CHAPTER 7

A Framework for Evaluating Medicaid Provider Payment Policy

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Key Points

- MACPAC's payment policy framework provides an anchor for our future efforts to assess the relationship of various approaches to payment and delivery system reform to the statutory principles of economy, quality, access, and efficiency.
- Using this framework, we hope to pinpoint the payment approaches that best address efficiency and economy while promoting access to quality services and appropriate utilization.
- Economy, quality, and access are discrete but related outcomes of payment policies. It is necessary, therefore, to consider the relationships of the principles to each other rather than attempt to evaluate them individually. Efficiency is not only a component of quality, economy, and access; it also is the overarching goal of payment policy.
- MACPAC is collecting the following information to support this analysis:
  - states' payment methodologies for various provider types;
  - comparative information on payment rates and methodologies across states and payers, provider costs, and the share of provider revenue that the payments represent; and
  - payment's effect on outcomes, including recommendations for appropriate measures and comparisons to other states and payers.
- Where quantitative data are insufficient, MACPAC will use other information to estimate the direction and magnitude of payment policy effects in promoting economy, quality, and access; determine appropriate metrics; and identify where better data are needed.
- For novel or emerging payment approaches, the framework recommends examining the goals, proposed methods, and anticipated effects of a policy to draw conclusions about how well it supports statutory principles.

CHAPTER 7: A Framework for Evaluating Medicaid Provider Payment Policy

The Medicaid program is a major payer of health care services in the United States, accounting for 15 percent of total health care spending in 2012. This share is projected to rise to nearly 18 percent over the next decade, primarily due to enrollment growth (OACT 2014). As MACPAC has documented in other reports, Medicaid is a dominant payer for obstetrics, pediatrics, behavioral health, and long-term services and supports (LTSS), as well as a critical source of revenue for safety-net providers, including public hospitals, community health centers, and children's hospitals (MACPAC 2011). All told, in fiscal year (FY) 2013, Medicaid expenditures totaled $460 billion, 58 percent of which were federal dollars.

Given Medicaid's size and anticipated growth, both federal and state policymakers are seeking to maximize the efficiency of its spending. After years of focusing primarily on prices, state Medicaid programs increasingly are adopting more sophisticated purchasing strategies emphasizing value. Payment policy can be a powerful lever to contain costs and improve access to and quality of care. Even so, most Medicaid policies, like most other payers' policies, continue to incentivize volume and not value (Bachrach 2010a).

The foundational statutory provision that governs payment for all Medicaid-covered services under the state plan is Section 1902(a)(30)(A) of the Social Security Act (the Act). As described in MACPAC's March 2011 *Report to the Congress on Medicaid and CHIP,* the statute identifies several fundamental aims for Medicaid payment policy:

- assure that payments promote efficiency, quality, and economy;
- avoid payment for unnecessary care; and
- promote access within geographic areas equal to the general population.

There is little federal regulation addressing these payment principles and states have considerable flexibility in the design of policies to achieve these aims. In May 2011, the Centers for Medicare & Medicaid Services (CMS) published a draft regulation that would implement a process for states to consider the impact of fee-for-service payment rates on access to care, but has not finalized the proposed rule to date (CMS 2011). While CMS has stated that Section 1902(a)(30)(A) of the Act and the requirements of the proposed rule apply to Medicaid services paid through a state plan under fee for service and not services provided through managed care arrangements, we believe that the principles are broadly applicable to the analysis of all Medicaid payments.

In the absence of detailed administrative rules, legal challenges (mainly by providers) have been used to determine the criteria by which these principles should be applied (Bachrach 2010b) (Box 7-1). These court rulings generally address payment levels, not methodologies, and do not necessarily help policymakers develop policies for payment or delivery systems that appropriately balance among the different aims articulated in statute or among various stakeholders, including providers, beneficiaries, and taxpayers.

