

THE LANDSCAPE OF MEDICAID ALTERNATIVE PAYMENT MODELS

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KEY FINDINGS

- States have increasingly sought to establish alternative payment models (APMs) for Medicaid.
- APMs build on a foundation of fee-for-service or managed care systems—or a mix of both.
- APMs typically leverage incentives to improve cost efficiency, coordination, and quality.
- Aligning Medicare and Medicaid payments and financing will be critical to improving care for dually eligible enrollees in APMs.

OVERVIEW OF EXISTING PAYMENT FRAMEWORK

States increasingly have turned to Medicaid alternative payment models (APMs) as platforms for better care and lower health care costs. These payment models vary widely in design, often building on a state's existing payment framework and delivery pathway.

Recent innovations in Medicaid payment typically build on underlying fee-for-service (FFS) or managed care models, or a mix of the two. Many state Medicaid programs

mix FFS and managed care for various categories of Medicaid-eligible populations—dual eligibles, pregnant women, or Affordable Care Act (ACA) expansion populations, for example. Here are the basics of each underlying payment system:

FEE-FOR-SERVICE

Within FFS, state Medicaid agencies pay providers a state-determined amount per unit of service, with total payments varying based on the volume of services delivered. Payments may be made per discharge or per day, or on a cost basis for inpatient services; and per ambulatory patient group or visit, or on a cost basis for outpatient services. States often provide supplemental payments on top of these base payments, up to the relevant upper payment limit. About one-quarter of all Medicaid enrollees are FFS patients.

MANAGED CARE

Under Medicaid managed care, states shift to managed care organizations (MCOs) varying levels of risk for the costs of services provided to designated individuals. This can occur through limited benefit plans, primary care case management programs, and comprehensive risk-based plans.

The MCOs, in turn, contract with providers to pay them negotiated rates for services, typically, but not exclusively, on a FFS basis. About three-quarters of all Medicaid enrollees are in managed care. Of those, one-half are in comprehensive risk-based plans, about one-third are in limited benefit plans, and one-sixth are in primary care case management programs. The following provides a description of each:

- Comprehensive risk-based plans provide a comprehensive package of acute or long-term care benefits, or both, through an MCO. MCOs receive a capitated payment to provide services to beneficiaries, governed by the contract with the state and subject to the requirement that the state's payments be "actuarially sound." States and the federal government generally do not regulate rates MCOs pay providers. Enrollment in an MCO can be optional or the state can mandate enrollment, although a waiver is required to mandate enrollment for certain populations (e.g., dual eligibles). In recent years, some states have directed MCOs to adopt alternative payment models for

their providers. Others have provided bonus payments for quality incentives that can or must be passed on to providers.

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- Limited benefit plans provide narrow or specialized Medicaid services to beneficiaries. Some states choose to carve out certain services and provide them through separate limited benefit plans—for example, mental health services or even hospital services. Some limited benefit plans provide supplemental services (e.g. transportation, or dental care) that are not covered elsewhere by Medicaid. Others provide limited benefits to certain populations, such as low-income childless adults, who do not qualify for full Medicaid coverage.
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- Primary care case management (PCCM) programs pay individual providers (or groups of providers) to coordinate primary care and any necessary specialty care referrals. States generally make a per-member-per-month (PMPM) payment to contracted providers on top of the FFS payments they otherwise receive for providing services to enrollees.
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TYPICAL ALTERNATIVE PAYMENT MODELS

States are increasingly looking to implement APMs in Medicaid—including models that can be implemented within FFS or managed care, as well as fundamentally different approaches—to create incentives for improving cost efficiency, coordination, and quality

in delivering health care services to Medicaid patients. These are designs typically employed:

PMPM PAYMENTS AND MEDICAID FFS

Providing monthly payments to providers on top of fee-for-service payments is not new to Medicaid (see managed care PCCM programs described above). This model can apply to FFS programs, with states making PMPM payments directly to providers, or to managed care, with the plans making the payments to contracted providers. This model has been used most often to support care coordination, although it could be expanded for other purposes.

