state officials and stakeholders we interviewed was that both Medicaid fee-for-service and traditional Medicaid managed care programs frequently result in the delivery of episodic care by multiple providers with misaligned incentives. The intent of all the Medicaid payment reform initiatives we studied was to change the delivery of care at the provider level through direct financial incentives, leading to improved health outcomes for enrollees, more efficient care delivery, and better value for taxpayers.

For example, the episode-based payment model in Arkansas and the HCDS demonstration project in Minnesota both directly modify payments to providers based on their performance on cost and quality benchmarks. In Arkansas, a state that continues to rely on a fee-for-service delivery system (along with a traditional primary care case management program) in Medicaid, designated providers and provider organizations are now accountable for how they perform relative to cost of care and quality benchmarks for defined episodes of care (e.g., perinatal care) and either receive shared savings payments or have to make payments back to the state accordingly.

In Minnesota, the HCDS demonstration project was created to operate alongside a longstanding managed care program, to add new opportunities for providers to *directly* share in the gains and risks of developing new clinical models that would improve quality for MHCP enrollees, and to test payment models that would increase provider accountability for these improved outcomes. In contrast to Arkansas' episode-based payment model, in Minnesota provider-led ACOs are accountable for performance across a more comprehensive set of medical services delivered at primary and specialty care clinics and hospitals.

Oregon's CCO model integrates funding and financial incentives even further by combining separate funding streams to meet Medicaid beneficiaries' physical, mental, and oral health needs into a single, global budget payment that holds local CCOs accountable for the total cost and quality of care. Individual CCOs are charged with ensuring that financial incentives for individual providers encourage coordinated care and better value at a lower cost than the state's previous model. Although Oregon made extensive use of managed care contracting prior to its CCO initiative, separate contracts for physical, mental, and oral health meant that there was no single entity with a financial incentive to work with providers to coordinate care for beneficiaries in a holistic way.

CCOs in Oregon are also expected to change the way that health care providers are paid (for example, through greater use of patient-centered medical home models). Interviewees agreed on the need to change the way that provider payment methods reward value over volume, but noted that it was important to stakeholders in Oregon that these conversations include community input; individual CCOs are still in the process of creating their transformation plans, which will include alternative payment methods (such as care coordination payments or shared savings) for health care providers. As noted by one interviewee, a key difference between the CCO model and the traditional Medicaid managed care model is that CCOs "push the budget conversation down to a community level."

Finally, of the five Pennsylvania Medicaid payment programs/policies discussed in this report, three directly impact providers (the provider P4P program and two hospital payment policies), and two directly impact MCOs (the MCO P4P program and efficiency adjustments). In talking to state leadership and staff, however, a motivation behind all of these initiatives is to foster improvements in health care quality and outcomes at the provider level through incremental changes to the volume-based provider payment structure that underlies the Medicaid managed care delivery system in Pennsylvania.

Improved data are key to reform success, but require significant investment

Another key theme that emerged from our study is the role of data and information sharing at multiple levels in facilitating improved care delivery and efficiencies downstream. In Arkansas, Minnesota, and Oregon, significant "behind the scenes" data analytics and cost and quality reporting are being established and provided to integrated provider delivery systems, group practices, and individual physicians. In each state, interviewees indicated that these data enhancements required a significant financial investment and a great deal of staff time, but that they were also key to the reforms' success. In fact, in Minnesota, access to improved data was states as the motivation for several provider organizations to participate in the HCDS

demonstration. Nonetheless, it is not clear at this point which providers in Arkansas, Minnesota, and Oregon are receiving better information, whether and how the information is being used, and what changes in care delivery at the patient-clinic level are taking place as a result of this information sharing. Each of the states also indicated that the data enhancements require significant investments of both time and money.

In Pennsylvania, while the state has shared some information about the efficiency adjustments with MCOs, several MCOs expressed concern about the level of information provided to them regarding the state's calculation of the adjustments. They advocated for more state transparency in these calculations so that they can more accurately pinpoint what areas of medical practice are not working well and make changes and progress in health care quality. This sentiment aligned well with a provider perspective that little has been heard by hospitals about the efficiency adjustments, leading to speculation that the adjustments have had neither positive nor negative influence on hospitals. As one stakeholder stated, "One doesn't want [the state] to be administratively burdened to create reports that no one is using, but if we're collectively going to tackle the cost curve, everyone has to look at the same data..."