This chapter describes how MACPAC will evaluate and compare Medicaid payments, but we also believe it will allow state and federal policymakers to weigh the effect of payment policies not just on bottom-line spending but on the fundamental aims of efficiency, economy, quality, access, and avoidance of unnecessary utilization. While there is no consensus on the correct amounts or methods of payment—and, given the heterogeneity of state Medicaid programs, a variety of approaches is probably appropriate—there is value in assessing different payment methods through a consistent

BOX 7-1. Recent Federal Court Activity on Medicaid Payment Adequacy

In January 2015, the U.S. Supreme Court heard arguments in the case of Armstrong v. Exceptional Child Care, Inc. to determine whether the Supremacy Clause of the U.S. Constitution (which gives the federal Constitution and federal laws precedence over state laws) grants providers the right to sue states over Medicaid payment adequacy. Importantly, the Court declined to consider whether Medicaid payment rates in the Armstrong case complied with 1902(a)(30)(A), instead focusing solely on whether providers can bring suit.

This is the same issue that the U.S. Supreme Court considered, but ultimately did not rule upon, in Douglas v. Independent Living Center of Southern California (2012). In the Douglas case, the Court agreed to hear the case prior to a final CMS decision on several Medicaid rate reductions proposed by the state of California. When CMS approved the reduction prior to the Court rendering a decision, the Court found the case to be in "a different posture" and declined to rule. (In a dissent, four justices found that the Supremacy Clause did not give providers the right to sue.)

In the Armstrong case, Idaho, with the support of 29 other states, contends that only CMS has the authority to decide whether Medicaid rates are sufficient and that private parties may not bring suit. States are concerned that a ruling in favor of providers would result in numerous lawsuits, circumventing state decisions made under CMS oversight.[1]

lens. A payment assessment framework helps policymakers consider whether a particular provider payment methodology, whether under fee-for-service or risk-based arrangements, is consistent with the fundamental aims of Medicaid payment policy or more or less likely to promote those aims when compared to alternative approaches. The goal is to get past the work of describing the elements or purpose of specific approaches to address the policy questions MACPAC first raised in our March 2011 report:

- What is the relationship of payment to access and quality?
- Which payment innovations best address efficiency and economy while promoting access to high-quality health care services and appropriate use of those services?

Answering these questions requires data regarding the statutory aims: efficiency, economy, quality, access, and avoidance of unnecessary utilization. In some cases, state and federal administrative data—including claims, quality measures, and cost reports—may allow for quantitative analyses. In other cases, particularly for emerging payment models, we may need to rely more on qualitative methods to inform discussion.

In addition to introducing MACPAC's Medicaid payment assessment framework, which builds on work started in 2010 and draws on findings from a variety of research projects, this chapter also:

- reviews each of the statutory principles for Medicaid payment and potential data sources;
- describes components of MACPAC's Medicaid provider payment assessment framework; and
- explains how we will apply the framework in practice.

Medicaid Payment Policy Principles

As noted above, the Medicaid statute identifies several aims of Medicaid payment policy: to promote efficiency, economy, quality, access, and to safeguard against unnecessary utilization. A framework for assessing Medicaid payments, therefore, requires a consistent understanding of these statutory principles, against which specific policies can be evaluated. States use a variety of payment methodologies in Medicaid (Box 7-2).

Economy, quality, and access are three distinct but related outcomes of payment policies and are discussed individually below. Efficiency is a measure of value that takes into account both cost (economy) and outcomes (access, quality, and appropriateness of service use). As a result, it is necessary to consider the relationships of the statutory principles to each other, rather than attempt to evaluate each of them individually.

Analyzing the elements of payment policy is problematic due to the lack of data. In our March 2011 report to Congress, MACPAC found that no sources of systematic and comprehensive Medicaid payment information exist, and the lack of timely and reliable sources of data is a major challenge for payment analysis (MACPAC 2011). Since then, MACPAC has developed new data to

BOX 7-2. Types of Medicaid Payments

Medicaid, like most other health care payers, uses a variety of payment approaches for different types of providers and for different kinds of services. These include:

- **fee-for-service payments** with payment for each service determined based on a fee schedule, relative value scale, percent of charges, or other basis;
- **per day, per visit, or per encounter payments,** which include all services rendered during the relevant period;
- **per episode or bundled payments,** which include services associated with a specific procedure or diagnosis, usually over more than one day, and which can be narrow (e.g., only inpatient services) or broad (e.g., inpatient, outpatient, and ancillary services);
- **capitation, premium, or global payments** that provide an individual with coverage for a defined set of benefits (whether or not they are used) for a specific time period (generally one month); and
- **supplemental or incentive payments** not directly related to a service, but generally to a provider characteristic (e.g., serves a disproportionate share of uninsured patients, located in a rural area, serves as a primary care case manager) or a desired outcome (e.g., achieves certain utilization or spending targets, performs well on quality measures).

