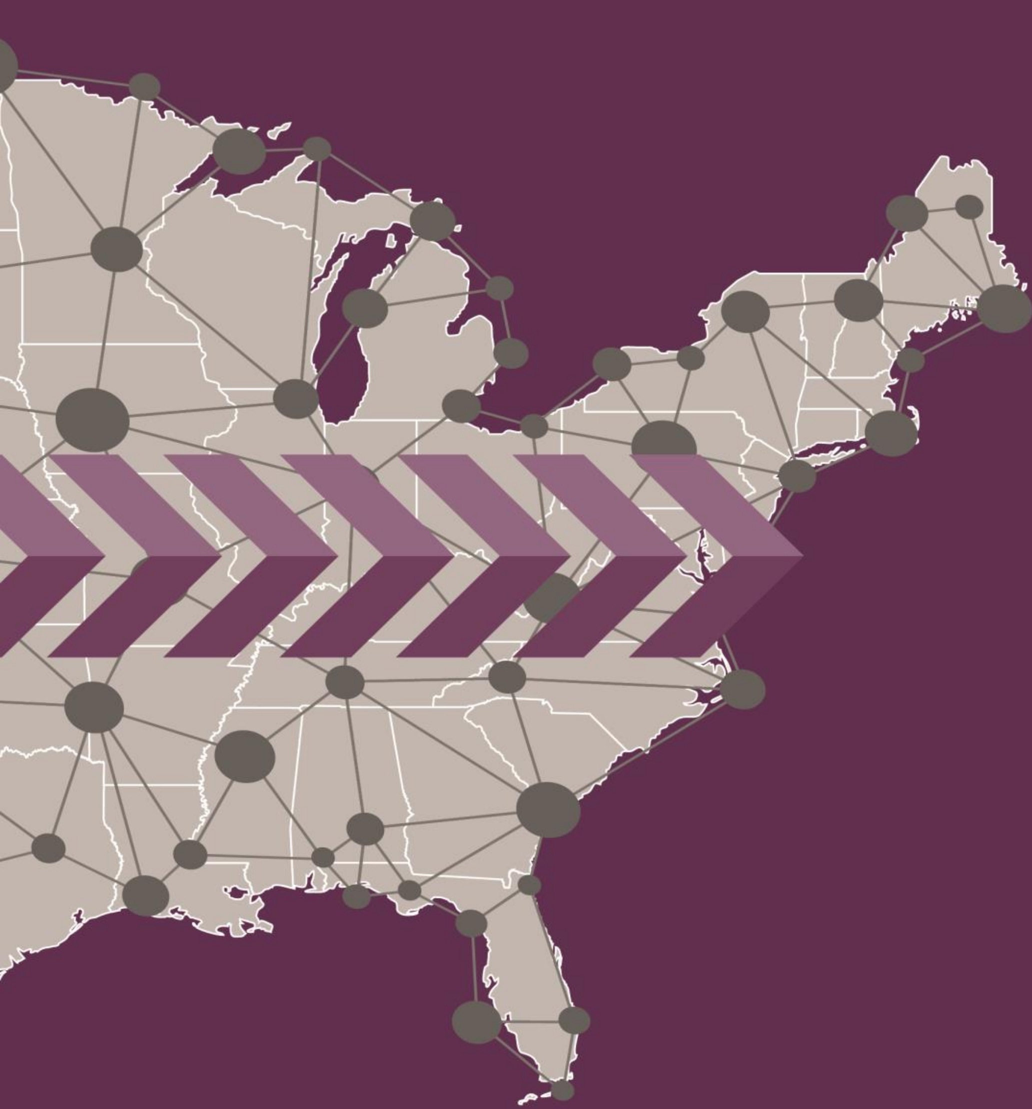


Medicaid Managed Care 101

Mary Beth Dyer, MPP &

Beth Waldman, JD, MPH

Bailit Health

October 3, 2019

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions about SHVS? Email Heather Howard at heatherh@Princeton.edu.

Support for this meeting was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Today's Agenda

1. Introductions and Meeting Purpose
2. Some Context on Medicaid Managed Care
3. Why Medicaid Managed Care?
4. What is Managed Care?
5. More about Medicaid Managed Care
6. What is Value-based Payment?

Address Your Comments and Questions! (ongoing)

What We Will Skip Over:

- *Managed Care payment methodologies*
- *Rate setting & Actuarial soundness*

SOME CONTEXT ON MEDICAID MANAGED CARE

Medicaid Managed Care: Facts & Trends

1. Over two-thirds of Medicaid beneficiaries receive their care through risk-based managed care organizations (MCOs).
2. Children and adults are more likely to be in MCOs than seniors or persons with disabilities. But states increasingly include beneficiaries with complex needs in MCOs.
3. Many states include behavioral health services in MCO contracts. Some include long-term services and supports, while others carve these out of MCO contracts.
4. Growth of Medicaid managed care is accompanied by greater attention to measuring quality and outcomes.
5. More states are looking at how MCOs pay providers.

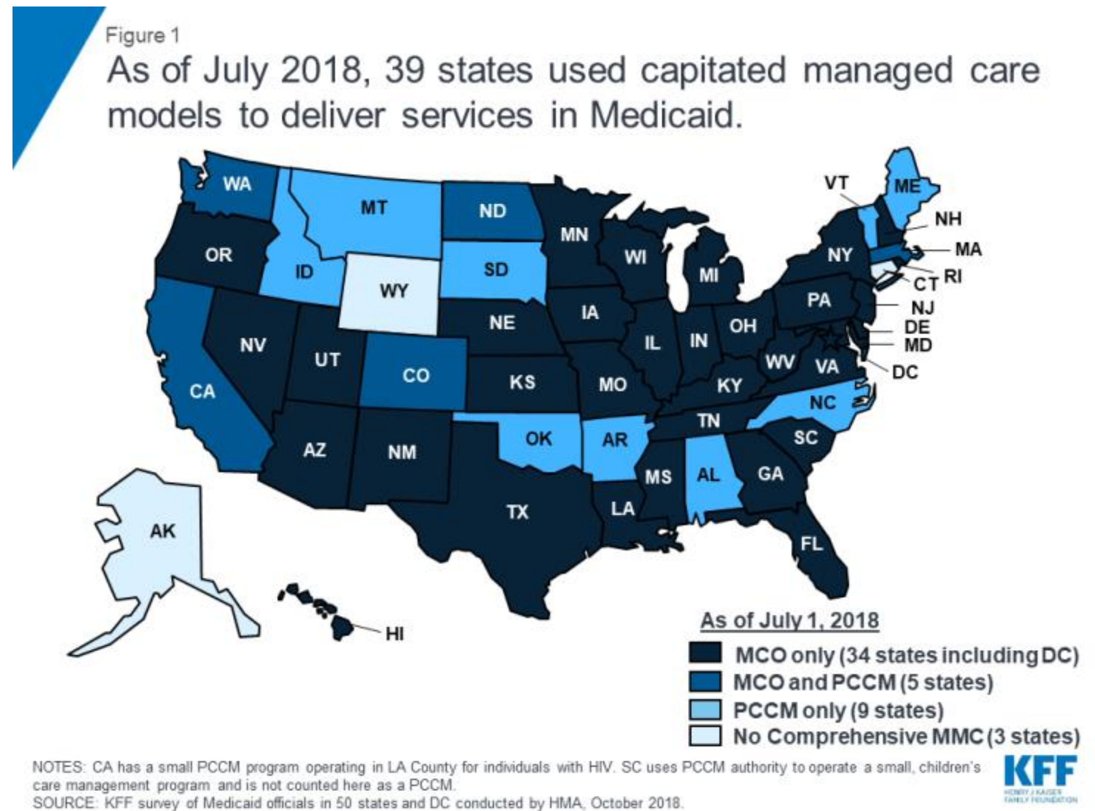
See: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