Each of these states pursued a reform model suited to its market characteristics and environment

While at a high level all of the states we visited are pursuing common goals and responding to similar budget realities, our discussions highlighted just how important each state's unique health care business environment, Medicaid program history, and culture were in shaping how state leaders approached reform and the degree of reform pursued. Our interviewees also emphasized that early conceptual models and plans for payment reform were often altered significantly as more state stakeholders became engaged in reform discussions and decision making in meaningful ways. An important consideration for the federal government—the largest payer of Medicaid—is determining its role in encouraging and overseeing effective payment reform within state Medicaid programs, while keeping in mind the balance between state accountability in standards and outcomes on one hand and, on the other, flexibility in how states implement reform within their own unique contexts.

In Oregon, strong state leadership, along with stakeholder involvement and willingness to commit to taking on financial risk and accountability for results, were cited as key to the development of the CCO model. Longstanding collaborative relationships between the state, community organizations, and other stakeholder groups helped to set the stage for inclusive reform conversations that were about the state's big-picture vision for a sustainable health care system, rather than reforms that would get the state through the next budget crisis. Another strength that helped to pave the way for the CCO model in Oregon was the ability to leverage

infrastructure that had been used previously under the state's Medicaid managed care program, something that may not be available in all states.

In Minnesota's payment reform initiative, several mature, vertically integrated health care systems comprised of hospitals, primary and specialty care clinics, mental health and other ancillary services were not only interested in demonstrating their value to the state, but were already participating in Medicare Pioneer ACO/Shared Savings programs and well-poised to jumpstart the HCDS initiative. This level of provider integration is not common across states, and allowed Minnesota to leverage provider infrastructure and expertise in testing new provider payment models within a largely managed care environment.

In contrast, a *lack* of provider integration in Arkansas meant that the state was *not* ready to create or encourage new "layers" of ACO-like provider entities that would be accountable for managing a set of services for Medicaid enrollees. Instead, the state put in place the building blocks for care integration on the acute side through the designation of episodes of care, accountable providers, and provider financial incentives, while still relying on the existing fee-for-service payment system. Perhaps equally unique in Arkansas was a consolidated payer market and history of payer collaboration that paved the way for a strong multi-payer partnership. This partnership has allowed the state to standardize and spread the episode-based approach beyond Medicaid enrollees to commercial populations, to make a stronger case for reform with providers.

And finally, as opposed to the other states described in this report, Pennsylvania has relied mostly on incremental and Medicaid-focused (as opposed to multi-payer) approaches to move toward value-based purchasing within its Medicaid managed care program. State officials communicated a "focus on quality, moving to payment redesign, pay[ment] for outcomes, try[ing] to get away from FFS approach without doing huge, huge payment reform." A key point that was raised during our discussions with the state is the importance of flexibility in designing and implementing initiatives at the state agency level. The P4P programs, efficiency adjustments, and hospital policies were all established and are maintained without legislative involvement. State department leaders and staff are appreciative of the autonomy this has given them to assess what works and make adjustments and corrections as needed. Broader and more system-transforming reform approaches would likely require a different level of involvement from the state legislature, other state agencies, CMS, and the broader stakeholder community in Pennsylvania.

In securing stakeholder buy-in, these states have balanced flexibility with accountability on multiple levels

Interviewees in all four states agreed that attempts at state health care reform will lack traction without a strong impetus for change and the buy-in of key stakeholders. Securing the participation of health care organizations (e.g., payers, ACOs, MCOs, provider groups) in new accountability standards and payment methods often requires providing these same organizations with flexibility on how to implement changes and to innovate on their own terms. When working towards stakeholder alignment, all four states sought to determine which program requirements and payment methods needed to be standardized and where flexibility could be accommodated without losing accountability for effectiveness.

One of the clearest examples of this balance was in Minnesota, where, in order to improve quality and reduce the total cost of care, participating delivery systems are all required to develop new care models and strategies, provide comprehensive and coordinated services, engage and partner with patients and families, and institute formal partnerships with community organizations to encourage the integration of social services. A standard shared savings/risk methodology is also applied in the same way across HCDS providers. However, participating providers have almost total discretion in how they decide to develop, refine, and invest in their own clinical models and infrastructure toward these ends.

Stakeholders interviewed in Oregon echoed a similar theme in that the flexibility of the CCO model is a key reason why they supported the model. Success of the Oregon model requires significant flexibility on the part of the federal government, state government, and the CCOs compared to the way that the Medicaid program is usually administered. In exchange for the flexibility needed to help make the model work, participants must be willing to be accountable for results. In addition to accountability for meeting cost targets, the state of Oregon is accountable to the federal government for 33 quality metrics. Similarly, individual CCOs require flexibility in order to be responsive to their local communities, but are accountable for both quality and cost; even further down the chain of accountability, individual providers vary in their ability to take on the challenges associated with transforming care delivery. Several interviewees in Oregon noted that experimentation across the CCOs will be helpful in learning what strategies are most effective and highlighted the importance of learning from each other.

