CHCS Center for Health Care Strategies, Inc.

Policy Brief

Payment Reform: Creating a Sustainable Future for Medicaid

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Medicaid payment policies may be the most significant lever available to states to contain costs and improve quality. Effective use of this lever is of paramount importance to improve value, address current budget shortfalls, and prepare for increased Medicaid enrollment under federal health reform.

Foreword

Health care reform creates enormous new responsibilities and opportunities for Medicaid. The scope of those responsibilities – both programmatic and financial – make it absolutely incumbent upon its leadership at the federal and state levels to get Medicaid's payment systems right.

To explore options for payment reform, the Center for Health Care Strategies (CHCS) worked with the leaders of the Center for Medicaid, CHIP, and Survey & Certification, to conduct a small group consultation on Medicaid payment methodologies and levels in April 2010. Participants, including federal officials, state Medicaid leaders, national payment reform experts, and several congressional staff, discussed ways to redesign Medicaid payment policies and provided comments on an initial draft of this brief (see Appendix for participants).

We thank the many individuals who contributed to the rich discussion on rethinking Medicaid payment strategies. In particular, we are grateful for the seasoned expertise of Deborah Bachrach, JD, who wrote this paper based on her wealth of knowledge on Medicaid payment issues as the former New York State Medicaid Director. Deborah and I acknowledge the editorial contributions of CHCS staff Melanie Bella, Julia Berenson, and Lorie Martin. And finally, I wish to recognize the Robert Wood Johnson Foundation for supporting this and future work to bring Medicaid to the payment reform table.

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Health care reform holds the promise of near universal coverage and Medicaid is the foundation for it, eventually covering more than 75 million Americans. This brief's goal is to promote Medicaid's ability to buy value — cost-effective, quality care — in both the acute and long-term care sectors. Specifically, it addresses four issues: (1) the importance of payment reform in Medicaid; (2) the challenges Medicaid faces in implementing payment reforms; (3) payment reform opportunities in Medicaid; and (4) how federal and state roles might shift to create a more dynamic and effective partnership for tackling complicated and politically charged payment issues. By raising questions about Medicaid's rate-setting policies and their relationship to access, quality, and cost containment, we hope to inform and advance discussions on reforming Medicaid's payment systems.

Background

Today, over 60 million Americans rely on Medicaid.[1] In March, the President signed into law the Patient Protection and Affordable Care Act (PPACA) extending coverage to 32 million people through an expansion of Medicaid and new subsidies for moderate-income individuals; the newly eligible Medicaid population could number between 15-20 million.[2,3] State Medicaid agencies will have an enormous responsibility: to purchase cost-effective, quality care for more than 75 million people. Medicaid's payment policies are its single most important tool for advancing these goals. It is widely recognized that the current fee-for-service payment model incents volume and intensity of services rather than the value of the services. Providers whose primary concern is keeping people healthy are in effect penalized for not delivering extra services. Providers should instead be

IN BRIEF…

Effective Medicaid payment reform will need:

- Sound payment fundamentals that accommodate patient acuity, encourage efficiency, collect accurate clinical data, and facilitate measurement of quality.
- Development of payment innovations that support improved models of care, including medical homes, bundled payments, and accountable care organizations.
- Alignment with other public and private payers at the state and regional/local level.
- A dynamic partnership with the Centers for Medicare and Medicaid Services (CMS), including both its Medicaid and Medicare leadership.

rewarded for delivering just the right care, at just the right time.

While there is widespread acceptance of the importance of payment reform, Medicaid has been largely absent from national payment reform discussions, which have focused almost entirely on Medicare. Already covering significant and growing numbers of medically complicated, high-cost patients — most of them in the unmanaged fee-for-service system — Medicaid must find ways to improve quality and reduce costs. Reducing eligibility levels, eliminating covered benefits, and imposing across-the-board rate cuts are blunt tools that produce short-term budget relief. However, these strategies may ultimately undermine efforts to reform the payment system and improve the efficiency and effectiveness of the nation's health system. Medicaid payment redesign offers an alternative cost containment strategy that can also improve access to quality care while delivering some significant savings relatively quickly. Moreover, national payment and delivery system reform can only succeed if all patient populations are accommodated and all significant payers participate. In short, Medicaid must be at the payment reform table.

Medicaid payment polices, like eligibility polices, are driven by individual states and as a result, Medicaid payment methodologies and payment levels vary considerably. Some states have embraced highly sophisticated payment methods, while others rely on flawed methodologies long abandoned by Medicare and private payers. Payment levels likewise vary, with many states paying well below Medicare rates, and, a few paying above Medicare levels. Federal review of state payment policies, while often extensive, tends to focus on issues of notice and transparency, and compliance with federal upper payment limit requirements rather than on the effectiveness of the payment policy in advancing access, quality, or cost containment.

States have led the nation in the effective use of managed care arrangements. However, while almost two-thirds of Medicaid beneficiaries are in some form of managed care, including primary care case management (PCCM), most spending remains in highly variable fee-for-service programs in large part due to the carve outs from managed care of complicated and costly populations and the absence of capitation in PCCM programs.