Helpful Abbreviations

- APM = alternative payment model
- FFS = fee-for-service
- HMO = health maintenance organization
- LTSS = long term services and supports
- MCO = managed care organization
- MMC = Medicaid managed care
- PCP = primary care provider
- PMPM = per member per month

Medicaid Managed Care Adoption by State

- In 2010, MCOs provided coverage for over 50% of Medicaid beneficiaries across 35 states.
- By 2017, over 54 million, (almost 70%) Medicaid beneficiaries, were enrolled in risk-based MCOs nationally.
- In 24 states, more than 75% of Medicaid beneficiaries are enrolled in MCOs.

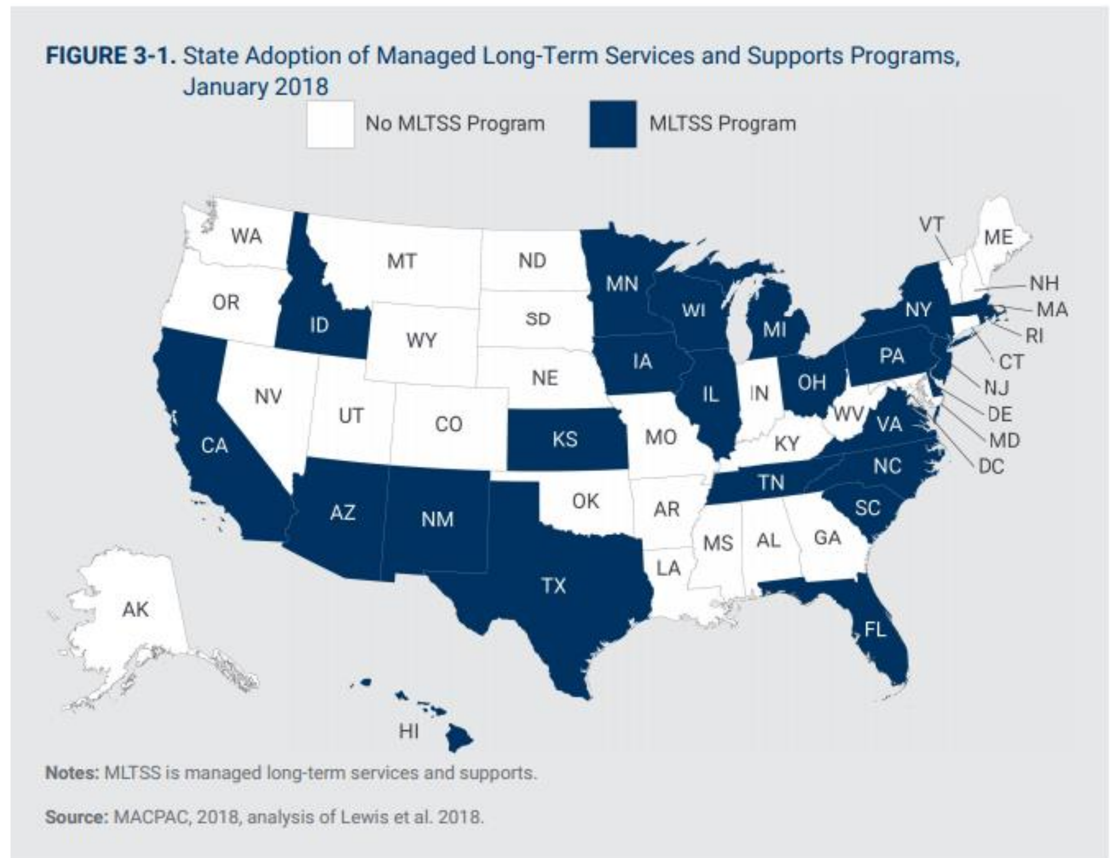


Source: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

- Managed Long Term Services and Supports (MLTSS) refers to the delivery of long term services and supports through capitated Medicaid managed care programs.
- An increasing numbers of states are using MLTSS as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality, and increasing efficiency.

MLTSS Adoption by State
January 2018

- In 2008, only 8 states had implemented MLTSS programs.
- In 2018, 24 states had implemented MLTSS programs. These 24 states operate 41 MLTSS programs, which are often targeted towards different populations.



Source: https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf

MLTSS Growth (2012-2017)

- Total enrollment in MLTSS programs more than doubled, from 800,000 in 2012 to 1.8 million in 2017.
  - Typically serving older adults (33 programs) and adults with physical disabilities (30 programs).
- More states offered multiple MLTSS programs in 2017:
  - The number of MLTSS programs more than doubled from 19 programs in 2012 to 41 programs in 2017.
    - Some states have separate MLTSS programs for dually eligible persons.
- A slight majority of programs (21) require mandatory enrollment for MLTSS participants.

Source: "The Growth of Managed Long-Term Services and Supports Programs: 2017 Update" Truven Health Analytics, January 29, 2018

MLTSS Program Structures

Structure	Description
Fully integrated MLTSS system (LTSS and non-LTSS populations)	Managed care entity serves both LTSS and non-LTSS populations and offers a comprehensive set of benefits
MLTSS with full benefits (LTSS population only)	Managed care entity provides most health benefits (physical, behavioral health, LTSS) to LTSS-only population.
MLTSS with long-term care benefits only for LTSS population	Managed care entity provides only long-term care/LTSS services to LTSS-only population