Given Arkansas' fragmented health care delivery system, multi-payer alignment (among Arkansas Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice) in the episode-based payment model was a crucial ingredient to securing provider buy-in for reform. Core components of the episode-based model—e.g., how episodes are defined, how PAPs are designated, which quality metrics are associated with each episode, and the overall methodology

by which provider shared savings or payments are calculated—are standard across payers. Other decisions about which episodes to pursue for episode-based payments, underlying provider fee schedules, and other items are left up to individual payers.

In Pennsylvania, the initial design of the P4P program was a product of discussions with numerous stakeholders including MCOs, the Medical Assistance Advisory Committee, state staff, and others. Stakeholders contributed to key design features including the scope of performance measures, specification of performance goals, and determination of incentive levels.²⁴ Likewise, the final PSAE policy was shaped by hospital input, which emphasized both clinical and hospital administrative burden considerations and helped to shape the key definitions contained within the policy. In fact, it was made clear that the PSAE policy may have had difficulty moving forward without these state/hospital conversations because the original state proposal would have garnered significant hospital opposition.

In addition, Pennsylvania has made modifications throughout the life of the payment programs and policies in response to stakeholder concerns and recommendations. As one example, the state eliminated a P4P measure due to MCO concerns about a “lose, lose” created by the MCO P4P program and efficiency adjustments. The MCOs were not achieving the P4P payments in emergency department utilization and were also experiencing a decrease in their base rate due to emergency department utilization. In response, the state removed the emergency department utilization as a P4P measure. From the state’s perspective, having the ability to make such modifications without a time-consuming approval process has been crucial to their administration of its payment programs and policies and has facilitated the ability to partner with plans. The state’s receptiveness to MCO feedback on the P4P programs specifically has not gone unnoticed by MCO representatives; during our meeting with them, they complimented the state for their responsiveness to MCO feedback.

It is also worth highlighting that the provider P4P program within Pennsylvania, as a pass through to MCOs, is designed in such a way to give MCOs flexibility in operationalizing and implementing the program via their provider contracts. While MCOs must work within state requirements (e.g., specific quality measures) in establishing their provider P4P specifications, they are able to define certain aspects of the program, such as the identification of providers targeted for the provider P4P program.

²⁴ Pennsylvania Department of Public Welfare. Health Choices MCO Pay for Performance (P4P) Program: Seven Year Progress Review (June 2005 – December 2011). Prepared June 2013.

Designing and implementing payment reform requires important state investments in staff time and resources

In designing and implementing Medicaid payment reforms, each of the states we visited required significant start-up and ongoing funding for additional staff resources, consulting and actuarial contracts, and investments in technology and data analytics. Pursuing payment reform at the state level is also likely to come with opportunity costs as limited staff resources are pulled from other health care initiatives. It is worth noting that all of the states we visited have received federal SIM grants to fund additional staff, consultants, and infrastructure needed to design or test enhancements and expansions to the Medicaid payment reforms studied as part of this project.²⁵

Arkansas has accomplished much of the design, rollout, and expansion of its episode-based payment model as it exists today through a multi-million dollar annual consulting contract. A small group of state officials and staff from DHS are deeply involved in every aspect of the project, including extensive and ongoing stakeholder engagement efforts. However, much of the “behind the scenes” work that goes into defining episodes, quality metrics, and payment mechanisms is accomplished through consultants. State officials interviewed for the project acknowledged that their receipt of one aggregate state budget appropriation (for medical services as well as administration) provides the agency flexibility in carrying out their work.

In contrast to Arkansas, the majority of the start-up work for the CCO model was done by state staff at the Oregon Health Authority, with high-level leadership deeply involved at every step along the way. Oregon has staff devoted to research and analytics who have the capacity to perform tasks that many states would need to contract out; for example, they have actuaries on staff to review and certify CCO budgets for actuarial soundness. Still, Oregon has found itself needing to make additional investments in data infrastructure to support the CCO effort. Specifically, the state is building an IT infrastructure to give CCOs access to the patient-level information needed in order to identify opportunities for care improvement.