While CMS has indicated that Section 1902(a)(30)(A) of the Act does not directly apply to payments for services provided through managed care arrangements, the principles described can be useful in evaluating all types of payment. Certain payment types are subject to additional statutory and regulatory requirements, as described in Chapter 5 of MACPAC's March 2011 report to Congress.

support discrete analyses of Medicaid payment policies and their effects on spending, quality, and access. We will continue to collect information and develop more effective measures. Specific examples of the types of information needed to better evaluate the degree to which Medicaid payments meet statutory requirements are provided below.

Economy

The level of payment, or payment rate, can be considered the most basic measure of economy and is essential to an assessment of payment efficiency, a measure of value that compares what is spent (economy) to what is obtained (quality, access, utilization). Typically, an analysis of whether a health care payment is economical includes comparison to the cost to provide a given service and comparison to what other payers (e.g., other states, Medicare, commercial insurance) pay for a comparable service in a given geographic area.

While the term economy has not been explicitly defined for Medicaid payment, both statutory and regulatory requirements affect payment levels for certain providers. The original statutory requirements for economical payment were based on providers' costs, with states required to pay institutional providers their "reasonable costs." Later, this requirement was loosened to require payments that were "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities." Eventually, however, the explicit link to provider costs was dropped entirely and, instead, states were required to develop rates through a public consultation process. To the extent they exist, regulatory requirements for economical payments are based on a comparison to Medicare payment levels. Specifically, the upper payment limit for aggregate Medicaid payments to facility providers is based on a reasonable estimate of what Medicare would pay for the equivalent services.

Other statutory payment requirements similarly rely on either providers' costs or Medicare payment levels. For example, Medicaid statutory payment requirements based on costs include:

- federally qualified health center payments, which are based on each provider's individual costs for providing services;
- disproportionate share hospital payments, which are limited to an individual hospital's uncompensated care costs; and
- Medicaid managed care payments, which the statute requires to be actuarially sound, defined by the American Academy of Actuaries as "provid(ing) for all reasonable, appropriate, and attainable costs" incurred by plans.

Those based on comparisons to Medicare payment include:

- Medicaid hospice payments may not be lower than what Medicare would pay.
- Primary care services provided by qualified providers were paid at Medicare rates in 2013 and 2014.

Assessing the economy of Medicaid payment typically requires knowing the amount of Medicaid payment and either the providers' costs to provide a given service or the amounts paid by others for the same or a comparable service. When considered in isolation, however, measures of economy provide limited insight into whether payments are appropriate, particularly if there are concerns about the benchmarks (e.g., provider costs) themselves. The total amount of Medicaid payment is the most readily available data element related to economy. All states are required to report aggregate spending by type of service on the quarterly CMS-64 expense form, which states are required to submit to CMS as an accounting of expenditures eligible for federal match. These data provide basic information on the aggregate

amount that each state spends for a given service and could be used to develop, for example, state spending amounts per enrollee for a particular type of service.

States also are required to submit claims and eligibility data to CMS through the Medicaid Statistical Information System (MSIS) each quarter allowing, in many cases, for examination of the amount that states pay an individual provider for a specific service in fee for service. Together, these data sources can be used to examine total benefit spending by major eligibility category (as MACPAC publishes as part of MACStats) and could also be used to examine spending for specific types of service by eligibility category.

However, each of these data sources has significant limitations. First, as discussed extensively in MACPAC's March 2014 report, most states make a significant amount of lump-sum supplemental payments, particularly to hospitals. While these payments generally are reported in the aggregate on the CMS-64, they are not reported at the provider level in a readily accessible format and cannot be reliably distributed across subgroups of enrollees (e.g., by eligibility category). CMS has indicated that it is working on resolving these issues, primarily through the implementation of the Transformed Medicaid Statistical Information System (T-MSIS). Further, for services provided to enrollees in Medicaid managed care plans, encounter data often do not include the amounts paid to providers. Without such data, analyses of Medicaid payment would exclude data regarding the majority of enrollees in many states.