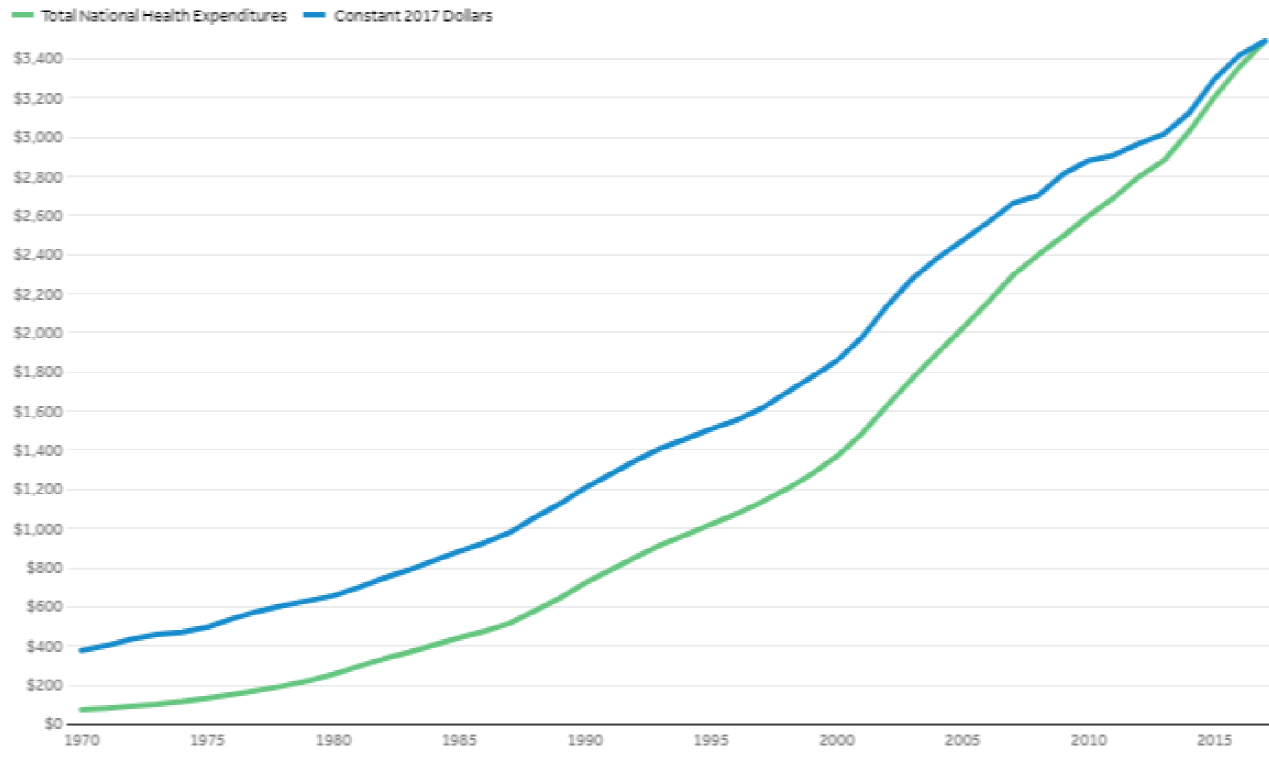
Questions/Comments?

WHY HAVE MEDICAID PROGRAMS MOVED AWAY FROM FEE FOR SERVICE?

#1. This is Primarily About…

Managing Care to improve quality/value rather than passively paying for services

Health Care Expenditures



Health Care Expenditures

In 2017:

- Health care expenditures **grew 3.9%** to $3.5 trillion
- Health care expenditures **averaged $10,739 per person** annually.
- Medicare spending **grew 4.2%** to $705.9 billion.
- **Medicaid** spending **grew 2.9%** to $581.9 billion.
- Private health insurance spending **grew 4.2%** to $1,183.9 billion.
- Out of pocket spending **grew 2.6%** to $365.5 billion.
- Hospital expenditures **grew 4.6%** to $1,142.6 billion.
- Physician/clinical services expenditures **grew 4.2%** to $694.3 billion.
- Prescription drug spending **grew 0.4%** to $333.4 billion.

Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

Getting What You Pay For…

"Fee-For-Service" pays for volume, so that is what we get:

LOTS OF VOLUME

(visits, tests, procedures, duplication of services)

Care Provided

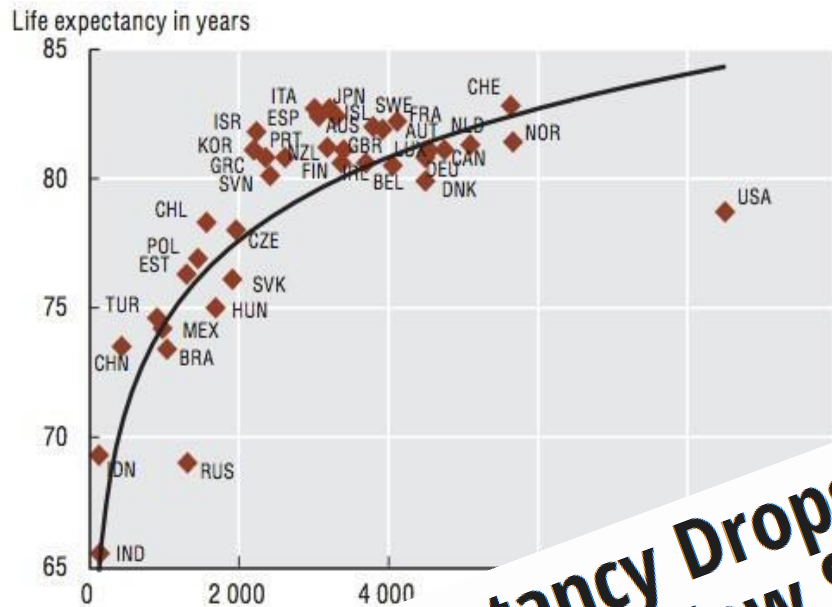
Payment to Providers

More Care Provided

More Payment to Providers

Expensive Health Care

As a Nation, Our Health Care Spending is *Not* Producing Better Care or Better Health Status



Source: OECD ...
World ...
.../888932916040

U.S. Life Expectancy Drops, Now Lowest Among High-Income Countries, New Study Finds

POSTED 8:40 AM, AUGUST 16, 2018, BY CNN WIRE

- On life expectancy, infant mortality and many other metrics, the U.S. health care system does not perf...
- While we ha... impr...
- ... life ... eases in
- ... ne expenditures produce no benefit to patients – and to varying degrees produce harm.
- Thousands of Americans die each year from medical errors.
- The list goes on…

Health Care Purchasing - Fee-for-Service Style

FFS Provides No Incentive for Quality or For Coordinating Care

- In traditional FFS arrangements, providers get paid the same amount, regardless of whether they provide excellent care or terrible care.
- Providers may actually be paid more for poor quality in FFS due to the need for "re-work."
- Providers do not get paid for coordinating care or for work to provide the right care at the right place at the right time.

#2. This is Also About…

- Flexibility from certain Medicaid FFS rules
- Flexibility to cover cost-effective alternative services at no additional cost to the state.
- Flexibility to use different, negotiated payment arrangements with providers.
- Fixed per member per month expenditures.
- Access to tools such as health information systems more advanced than FFS-based Medicaid Management Information Systems.