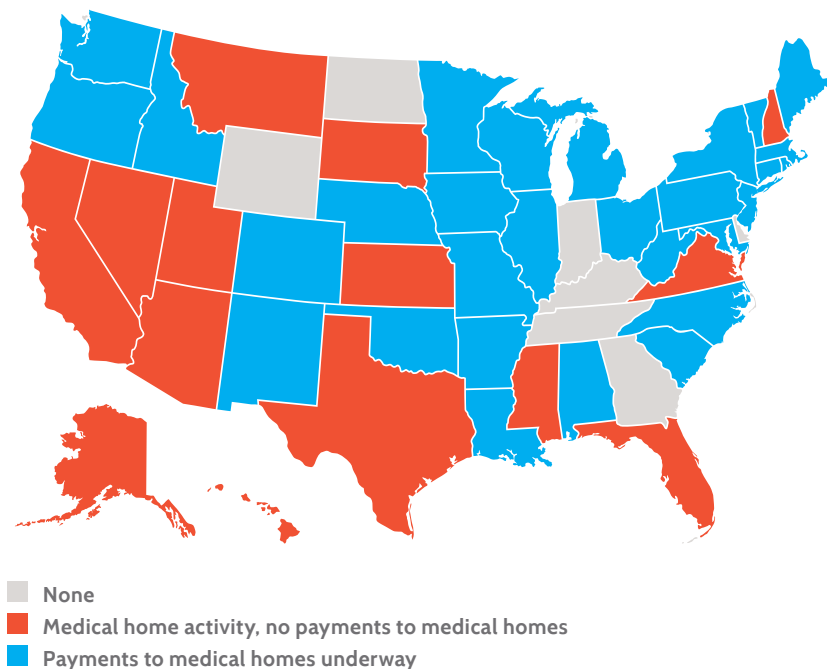
Indeed, states are now experimenting with this model as an incentive for reducing costs or improving quality of care. For example, the PMPM payments made to PCCMs may be increased if certain quality improvement processes or outcomes are achieved, such as providing health education services or reducing the rate of preventable hospital readmissions. These arrangements can also incorporate risk, in which a portion of PMPM payments is withheld if a provider does not achieve the necessary cost savings.

In addition, states may integrate payment models to create incentives for establishing [patient-centered medical homes] within alternative payment models.

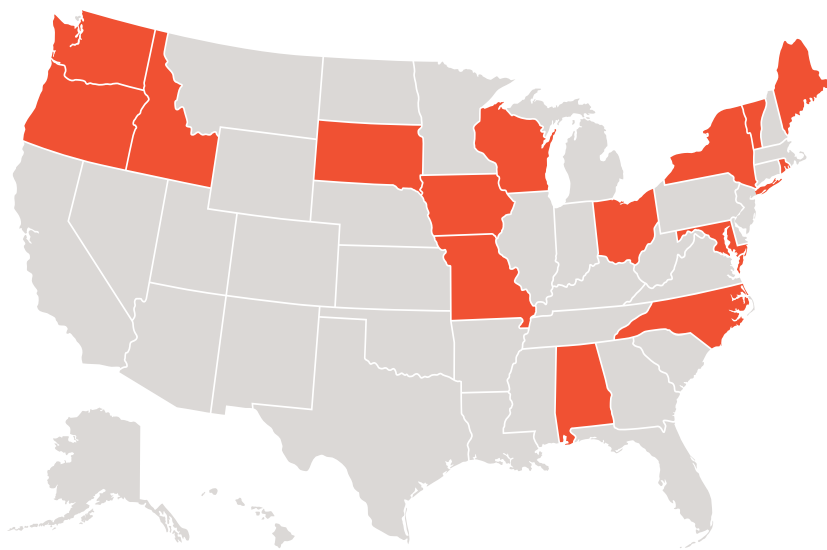
MEDICAL HOMES

The medical home model builds off of the PCCM model. While case management is one critical role of a PCCM, a medical home goes significantly further in focusing on whole person care—integrating routine physical and mental health care, primary and preventive care, and urgent care. Patient-centered medical homes (PCMHs) are generally physician- or nurse-led primary care practices, serving as primary access points to the health care system for enrolled patients. Providers that meet a set of often demanding and comprehensive standards can qualify as a PCMH. Many states use the National Committee for Quality Assurance PCMH certification program as their standard for certifying PCMHs.¹