Data on providers' costs are available for some types of providers. Most hospitals and nursing facilities, for example, are required by the Medicare program to submit annual cost reports to the federal government. While the reports are not designed to capture Medicaid costs specifically, and individual state definitions of allowable Medicaid costs vary, such cost reporting allows for some analysis of the relationship between Medicaid payment and provider costs across states. Some states also collect hospital-level cost and revenue data and make these data available for analysis. However, even when there is standardized reporting of financial data at the state or federal level, such information generally is not sufficient to analyze costs at the service level. Further, there is little standardized information regarding the costs for most other types of Medicaid providers, making it rarely possible to compare provider payment amounts to the related costs.

Information on the amounts paid by commercial payers usually is not available, but service-level payment rates for Medicare often are used as a comparator for Medicaid. For example, states were required to temporarily increase payment rates for certain primary care services to Medicare levels to promote primary care physician participation in Medicaid (MACPAC 2013). States may also compare their payment rates to Medicaid payment rates in bordering states. Information on provider payments made by other payers, including exchange plans, is not widely available. Some databases have been developed recently with detailed information on provider charges, but the relationship between billed charges and fees paid by insurers is not always known (GAO 2011). In a number of states, all-payer claims databases are being developed but, at present, their utility for Medicaid analyses remains limited. Comparisons of payments across payers also can be complicated by variations in both the health status of the covered populations and in definitions of the covered service. For example, sicker patients might be more expensive to treat and, therefore, higher payments for those patients may be appropriate. In such cases, comparisons should account for the acuity of patients. Another source of complication is variation in service definitions. Payment for a day of nursing facility care, for example, might be higher in a state that includes payment for therapies and medical equipment in its rate, compared to a state that does not.

Access

In its March 2011 report to Congress, the Commission presented a framework for examining access to services in Medicaid and the State Children's Health Insurance Program (CHIP) (MACPAC 2011). The Commission's access framework takes into account three elements: enrollees, including their unique and diverse characteristics and health needs; availability of necessary services; and utilization of services by enrollees. In addition, the Commission noted that evaluation of access must include consideration of the appropriateness of services and settings—consistent with the statutory requirement that Medicaid payment should "safeguard against unnecessary utilization"—as well as the efficiency, economy, and quality of care. All of these elements must be considered when evaluating whether Medicaid and CHIP enrollees have adequate access to health care services that are economical and produce positive outcomes.

The equal access provision of the Act, requiring payment to be "...sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area," was added in 1989 (P.L. 101-239). While the 1989 law also included a requirement for states to demonstrate compliance with the access requirement for obstetrical and pediatric services, this requirement was repealed in 1997 after states reported significant difficulty with compliance. In May 2011, CMS released a proposed rule that would, for the first time, create regulatory requirements for states to demonstrate appropriate access to Medicaid covered services paid under fee for service. This proposed rule would require states to analyze access based on enrollee needs, availability of providers and services, and utilization of services, and to submit related data in conjunction with state plan amendments that reduce rates or restructure payment in circumstances that could result in access issues (Box 7-3).

While the proposed rule does not apply to services paid for under managed care arrangements, there are separate regulatory requirements for network adequacy and availability of services under 42 CFR 438. For example, states contracting with managed care plans must ensure that each plan maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract, taking into consideration anticipated enrollment, expected utilization, the characteristics and health care needs of enrollees, and the location of providers and Medicaid enrollees.

Various data sources could be used to assess access consistent with the Commission's framework. For provider supply and participation, for example, national (e.g., National Ambulatory Medical Care Survey) and state-specific surveys could be used to develop such measures as provider-to-population ratios and changes in provider enrollment and participation. Further, a variety of state-specific measures related to provider availability could be available through current state Medicaid information systems.

Data regarding enrollees' use of health care services generally are available to states through claims systems and to the federal government through state MSIS data submissions. Because a comparison to the general population is a key element of the equal access provision, however, survey data may also be required for populations for whom claims data are not accessible, including commercially insured populations. The appropriateness of utilization should also be considered (e.g., analyses of emergency department use and hospital admissions for potentially preventable conditions.)