Managed Care Rationale

For best results and efficiency, the health care payment system must:

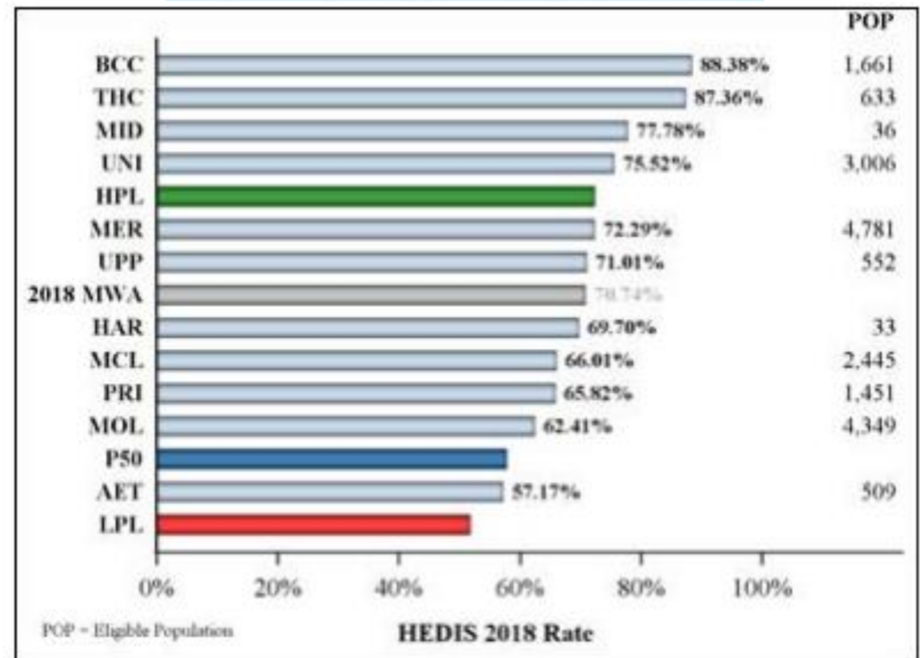
- ***recognize*** more than the volume of care
- ***value*** primary care, prevention, coordination & outcomes
- ***reward*** quality and efficient care delivery

So What Does this Mean for States?
Moving Away from FFS

Medicaid as a health care purchaser

- Medicaid agencies are *uniquely positioned* to facilitate *positive change* in the health care marketplace on behalf of consumers.
  - In terms of both covered lives and expenditures, **in many states, Medicaid is the largest purchaser of healthcare services**.
  - **Medicaid** plays an important role as **a payer and a convener.**
  - **Medicaid agencies can bring together a variety of stakeholders** to align quality improvement and delivery system reform efforts that affect the entire healthcare market.
  - **Medicaid programs can promote payment innovation**, including transitioning from fee-for-service to managed care, and increasing value-based payments to providers.

State Medicaid Program Role Changes from Claims Payer to Vendor Management!



https://www.michigan.gov/documents/mdhhs/MI2018_HEDIS-Aggregate_Report_F1_638961_7.pdf

Questions/Comments?

WHAT IS MANAGED CARE?

What is Managed Care?

- It is a prepaid, comprehensive system of health care ***delivery***.
- It is more than simply ***paying*** for services.
- It is a "mechanism of providing health care services in which a single organization takes on the management of ***financing***, ***insurance***, ***delivery***, *and* ***payment***" for a defined population.

Source: Essentials of U.S. Health Care System, Shi & Singh, 2013

What is Medicaid Managed Care?

- **Medicaid managed care** provides for the delivery of Medicaid health benefits and additional services to eligible Medicaid beneficiaries (members) through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs).
- In risk-based MCO contracts, a set capitation rate (per member per month fee) places full financial risk for the provision of Medicaid MCO covered services on the MCO, even if the cost is over the fixed rate.

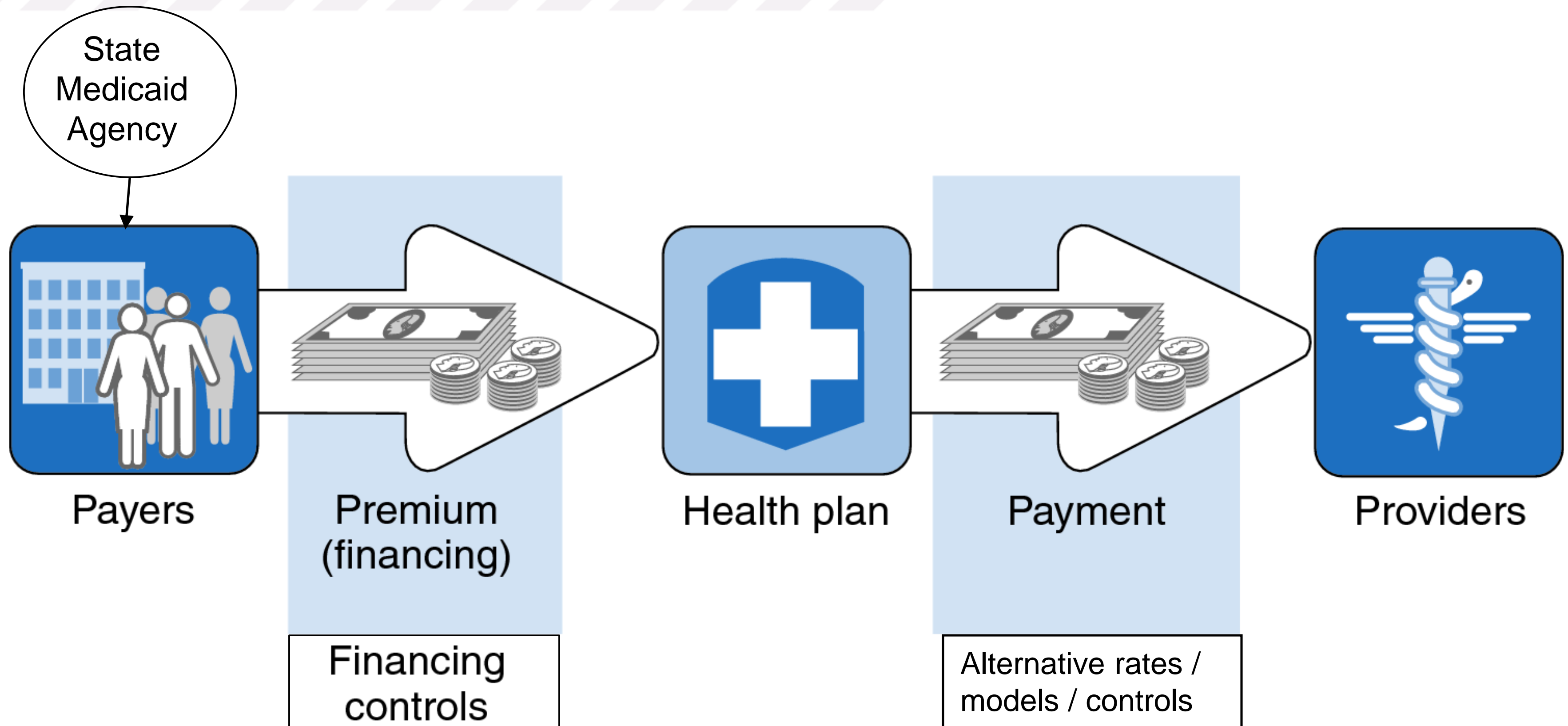
What is an MCO?