Oregon’s experience is somewhat similar to Minnesota’s, where a very small group of state staff managed the development and roll-out of the HCDS demonstration initiative, including the quality measurement, data analytics and reporting activities accompanying the effort. According to interviews with executive leadership, staff capacity was an enormous challenge at the time given multiple state health care initiatives occurring simultaneously. Both state staff and HCDS providers suggested that working with a talented actuarial consultant who was trusted by both

²⁵ Arkansas, Minnesota, and Oregon were awarded approximately \$42 to \$45 million each to implement and test their payment reform models, and Pennsylvania received approximately \$1.5 million for payment reform design work.

state staff and provider organizations was integral to developing the detailed payment methodology and addressing provider concerns through changes to the methodology along the way.

Pennsylvania's initiatives have involved ongoing relationships with at least two contractors, one responsible for the claims analysis behind the efficiency adjustment determinations and another assisting with different aspects of Pennsylvania's Medicaid programs including estimating MCO P4P payments. In addition, the labor-intensiveness of the P4P programs was highlighted by state staff involved in the operations and oversight of these programs. There are many participating MCOs in the state (9), each with its own contract, including individual P4P goals. The state establishes these contracts, monitors MCO quality performance, budgets and issues P4P payments, and ensures MCO carry out of provider P4P programs. As state participants indicated, there has been a shift from simply administering and monitoring MCO contracts from a procedural perspective to *engaging* with MCOs about health delivery quality. Likewise, the state resources needed to engage with hospitals on quality (in identifying, reviewing, and administratively processing readmissions and PSAEs) are not insignificant.

Looking Forward

These in-depth site visits and project findings raise several broad policy questions regarding the role the federal government can play when it comes to encouraging value-based payment strategies in state Medicaid programs.

1. What policy, regulatory, or financing levers can the federal government use to spur and reward state payment innovations in Medicaid, both in terms of experimentation with new models and encouraging more states to participate?
2. For federal policy, what is the appropriate balance between providing states with flexibility to implement payment model changes through Medicaid waivers or SPAs, while at the same time ensuring the transparency of state efforts and monitoring the value of these changes to the Medicaid program as a whole?
3. What is the best path forward for a consistent general approach to payment reform in federal programs, especially as states pursue broadening their Medicaid efforts into multi-payer initiatives?
4. How can the goals of these reform efforts be applied to other (non-acute) services within the Medicaid program?

Appendix: Organizations Participating in Site Visit Interviews by State

| Site Visit | Organizations/Divisions Participating in Interviews |
|--------------------------|--|
| Little Rock, Arkansas | Arkansas Department of Human Services (DHS): <ul style="list-style-type: none"> • Executive Leadership • Division of Administrative Services • Division of Aging and Adult Services • Division of Behavioral Health Services • Division of Developmental Disabilities Services • Division of Medical Services (Arkansas Medicaid) Arkansas Blue Cross Blue Shield (Payer) Arkansas Hospital Association Arkansas Medical Society |
| St. Paul, Minnesota | Minnesota Department of Human Services (DHS): <ul style="list-style-type: none"> • Executive Leadership • Health Care Administration Forma Actuarial Consulting Services, LLC Children’s Hospitals and Clinics of Minnesota (HCDS Provider) Essentia Health (HCDS Provider) North Memorial Health Care (HCDS Provider) Southern Prairie Community Care (Prospective HCDS Provider) Medica (Medicaid Managed Care Organization and Commercial Health Plan) |
| Portland, Oregon | Oregon Health Authority (OHA) <ul style="list-style-type: none"> • Executive Leadership • Oregon Health Plan • Health Care Transformation Center Health Share of Oregon (CCO) Yamhill County Care Organization (CCO) CareOregon (Former Medicaid MCO, now provides management/support services to CCOs) Oregon Association of Hospitals and Health Systems Oregon Law Center Oregon Primary Care Association |
| Harrisburg, Pennsylvania | Pennsylvania Department Of Public Welfare (DPW) <ul style="list-style-type: none"> • Office of Medical Assistance Programs (OMAP) <ul style="list-style-type: none"> ○ Office of Clinical Quality Improvement ○ Bureau of Managed Care Operations Pennsylvania Department of Health (DOH) Mercer Navigant Hospital and Healthsystem Association of Pennsylvania American Academy of Pediatrics, Pennsylvania Chapter Aetna Better Health (MCO) AmeriHealth (MCO) |

Coventry Cares Health Plan (MCO)
Gateway Health Plan (MCO)
Geisinger Health Plan (MCO)
Health Partners Plans of Philadelphia, Inc. (MCO)
Keystone First (MCO)
UnitedHealthcare Community Plan of Pennsylvania (MCO)
UPMC Health Plan/UPMC for You (MCO)