Each of these data sources has limitations. For example, as previously noted, surveys and studies specific to the Medicaid program are sparse and often outdated, and sample sizes often do not permit examination of access for subgroups of enrollees. State administrative data are of varying

BOX 7-3. Proposed Rule Regarding Methods for Assuring Access to Covered Medicaid Services

In the May 6, 2011 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published a notice of proposed rulemaking regarding methods for assuring access to covered Medicaid services provided on a fee-for-service basis. Specifically, the proposed rule would create a standardized, transparent process for states to follow as part of their broader efforts to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" as required by section 1902(a)(30)(A) of the Social Security Act. The proposed rule also would require states to collect enrollee and stakeholder feedback regarding access and to conduct a public review process prior to submitting state plan amendments that propose Medicaid provider payment rate reductions or changes in the provider payment structure.

The proposed rule would fill the gap in federal guidance regarding the types of information states were expected to analyze and monitor in determining compliance with statutory access requirements. CMS stated that this lack of guidance complicated its review of state plan amendments (SPAs) relating to changes in provider payment rates and had been cited in litigation relating to Medicaid provider payments.

States would be required to determine appropriate data elements that address enrollee needs, availability of care and providers, and utilization of services. This and other information that the state believes to be relevant would be periodically analyzed by states to demonstrate and monitor sufficient access to care. The data and analysis would be made available to the public and furnished to CMS as requested in the context of a SPA that reduces provider rates or restructures provider payments in circumstances that could result in access issues, or as part of ongoing program reviews. The rule would not require that states use uniform data elements or standard analyses to demonstrate and monitor access, so there potentially could be a unique method in each state for assuring access under the regulation.

CMS received 181 comments on the proposed rule from a variety of stakeholders, including providers and provider associations, consumer groups, and states. Many commenters supported the proposed rule and some suggested additional factors that should be considered as part of the evaluation of provider payment, such as efficiency, economy, or quality. Several providers and provider associations submitted comments in support of the proposed regulation and encouraged CMS to require states to use clear and consistent access measures or to provide additional federal guidance on acceptable levels and measures of access. Several states raised concerns that the proposed rule would not reduce the potential for litigation and pointed out that the process and timing for the proposed access studies would be administratively cumbersome for states to implement and difficult to coordinate with the legislative cycle. The proposed rule had not been finalized as of March 2015.

Source: Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Medicaid program; Methods for assuring access to covered Medicaid services. Proposed rule. *Federal Register 76,* no. 88 (May 6): 26342-26362. http://www.regulations.gov/#!documentDetail;D=CMS-2011-0062-0001.

levels of quality, particularly for managed care enrollees, and typically do not include comparison groups. There also are some Medicaid services, such as non-emergency transportation, that do not have a commercial or Medicare equivalent. Thus, it may be difficult to determine whether access issues are specific to the Medicaid program or system-wide within a given geographic area (MACPAC 2013).

Quality

Medicaid is intended to provide not just access to care, but access to quality care. Although definitions of quality may emphasize different aspects in different contexts, quality care is generally considered to be safe, effective, patient-centered, timely, equitable, and reliable (IOM 2001). HHS defines the goal of quality efforts as "ensuring that all patients receive the right care, at the right time, in the right setting, all the time" (AHRQ 2011). Quality is related to the goals of access and efficiency, as well as to the statutory requirement that states develop methods to safeguard against unnecessary utilization of care and services.

Quality measurement is a necessary component of payment and delivery reforms intended to improve efficiency, but definitions and measures for different aspects of health care quality vary (AHRQ 2014). As MACPAC noted in its March 2012 report to Congress, identifying appropriate quality metrics for Medicaid enrollees, particularly people with disabilities, presents challenges because of their diverse needs. For example, people with disabilities have more complex health conditions and greater functional needs, and use many more medical and other health-related services than do other Medicaid enrollees, yet it is not clear whether commonly used quality measures adequately assess quality of care for these individuals (MACPAC 2012).