- An MCO is an insurance plan and sometimes referred to as an HMO (Health Maintenance Organization).
- MCOs operate under a contract to provide healthcare services through a network of healthcare professionals.
- The MCO develops its provider network by subcontracting with (or hiring) various health care professionals.
- MCOs have incentives to improve members' primary and preventive care to reduce the potential for more expensive health care needs later.
- A member's primary care physician (PCP) and/or the health plan may need to refer or authorize certain services.

Managed Care Explained

- Managed care creates incentives for the MCO to organize health care service delivery more efficiently and improve care.
- An MCO has both clinical (treatment) and fiscal (financial) accountability for covered services provided to its members for a set period of time.
- Managed care typically includes a comprehensive set of covered benefits and services such as preventive, primary, specialty and ancillary health services as well as pharmacy benefits.

Managed Care - Flow of Funds



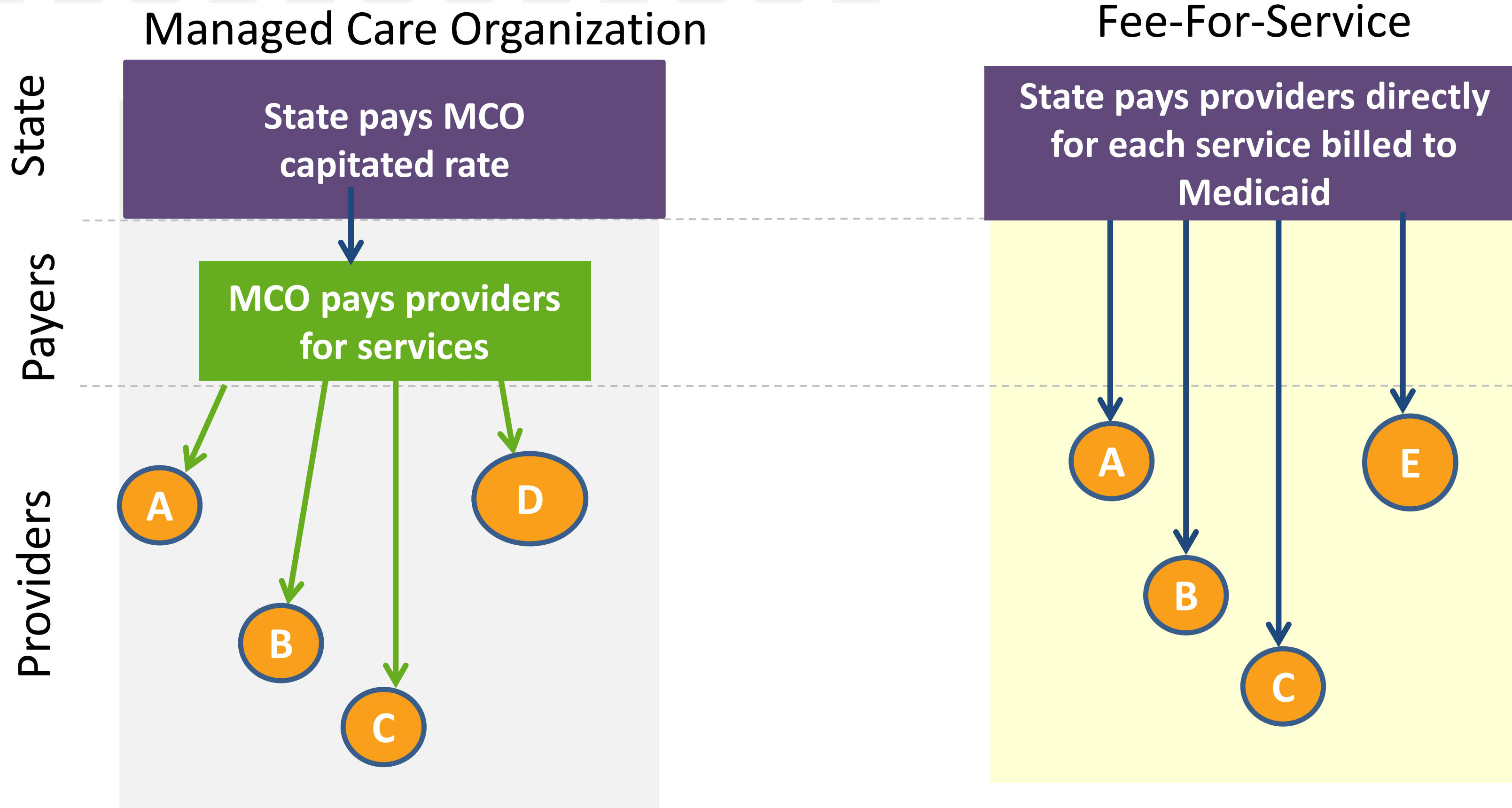
Source: Thomas Bodenheimer, Kevin Grumbach: *Understanding Health Policy: A Clinical Approach*, 7th Edition: www.accessmedicine.com

Copyright © McGraw-Hill Education. All rights reserved.

How Does Managed Care Work?

- Purchaser (state) contracts with an entity (MCO) to provide certain health care services to a defined population for a fixed price during a set period, (e.g., month/year).
  - Defined set of services = *covered benefits/services*
  - Population = prospectively identified "*members*"
  - Plan is paid *capitation* = fixed fee per member per month (*PMPM*) whether or not a member uses services; rate reflects enrolled population (e.g., kids, adults, etc.) and is typically risk-adjusted
  - Health plan accepts *financial risk* for delivering services to the population during the time period within its contractual "budget"
  - PMPM capitation rate X # of member months

Network and Payment Differences



Managed Care Operations

- 24 hour call center – members
- Member education and outreach
- Member materials
- Community events
- 24 hour call center – providers
- Provider education
- Claims adjudication process
- Information Technology
- Clinical teams

What Tools Do MCOs Use?

- To manage cost growth and improve the quality of care MCOs may using multiple mechanisms such as:
  - Medical home: establish a primary care provider relationship and coordinating care
  - Care and disease management programs: help improve efficiency and quality of care
  - Evidence-based care: clinical practice guidelines, provider education, data and clinical support
  - Utilization Review: review appropriateness of care, prospectively, concurrently, and/or retrospectively
  - Alternative Payment Models: provide financial incentives to providers based on quality and efficiency measures
  - Specialty Centers: refer members with complex needs to specialty, high quality providers in the network

Primary Care Providers

- Primary Care Provider (PCP) is: A member's assigned doctor or clinic, who is responsible for preventative care, referrals to specialists, and acting as a "medical home" for the member.
- Members can select any open PCP in the health plan.
- In Medicaid, if a member does not choose, a PCP will be automatically assigned to them.
- Medicaid members can change their PCP and/or their health plan according to federal rules and state contracts.