States are implementing PCMHs within their FFS and managed care programs, as well as integrating PCMHs into other alternative payment models, with various payment incentives (see Figure 1). Medical homes are typically paid a PMPM payment in addition to FFS payments. These medical home programs may incorporate risk, quality bonuses and shared savings. For example, the state may withhold the PMPM payment if established cost or quality thresholds, or both, are not met. Or, a medical home can receive a shared savings payment if cost (and possibly quality) thresholds are met or exceeded. In addition, states may integrate payment models to create incentives for establishing PCMHs within alternative payment models. For example, accountable care organizations (ACOs) with PCMHs may receive incentive payments not available to ACOs without PCMHs.

FIGURE 1: MEDICAL HOME ACTIVITY AT THE STATE LEVEL

Source: National Academy for State Health Policy

FIGURE 2: STATES WITH STATE PLAN AMENDMENTS AUTHORIZING MEDICAID HEALTH HOMES

Source: Centers for Medicare & Medicaid Services

MEDICAID HEALTH HOMES

The ACA created an option for state Medicaid programs to permit payment for defined “health home” services targeted to eligible chronically ill patients. Health homes are a specialized type of medical home, designed for individuals with multiple chronic illnesses or severe mental health conditions. Under the specific rules established in the ACA, the federal government will pay 90 percent of the costs of defined “home health services” provided to eligible beneficiaries for the first eight quarters that a state plan amendment authorizing health homes is in effect (see Figure 2). The health home model provides flexibility in designing the payment methodology, including FFS or PMPM payment methodologies or other payment models the state may propose.

Bundled payments can reflect a set of services provided by the same provider or by a team of providers, such as the hospital and its physicians.

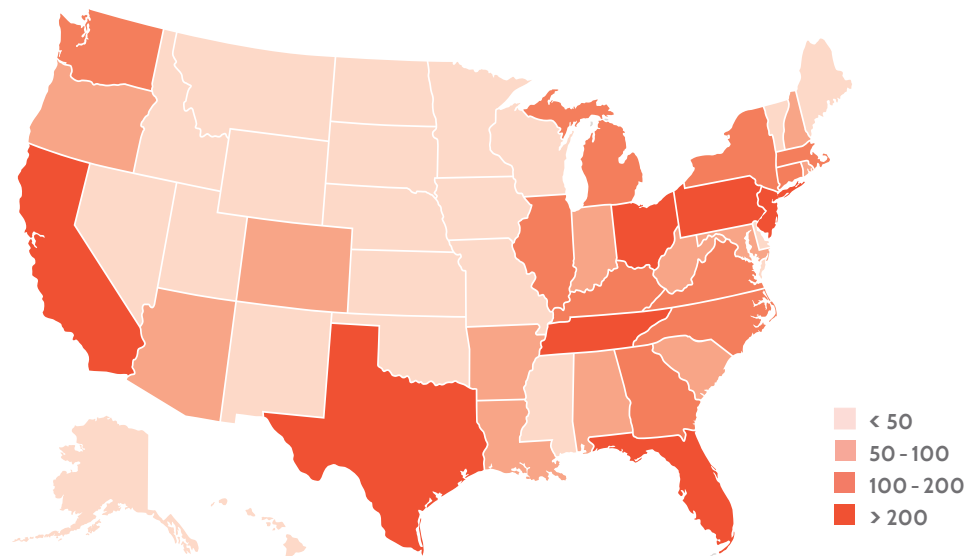
EPISODIC OR BUNDLED PAYMENTS

In an episodic or bundled payment model, payment revolves around a patient’s specific condition or procedure (e.g., joint replacement surgery or pregnancy and delivery) for a defined period. Bundled payments can reflect a set of services provided by the same provider or by a team of providers, such as the hospital and its physicians. It also may involve other providers, such as post-acute care providers.