In an effort to develop more consistent and robust quality metrics for Medicaid (and in compliance with statutory requirements), CMS released a core set of measures for children enrolled in Medicaid and CHIP in December 2009 and for adults enrolled in Medicaid in January 2012. However, these quality measures currently are voluntary, and many measures are not being reported. (In 2013, states reported a median of 16 of the 26 core measures for children and 16 of the 26 adult core measures.) In addition, the adult measures do not currently include measures specific to people with disabilities and other populations receiving LTSS, although states are beginning to pilot test new tools that may support these measures. Many states require Medicaid managed care plans to use the standardized Healthcare Effectiveness Data and Information Set (HEDIS) measures to report on quality. While the HEDIS measures are widely used measures of quality in health insurance, they have some of the same limitations as other measure sets (e.g., no measures relating to home and community-based services).

Many payment reforms are intended to improve quality by encouraging providers to be accountable for transitions between settings of care and to better coordinate care for patients with complex and chronic conditions. However, there are few consistent metrics to measure the success of these efforts, particularly those that are clearly linked to payment. For example, 9 million adults are eligible for both Medicaid and Medicare, and CMS has implemented a large-scale demonstration program intended to better align the financial incentives for providers to integrate primary care, other acute care, behavioral health services, and long-term services and supports (CMS 2014a). The quality metrics being used in these demonstrations vary considerably, which will make it difficult to compare the effect of different payment approaches on outcomes (Zainulbhai et al. 2014).

In the Medicaid program, collecting complete and timely quality data is further complicated by limitations and variations in state data systems. Quality improvement efforts and specific quality measures can use a variety of data sources, including administrative data (the information contained in eligibility, claims, and encounter files),

clinical data (from medical records), and patient-reported outcomes. Of these, administrative data are the most widely available and can be used to calculate measures of process and appropriateness of care. For example, claims data include details on use of services that can be used to examine receipt of recommended care, such as well-child care and preventive dental visits. While states and providers continue to implement electronic health records and health information exchanges to improve the timeliness and availability of clinical data, there are few sources of robust clinical data to support quality measurement.

Quality measurement in Medicaid remains challenging for several reasons. Many Medicaid enrollees are eligible for short periods of time or may cycle in and out of the program or between Medicaid and other sources of coverage, making it difficult to reliably measure the effect of a Medicaid payment policy on quality (Ku 2013). State Medicaid programs (not national insurers) are the dominant purchaser of some services, such as home and community-based services (HCBS), and there is little standardization in the measures for these services (Lind 2013). Even quality measures that are widely used, such as measures for common health conditions like asthma, diabetes, and heart failure, may not be comparable for certain subgroups of Medicaid enrollees, particularly those with disabilities or who rely on LTSS. Most Medicaid enrollees are enrolled in managed care plans but, in many states, some services (e.g., behavioral health, dental) remain in fee for service or are provided through specialty managed care plans, making it difficult to link quality outcomes with a particular delivery and payment approach. Finally, the science of measuring transitions of care and person-centeredness is still evolving, particularly for goals that go beyond clinical outcomes, such as quality of life, autonomy, and social supports (LTQA 2011). All of these challenges make it difficult for policymakers to better align payment incentives to improve quality or to assess the relationship between payment and quality.

Efficiency

Medicaid payment should provide access to the appropriate amount of high-quality care, at the appropriate time, and in the appropriate setting, while controlling overall costs. In other words, Medicaid payment should be efficient. A 2010 report commissioned by the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services defined state Medicaid efficiency as "that which produces better outcomes for a given level of spending relative to other states or similar outcomes for lower costs" (Lipson 2010). This definition, which was selected based on Medicaid's role as a health care payer, accounts for each of the required statutory principles. Assessing Medicaid payment efficiency, therefore, requires measures of economy, access, and quality—and the same data limitations that affect these measures affect the measurement of efficiency as well.

Analyses of efficiency could include comparisons of access or outcomes across states or payers relative to the amount of payment for services. For example, the Medicare Payment Advisory Commission (MedPAC) commonly considers the appropriateness of providing particular services in a particular setting (e.g., hospital outpatient department) compared to others that may be less expensive (e.g., physician's office). In some states, including Arkansas and Tennessee, Medicaid programs have begun directly comparing the amounts paid for specific episodes of care (e.g., deliveries, joint replacement), identifying significant variation even after accounting for patient complexity and outliers.