Provision of Services to MCO Members

1. Is the patient a current health plan member?
2. Is the service or product a covered benefit?
   - If it is not a covered benefit, is it a Medicaid service?
   - Is it a cost-effective alternative to a covered benefit?
3. Is it medically necessary?
4. Has it been authorized, if authorization is required?
5. Is it a network provider?
   - If it is not a network provider, is the plan required to cover the service?
     - Emergency services – prudent layperson definition
     - Continuity of care for members previously seen by other providers, short term for members that move out of area

Managed Care Objectives (sample)

Increase Preventive Care	Expand the use of Evidence-Informed Care
Promote Early Intervention	Decrease Overuse and Underuse of Services
Improve the Coordination of Care	Reduce Error Rates

Why Medicaid Managed Care?

- By contracting with MCOs to deliver Medicaid health care services using a set per member per month (Capitation) payment approach:
  - States are not subject to certain Medicaid FFS rules and payment requirements.
  - Members have access to different services, care coordination, a medical home and other MCO support.
  - MCOs focus on the bigger picture – the cost and quality of care for a set population.
  - States can hold MCOs accountable for improvement in Medicaid program quality and utilization of health services.

How Is Managed Care Different?

1. Medicaid MCOs have the ability to:
   - contract for more broad and varied provider network
   - offer flexible incentives and more oversight of providers
   - utilize PMPM dollars to include services for members that otherwise are not provided under FFS
2. With care coordination embedded in the MCO model (along with clinical and financial accountability), there is greater potential for overall health improvement and population health management for Medicaid compared to FFS.

Questions/Comments?
What is Managed Care?

MORE ABOUT MEDICAID MANAGED CARE

Medicaid Managed Care Authorities

- Managed Care programs can be operated under multiple federal authorities as approved by CMS.
- There are three basic types of federal authorities:
  - State plan authority [Section 1932(a) of the Social Security Act]
  - Waiver authority [Section 1915 (a) and (b)]
  - Waiver authority [Section 1115]
- Each authority has requirements and limitations.
  - Managed care authority can be combined with other home and community based authorities to operate the MLTSS program (e.g., with a concurrent 1915(b)/1915(c) waiver).

CMS Criteria for MMC Contracts

- 140 page State Guide.
- Outlines MCO contract requirements based on federal requirements in Title XIX of the Social Security Act, 42 CFR §438 and other applicable laws.
- Include requirements in the Medicaid and CHIP Managed Care Final Rule published May 6, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval

January 20, 2017

This guide covers the standards that are used by the Centers for Medicare & Medicaid Services (CMS) Regional Office staff to review and approve State contracts with Medicaid managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), non-emergency medical transportation prepaid ambulatory health plans (NEMT PAHP), primary care case managers (PCCM), primary care case manager entities (PCCM entity), and health insuring organizations (HIO).[1]

https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

Medicaid & CHIP Managed Care Rule Revised 2016 - 42 CFR 438

1. CMS Review of MMC Contracts, Rates, Plans
2. Enrollment Processes and Choice Counseling
3. Network Adequacy and Access to Care
4. Provider Enrollment and Credentialing
5. Care Coordination Continuity of Care
6. Grievances and Appeals
7. *Long Term Services and Supports (LTSS)*
8. Program Integrity
9. State Monitoring and External Quality Reviews

Key MLTSS Provisions in MMC Rule

1. Adequate planning
2. Stakeholder engagement
3. Enhanced Home and Community-Based services
4. Alignment of payment structure and goals
5. Support of beneficiaries
6. Person-centered care
7. Comprehensive, integrated service package
8. Qualified providers
9. Participant protections
10. Quality (specific MLTSS measures required)

Covered Services/Benefits

Basic Managed Care requirement:

- States must ensure that all services covered under Medicaid state plan are "available and accessible" to beneficiaries in managed care – *from the MCO, another vendor, and/or FFS as determined by the state's contract with the MCO, and its Medicaid policies and procedures* .

Typical Medicaid MCO Services (largely existing Medicaid FFS services)

- Comprehensive primary care and physician services
- Hospital, surgical, & ancillary services
- Durable Medical Equipment (DME)
- Case management and care coordination
- Transportation (emergency and in some cases non-emergency medical transportation)

- In some states/programs:
- MCOs cover pharmacy, behavioral health, dental, vision and/or Long Term Services & Supports (LTSS)

Medicaid Managed Care Services (non-FFS benefits)

Examples *may vary by MCO and State*:

- Disease management
- Care coordination
- 24 Hour Nurse Line
- Wellness Programs
- Value-Added Services (adult vision/dental)
- Cost-effective Alternatives/In Lieu of Services

Medically Necessary

- Under federal rules and state contracts, MCOs are required to provide members with "*medically necessary*" care for all contracted services.
  - Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) services are for children under the age of 21.
  - If an MCO is responsible for EPSDT service, the MCO must cover the EPSDT service regardless of whether its otherwise a Medicaid benefit
- MCOs are not bound by Medicaid (or Medicare) service settings or provider types.
  - For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

Adequacy of Services/Networks

MCOs must:

- Make covered services available to Medicaid beneficiaries to at least the same extent as FFS beneficiaries
- Assure state (and CMS) that they have adequate capacity to serve expected MCO enrollment
- Provide for arrangements/referrals to sufficient numbers of geographically disbursed providers to ensure timely access and service delivery

Network Adequacy Standards

- States must develop and implement time and distance network standards for MCOs related to the following services if covered in the contracts:
  - For adult and pediatric care:
    - Primary care, specialty care, behavioral health
  - Pediatric dental care
  - OB/GYN services
  - Hospital services
  - Pharmacy services

MCO Provider Networks

- The 21st Century Cures Act requires States to "enroll" all Medicaid providers, both those in FFS and MCOs.
- *The State must :*
  - screen, enroll, and periodically revalidate MCO network providers
  - assure CMS that its MMC plans meet state requirements for availability of services and provide supporting documentation.
- *MCO contracts must*:
  - require plans to meet state standards for access to care
  - promote linguistically and culturally competent care
  - provide physical access, reasonable accommodations, and accessible equipment for enrollees with disabilities

Provider Payment

- MCO have more payment options – they do not need to follow the Medicaid FFS fee schedule exactly.
  - May be required to reimburse at or above the FFS schedule.
  - MCOs need to follow some rules - federal and state - including contractual requirements.
- Rates/payment models may include:
  - Negotiated fee for service (e.g. physicians, ancillary services, etc.)
  - Per diem (fixed daily payment for inpatient care (hospital, SNF)
  - Hospital diagnostic related groups (DRGs)
  - Alternative Payment Models (APMs) – with a link to quality

Enrollee Rights & Responsibilities

- Each Medicaid MCO shall make available to enrollees and potential enrollees in the organization's service area information concerning:
  - The identity, locations, qualifications, and availability of health care providers that participate with the organization.
  - The rights and responsibilities of enrollees.
  - The procedures available to an enrollee and a provider to challenge or appeal the failure of the MCO to cover a service.
  - All items and services that are available to enrollees under the contract between the State and the MCO that are covered either directly or through a method of referral and prior authorization.