Once the payment for the episode is determined, providers are held to the episodic rate regardless of their actual costs of delivering the care. Providers can be paid “virtual” bundled payments in which each provider receives directly from the state a defined rate for its portion of the episode. Alternatively, a single payment may be made to the entire team of providers who cared for a patient during that episode, with one provider responsible for distributing the reimbursement among the other providers. In some virtual models, providers continue to be paid the same FFS rates as they would outside the program. At the conclusion of the episode, their total costs are calculated and compared with the established episodic rate. Providers with total reimbursements exceeding the rate are held responsible for a share of the costs above the threshold, while providers with reimbursement amounts below the threshold can receive a share of the savings.

In addition to giving providers an incentive to coordinate care to control costs, episodic or bundled payment models can integrate quality expectations for each condition, with failure to meet quality metrics leading to, for example, disqualification from receiving bonus payments (see Figure 3 for Medicare bundled payment activity).

FIGURE 3: MEDICARE BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE SITES



Source: Centers for Medicare & Medicaid Services

In many states, alternative payment models specifically exclude Medicare-Medicaid dual eligible individuals to avoid the complexity inherent in coordinating a Medicaid payment structure with Medicare.

ACCOUNTABLE CARE ORGANIZATIONS

An ACO is a formally structured group of health care providers who are collectively held responsible for the health needs of Medicaid patients assigned to the ACO (see Figure 4 for ACO activity in the states). ACOs include physicians and often hospitals, but can also include mental health providers, community health workers, public health departments, and even community organizations that do not directly provide medical care. Medicaid pays

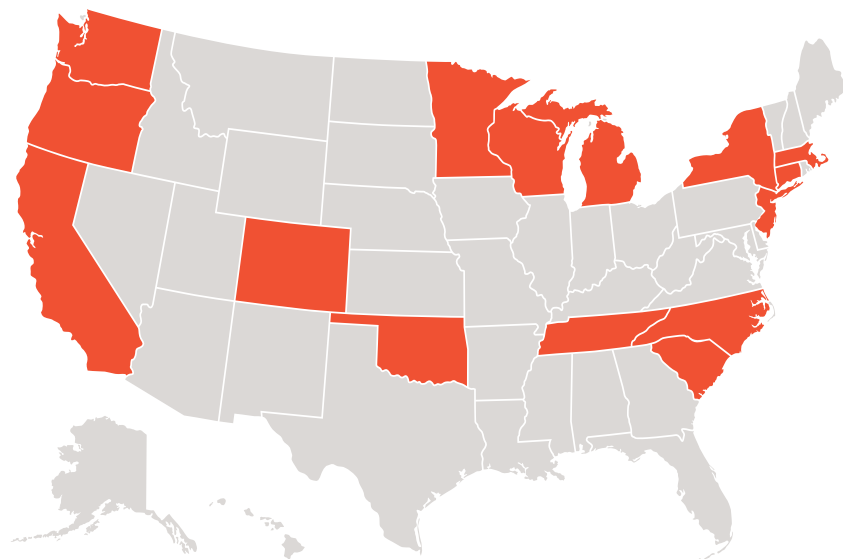
an ACO as one entity—sometimes with a global, population-based payment²—and it is the ACO’s responsibility to distribute payment to the participating providers and organizations. Models can provide only positive incentives for shared savings, or can also put payments at risk if the cost of care exceeds the baseline estimates for providing care to the assigned population. Attribution of patients to the ACO can be retrospective or prospective. ACOs can be an alternative to comprehensive, risk-based managed care plans for managing delivery of services to populations, or they can contract with managed care plans as providers.

GLOBAL BUDGETS

Global budgets reimburse providers with a fixed, risk-adjusted sum for the total cost of care for all services for which the provider is held responsible. Global budgets can be relatively narrow in scope (e.g., a global budget for a single

[illegible]

FIGURE 5: DEMONSTRATIONS TO INTEGRATE CARE FOR DUALY ELIGIBLE PARTICIPANTS



practice or hospital) or encompass a large group of providers in an ACO. Global budgets in Medicaid often integrate performance payments and may reward higher quality by adjusting payment rates or making separate incentive payments. For example, Maryland has an all-payer, hospital-based global budget, while Oregon has shifted to regional risk for care using regional coordinated care organizations paid under a global budget that covers physical, mental, and dental care.