Many other states are attempting to reform their Medicaid payment methods to encourage greater efficiency. In 32 states, these efforts have been supported through State Innovation Model (SIM) grants awarded by the CMS Center for Medicare and Medicaid Innovation and totaling nearly $1 billon (CMS 2014b). In addition to the episode-based payment models mentioned previously, states are experimenting with global budgeting, accountable care models with shared savings, and a variety

of financial incentives to encourage greater care coordination. All of these approaches are designed to provide financial incentives for greater efficiency—improved outcomes for lower cost. At the same time, it is important to recognize that Medicaid is only one payer and, in many cases, not the dominant payer for particular providers. It is important, therefore, to keep in mind that efforts to reform the broader health care system cannot be evaluated based solely on their result for any one payer, including Medicaid. Many of the state reform efforts are intended to be multi-payer and, in fact, this is an explicit goal of the SIM initiative.

Other Payment Policy Goals

It is worth noting that, in addition to the explicit statutory goals for Medicaid payment described in §1902(a)(30)(A) of the Act, Medicaid policymakers may consider several other factors when developing payment policies. These include:

- **Administrative simplicity.** Given constraints on state administrative capacity, states may prefer to develop or maintain payment policies that are straightforward to implement and administer.
- **Program integrity and transparency.** States may consider the potential for waste, fraud, and abuse when designing and implementing a payment policy and seek payment methodologies that are more transparent or easier to audit.
- **Budget predictability.** States may develop payment methodologies that transfer insurance risk to third parties, leaving states responsible for costs associated with enrollment growth, but not for unexpected increases in medical spending.
- **Broader health policy goals.** Policymakers may develop payment methods to support health policy goals, such as workforce development, public health, and stability of safety net providers.
- **Alignment with other payers.** States may seek to align payment policies with other payers (e.g., Medicare, state employee insurance plans, commercial insurers) to leverage purchasing power and reduce administrative burden on providers.
- **Fairness.** States may opt for payment methods that pay providers similar amounts for similar patients or services, regardless of setting or provider type.

Finally, it must be acknowledged that states' Medicaid payment policies reflect state-specific approaches to non-federal financing. For example, it is common for states to use revenue generated by a health care related tax to support payments to the class of providers paying the tax. In such cases, the net payment received by the providers is less than payment data might indicate. In other cases, localities may contribute non-federal share through intergovernmental transfers or certified public expenditures. Due to the way these contributions are captured in different systems, the total payment for these services also may be different from that indicated by available payment data.

Applying the Framework

The Commission's framework provides a foundation for our future efforts to assess the consistency of particular Medicaid payment policies relative to statutory principles of economy, quality, and access and to assess their overall efficiency. This framework builds on work MACPAC has conducted over the past several years to collect and document different aspects of Medicaid payment policy, including details for specific provider and service types. MACPAC will continue to update and add to our payment policy research to inform application of the framework. Specific information we will continue to collect includes:

- **Payment methodology:** What is the payment for? To whom is it made? How is the rate

or fee determined? Did the state develop the payment method or adopt a method established by other payers? Does the methodology account for the relative acuity of enrollees? What information is used to adjudicate a claim or authorize a payment?

- **Payment amount:** What is the payment amount? How does this amount compare to other states and other payers (e.g., Medicare or exchange plans)? How much provider revenue derives from Medicaid? How does this amount compare to the provider's cost, and is cost an appropriate benchmark? What is the effect of any supplemental payments?
- **Outcomes related to the payment:** What are the appropriate measures to evaluate the effect of the payment on access and quality and overall program spending? What payment-related data are available? What outcomes data are available? What comparative information is available from other payers?

MACPAC currently is conducting a number of projects to evaluate various Medicaid payment policies. We are interested in learning more about differences in service-level inpatient hospital payments across states and compared to other payers. MACPAC has collected information on state-level inpatient payment methodologies for all 51 state Medicaid programs and is now developing an index of fee-for-service inpatient hospital payment amounts across states, controlling for certain demographic factors and case mix to provide an indicator of the relative economy of payments across states. By combining information on payment amounts (economy) from the index with information on outcomes (quality and access) from other sources, the Commission potentially could assess the relative efficiency of different inpatient payment methodologies.