Care Coordination

Federal rules require MCOs to make a "best effort" to conduct a health screening within 90 days of enrollment for new enrollees

- Federal standards for care coordination encompass coordination between settings, coordination with services provided outside the plan, by a different plan, or through FFS, and coordination with community and social support providers
- Requirements for identification, assessment and service planning to enrollees with long term service and support (LTSS) needs and requires service planning to be conducted in a person-centered manner.

Sample MCO Contract Outline

1. <u>Definition of Terms</u>

2. <u>Contractor Responsibilities</u>
- Compliance
- Contract Transition/Readiness
- Administration and Contract Management
- Enrollment and Education Activities
- Care Delivery, Coordination, Management
- Covered Services
- Provider Network, Contracts, and Related Responsibilities
- Network Management
- Accessibility and Availability

2. <u>Contractor Responsibilities (continued)</u>
- Enrollee Services
- Marketing Activity Requirements
- Enrollee Inquiries, Grievance, Appeals
- Quality Management and Quality Improvement
- Data MIS Requirements, Reporting
- Financial Stability Requirements
- Performance Evaluations
- Operational Audits
- Additional Enrollee Groups
- Benefit Coordination
- APMs

Sample MCO Contract Outline:

3. State Responsibilities

- **Contract Management, Compliance, Audits**
- **Performance Assessment**
- **Quality Strategy**
- **Coordination of benefits (TPL)**
- **Enrollment, Assignment and Disenrollment**
- **Marketing**
- **Additional Enrollee Groups**

4. Payment and Financial Provisions

- MCO Rating Categories
- Payment Methodology
- Adjustments or Additions to Payments
- Payment Reconciliation Process
- Performance Incentive Arrangements/Withhold
- Additional Terms and Conditions

Monitoring MCO Performance ("compliance")

State Medicaid agencies typically:

1. Define performance measures for relevant dimensions of MCO performance (administrative, clinical, and financial)
2. Review national accreditation status/findings and standardized MCO performance measures
3. Collect MCO performance data at regular intervals, review the data, and share the data
4. Use targeted operational reviews/audits/surveys of MCO performance, (such as for quality measures, network adequacy, financial performance, grievances, etc.)

MCO Measure Sets

Typically include:

- Preventive care
- Acute care
- Maternity care
- Chronic illness care
- Access
- Patient experience
- Efficiency
- Utilization
- Cost; Financial stability
- Administrative services

May include:

- Behavioral health care
- Pharmacy
- Oral health
- Long-term services and supports

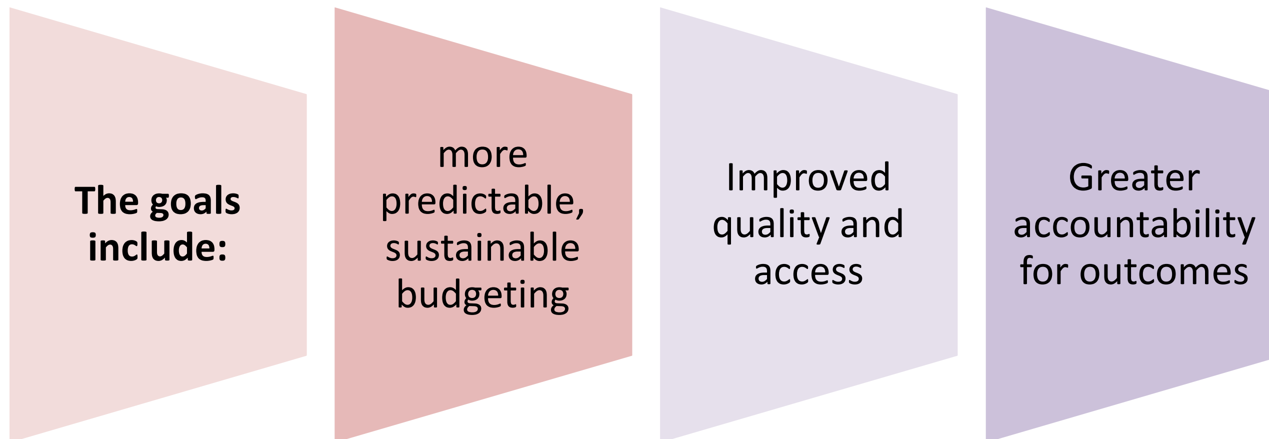
Performance Incentives

1. Financial (+/-)
2. Members (+/-)
3. Recognition (+/-)

Questions/Comments?
Medicaid Managed Care

WHAT IS PAYMENT REFORM?

Improving Accountability in Medicaid



Payment is the First Domino

- Payment influences the delivery of care & provider behavior.
- It's not the only influence – but it is a significant one.
- If we want to improve care delivery (and overall efficiency), we have to improve payment.

Payment Reform Objective

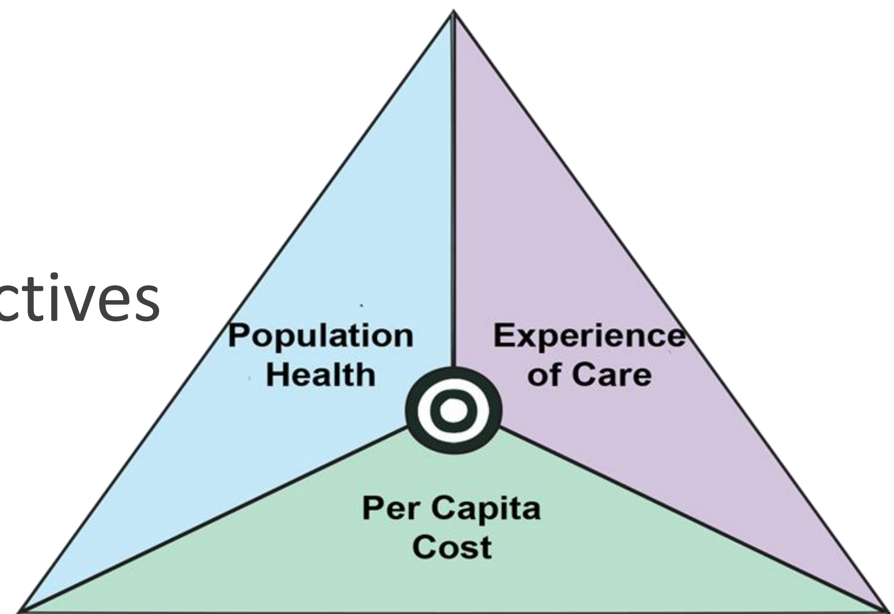
- States have started to consider 'the payment beneath the payment' – or how MCOs are paying their provider networks.
- Provide health care services within a defined network of health care providers who are given the responsibility to manage and provide quality, cost-effective health care for an attributed population.

Why Focus on Alternative Payment Models?

- Contracting with an MCO does not address all the "FFS" issues…
- The push for APMs is based on shortfalls of FFS payment systems *at the provider level* which…
  - Do not incentivize coordination across providers.
  - Do not promote whole-person care.
  - Do not reward quality.
  - Can actually reward *poor* quality.
  - Do reward *volume*, and particularly reward volume of highly priced services.