In many states, alternative payment models specifically exclude Medicare-Medicaid dual eligible individuals to avoid the complexity inherent in coordinating a Medicaid payment structure with Medicare. But other states are pursuing new models for integrating Medicare and Medicaid.

The first initiative by the Centers for Medicare & Medicaid Services (CMS) in this area was the State Demonstrations to Integrate Care for Dual Eligible Individuals, launched through the Center for Medicare and Medicaid Innovation (CMMI). CMS awarded design contracts to 15 states to develop and test new integrated delivery system and care coordination models for dually eligible individuals (see Figure 5). These states may design their own model, or choose to pilot one of the models testing financial integration between Medicare and Medicaid under the more recent CMS Financial Alignment Initiative (see sidebar).

CMS Financial Alignment Initiative

Based on early work with states selected for the State Demonstrations to Integrate Care for Dual Eligibles, the Centers for Medicare & Medicaid Services (CMS) created a Financial Alignment Initiative to offer streamlined approaches for states to test financial models.³ Under this initiative, 12 states will test models to better align the financing of Medicare and Medicaid through “integrated programs” (defined as programs that integrate primary, acute, and behavioral

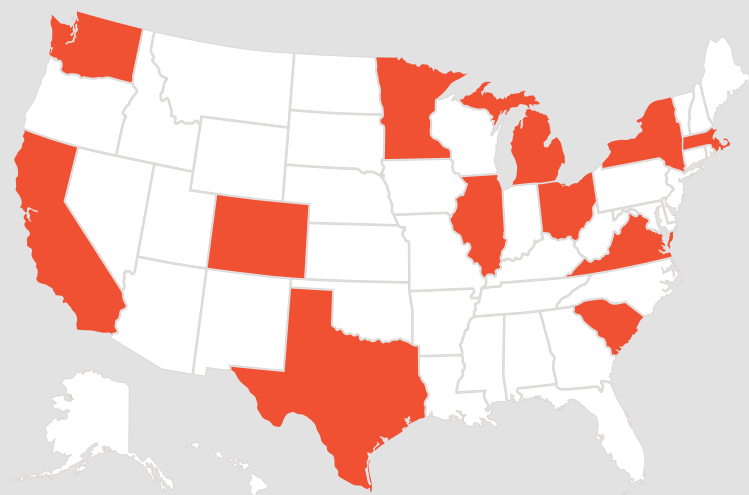
health, and long-term services and supports for their Medicare-Medicaid enrollees; see Figure 6).

These 12 states will pilot one of two payment models established by CMS. The capitated model uses three-way contracts between the state, CMS, and a health plan, in which (1) the plan receives a prospectively blended Medicare-Medicaid payment rate to provide Medicare and Medicaid services for dual eligibles; and (2) the plan, the

state, and CMS can share in savings. The managed FFS model uses an agreement between CMS and the state, in which the state agrees to pursue initiatives to improve quality and reduce costs for dual eligibles—for example, through fund investments in care coordination—in exchange for eligibility to share in Medicare savings. CMS also is working with states to explore models outside the capitated and managed FFS models.

CMS has expressed its intent to continue—through CMMI, the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”), the Center for Medicaid and CHIP Services, and the Center for Medicare—to partner with states on additional integration initiatives to improve access, quality, and efficiency of care for dually eligible individuals.

FIGURE 6: CMS FINANCIAL ALIGNMENT INITIATIVE PARTICIPANTS



Source: Centers for Medicare & Medicaid Services

Notes

1. National Committee for Quality Assurance. Patient-Centered Medical Home Recognition. <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>. Accessed August 6, 2014.
2. Population-based payments are a form of global budgeting in which a provider cares for a predetermined population of Medicaid-enrolled patients (based on health condition or geographic location, or both) for a fixed, risk-adjusted sum.
3. Centers for Medicare & Medicaid Services. Financial Alignment Initiative. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>. Accessed August 6, 2014.