The Commission also is interested in reviewing managed care payment methods. In March 2014, we convened a roundtable discussion of the technical issues involved in capitation rate setting and ways that federal and state governments can use capitation payment levers to drive greater value. The discussion topics included payment methodologies, including rate setting for low-income adults covered under Medicaid expansion groups, rate setting for enrollees in managed long-term services and supports (MLTSS) programs, and risk sharing; payment amounts, including medical loss ratios; and payment outcomes, including pay-for-performance and value-based purchasing. Through this roundtable discussion, the Commission was able to identify a number of additional research questions and potential policy recommendations to support more efficient and accurate capitation rate setting, such as studying MLTSS rate-setting methods to determine if certain incentive structures are better than others in promoting a shift to more cost-effective care and improved outcomes. MACPAC will continue to investigate state payment reforms, including capitated arrangements and other innovative models that seek to reward value instead of volume.

The Commission will complement quantitative information on payment policy outcomes with other available information to inform assessments of specific Medicaid payment policies. As noted above, MACPAC has access to certain information such as fee-for-service payment amounts, utilization, and total spending. However, other information, such as capitation payment rate schedules or provider-level supplemental payment amounts, are held by individual states but not readily available for analysis, so more work must be done to collect and evaluate them. In addition, some outcomes data, such as quality measures, may be available but often are much older than payment information. While it may be difficult to obtain sufficient quantitative information to make clear-cut assessments of the effects of a given payment policy, particularly at the individual state level, the Commission will use available information to estimate the direction and magnitude of payment policy effects on economy, quality, and access; determine the appropriate metrics and data points

to measure the effects; and identify where better data or more appropriate metrics are needed to inform the development of those tools.

MedPAC has long employed a similar approach to assessing payment adequacy and updating payments in Medicare. MedPAC's responsibilities are somewhat different from MACPAC's—MedPAC is explicitly required to inform Congress whether the uniform set of Medicare payments for the current year are adequate to cover the costs of efficient providers and how much payments should change in the coming year. Its payment adequacy framework, described in its March 2014 *Report to the Congress on Medicare Payment Policy,* includes examination of the capacity and supply of providers, quality of care, providers' access to capital, and Medicare payments and provider costs (MedPAC 2014). However, MedPAC acknowledges that the relevance, availability, and quality of data on these four elements varies depending on the payment and provider type being considered, meaning that it often must make decisions and recommendations on payment adequacy with incomplete information. MACPAC will take a similar approach, assembling the best data available and considering the various factors outlined here when making payment policy recommendations.

To support meaningful analyses of Medicaid payment, the Commission will continue to fill data gaps where possible and use qualitative methods to assess policies when the data do not support quantitative analysis. For novel or emerging payment approaches, the Commission can examine the goals, proposed methods, and anticipated effects of a policy to draw conclusions about the consistency of the payment method with the statutory principles based on the incentives that the method creates. The Commission will:

- consider whether the stated goals are consistent with each of the statutory principles or appropriately balance among them where they are in conflict;
- assess the degree to which the design of a payment policy relates to the stated goals and consider whether the data and metrics associated with a given policy are appropriate or realistic; and
- identify what other types of data or measures would be needed to assess the effect of a policy on the statutory principles in order to inform potential recommendations.

It also will be important to consider the effects of payment policies over time, recognizing that policy changes take time to fully implement and the effects may not be immediately apparent. Further, states' payment reform efforts often involve multiple simultaneous policy changes and, thus, it may be necessary to consider any individual change in context.

Next Steps

MACPAC's payment policy framework provides an anchor for our future efforts to assess systematically the relationship of various payment and delivery system approaches to the statutory principles of economy, quality, access, and efficiency. Using this framework, we hope to pinpoint the payment approaches that best address efficiency and economy while promoting access to quality services and appropriate utilization.

The Commission will continue to collect additional information on payment methods and levels that will inform our analyses of Medicaid payment policies and their effects on spending, quality, and access. We will continue to point out important gaps in federal data sources and make recommendations where appropriate. The Commission also will collect more information and develop better measures to more precisely evaluate the degree to which Medicaid payments meet statutory requirements.

Endnotes

[1] *Armstrong v. Exceptional Child Center, Inc., et al.,* 14-15, (SCT July 7, 2014). http://www.supremecourt.gov/search.aspx?filename=/docketfiles/14-15.htm.

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