What is Paying for Value?

- Payment that explicitly rewards health care providers for *performance* to identified measures and targets for:
  - Quality
  - Access
  - Service utilization objectives
  - Cost effectiveness



The Jargon of Payment Reform

BRIEF

Nearly all states using value-based payment models

Joint replacement bundles saved $1K per patient

Amy Baxter | July 01, 2019 | Healthcare Economics & Policy

BRIEF

APM adoption up to 34%, but downside risk slow to catch on

A majority of physicians now take part in an ACO

SEPTEMBER 12, 2019

Need to Create Incentives for Providers to: "Do the right thing"

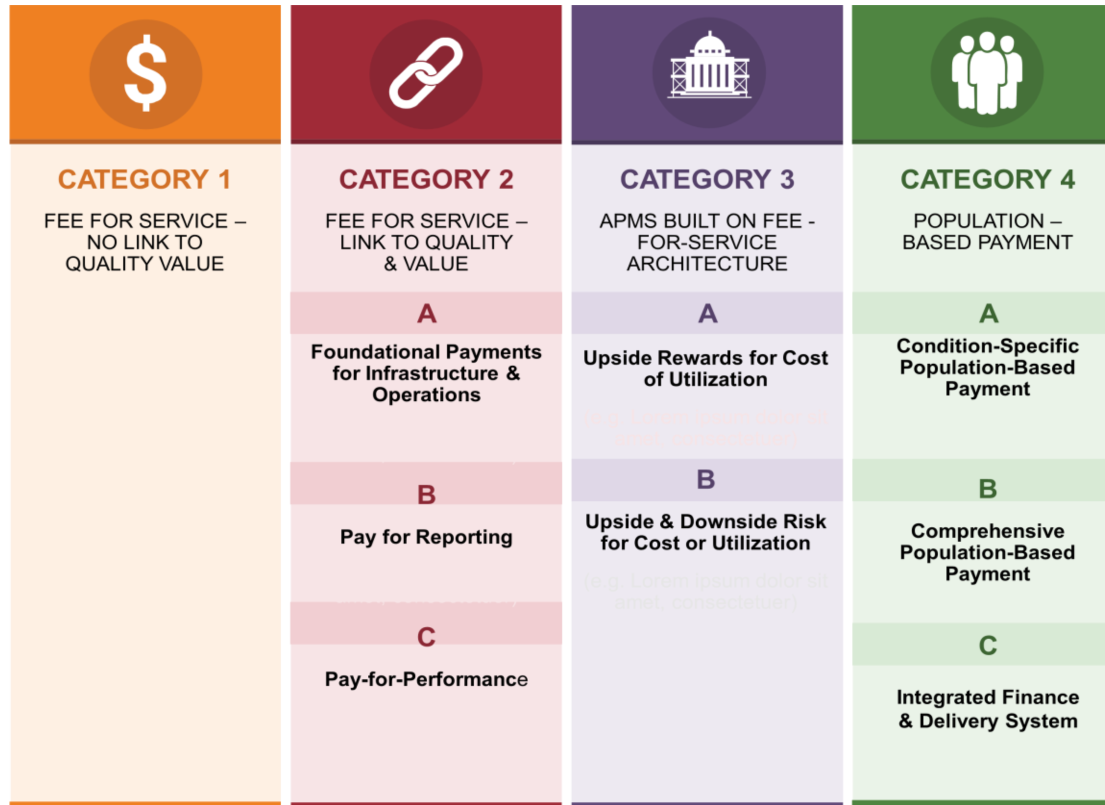
- **Alternative Payment Models (APMs)** explicitly reward health care ***providers*** with higher/better payment methods based on the **'value'** of the provider's performance relative to cost, quality, access, and/or service utilization objectives.
- FFS payment provides a financial *dis*incentive to:
  - Deliver services that generate comparatively lower remuneration – e.g., primary care, psychiatry.
  - Provide services for which there is no FFS compensation – e.g., patient outreach, care coordination, treatment plan development, e-visits, web visits.

Using Payment to Improve Quality and Value in Medicaid Programs

Significant APM Activity

- CMS is actively encouraging efforts by purchasers, plans, and providers to **change payment** and **improve care delivery**.
- Medicare payment structures have changed to incorporate alternative payment models.
- Medicaid programs and Commercial payers are implementing payment reform models.
- **HCP-LAN APM framework** commonly used. The LAN website is full of resources applicable to state purchasers: https://hcp-lan.org/

HCP "LAN" Alternative Payment Model (APM) Framework



http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

APM Models Are Not Mutually Exclusive

- Medicaid agencies and MCOs are using multiple payment models – and often in the same provider contracts - to enhance delivery system reform and improve care for Medicaid members!
- Each APM carries with it *strengths* and *weaknesses*.
- Some APMs are more *administratively* demanding.
- Advanced APMs are designed to <u>fundamentally change the way providers (and MCOs) do business!</u>

Quality in Payment Reform

- Performance must be integrated directly into how providers are paid: linking quality to $ = value.
- States are measuring quality of MCOs generally; here we are talking about measuring quality for providers.
- Measuring quality can be complicated. There are many measures from which to choose.
- States and MCOs must think carefully about how to choose quality measures and how to utilize those measures in financial arrangements with providers.
- States also must consider how their MCO expectations drive provider payment.

Five Options for States

1. Assume plans will advance payment reform
2. Define a vision and specify desired outcomes, but give plans flexibility to achieve those outcomes
3. Require, incentivize and/or sanction implementation of new provider payment models, but don't specify which payment model(s) or how implemented
4. Specify specific payment models/options and timelines for MCOs to implement the models
5. Work directly with providers on reform, and then require MCO to adopt the established reform(s)

Reminders and Rationale

- **Traditional FFS** payment creates **strong economic incentives** for providers to deliver high volumes of high margin services – and **barriers** to delivering non-reimbursable services.
- **Managed Care AND Payment reform** entails *moving away from FFS* <u>and toward</u> other ways of payment that create incentives for high quality, efficient care.
- **Managed Care AND Payment reform are not an end in themselves** but rather a means to motivate improvement in the way that states pay for health care, in the way that providers deliver care, and in the way people receive care.

Rationale for Payment Reform

- The health care payment system must:
  - *recognize* more than the volume of care
  - *value* primary care, prevention, coordination & outcomes
  - *reward* quality and efficient care delivery
- Cost growth will not slow without providers having a meaningful, coordinated financial incentive to do so *and* a means to transform care delivery.
- Delivery system reform requires payment reform. "**The payment beneath the payment matters.**" Health plans do not provide care, they pay for it.

Questions/Comments?

What is Payment Reform? Overall?

Contact Information

Mary Beth Dyer, MPP
Senior Consultant
Bailit Health
MBDyer@bailit-health.com
904-397-2757

Beth Waldman, JD, MPH
Senior Consultant
Bailit Health
bwaldman@bailit-health.com
781-559-4705

bailit health