For ease of exposition, this first CHCS brief on payment reform focuses on Medicaid payment policies in the acute sector. However, the principles are equally relevant to a consideration of payment policies for nursing homes, home health, and home- and community-based services. With the increasing emphasis on home health, personal care, and other alternatives to institutional care for elderly and disabled beneficiaries, identification and implementation of sound payment and delivery models in this sector are both timely and essential. Medicaid's prominent role in these markets offers additional challenges and opportunities that require separate exploration. (See Figure 1 for a template to help outline Medicaid payment reform strategies.)

Also beyond the scope of this brief are: (1) a comprehensive discussion of state managed care arrangements, which should ultimately be subjected to the same questions about value; and, (2) payment policies for the dual eligibles that present unique challenges and untapped opportunities for both Medicare and Medicaid. Getting Medicaid payment policies right is critical in each of these areas; and, each needs to be addressed.

Payment Reform – An Imperative for Medicaid

Payment policies are powerful tools for federal and state governments seeking to rein in health care spending while preserving or improving quality. For states, cost containment is an immediate imperative. However, states face some unique challenges as well as real opportunities as they seek to redesign their payment systems.

Today, Medicaid represents 70 percent of state health expenditures and is the largest or second largest item in every state budget. Prior to enactment of the American Recovery and Reinvestment Act (ARRA) in 2008, states financed 43 percent of Medicaid costs with the federal government assuming 57 percent.[7,8] Under ARRA, the average state share has decreased by 6.3 percentage points.[9] However, even with this temporary increase in the Federal Medical Assistance Percentage (FMAP), states are currently hard pressed to fund their share of Medicaid spending as enrollment increases significantly and state tax revenues plummet.[10] When ARRA's enhanced FMAP authorization expires as currently planned at the end of 2010 (or at best six months later), the situation will only get worse. The situation will change again in 2014, when a national eligibility level of 133 percent of the Federal Poverty Level (FPL) goes into effect and the FMAP increases to 100 percent for three years for

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Figure 1: Initial Framework for Outlining Medicaid Payment Reform Strategies

This template provides a framework for applying the principles covered in this brief to help guide initial state planning efforts around payment reform strategies for acute, long-term, and managed care.

	Payment Method	Payment Level	Linking Payment to Quality/Outcomes
ACUTE CARE			
Inpatient[4]			
Hospital OPD			
Community Clinic[5]			
Physician Primary Care/Specialty Care			
Ancillaries			
LONG-TERM CARE			
Home Health Care			
Personal Care			
Nursing Home			
MANAGED CARE[6]			
Medicaid-Only			
Dual Eligibles			

most childless adults and some parents and again in 2017 when the FMAP for these populations begins to phase down to 90 percent. While it is clear that Medicaid enrollment will increase dramatically starting in 2014 under PPACA, the impact on state budgets is less clear as a result of increased FMAP for some existing enrollees as well as the potential redundancy of state-funded coverage and public health programs with increased enrollment through Medicaid and state-based exchanges.

As a result of the recession and four years before implementation of the Medicaid expansion, over four million more people have enrolled in Medicaid and Medicaid's enrollment growth is the highest in six years.[11] At the same time, 48 states are facing budget shortfalls totaling $194 billion or 28 percent of state revenues.[12] Constrained by balanced budget requirements, states are targeting Medicaid spending. As a condition of enhanced FMAP, ARRA prohibits states from cutting Medicaid eligibility (maintenance of effort). PPACA contains a similar bar.[13,14] States are therefore slashing provider reimbursement rates — generally with across-the-board cuts — and reducing or eliminating covered benefits.[15]

Enhanced FMAP certainly helps, but there are no easy answers to the countercyclical effect of Medicaid. Increasing FMAP does not address Medicaid cost growth; it is simply a short-term "fix" that does not solve the problem. Medicaid desperately needs sound strategies — such as payment reform — that improve access and quality while bringing down costs. Poor cost containment choices today will have lasting impacts on states' ability to connect millions of new Medicaid enrollees to cost-effective, quality care starting in 2014.

Looking beyond cost containment goals, Medicaid's growing role as a purchaser enables it to influence delivery models not just for Medicaid patients but for all patients. Consider that even before the enrollment of 16 million more people under federal reform, 26 state Medicaid programs would be on the Fortune 500 list, if they were publicly traded companies. Indeed, New York Medicaid would be on the Fortune 50, ahead of Pfizer and Aetna. Likewise, with respect to some services — most notably obstetrics, pediatrics, behavioral health, and long-term care — Medicaid is increasingly the major payer.

Unfortunately, payment reform in Medicaid is extraordinarily difficult to do. Medicaid faces many unique challenges emanating from its history in the welfare system; its central role in supporting safety net providers; a federalist structure that divides programmatic, administrative, and fiscal responsibility among multiple levels of government; and, the 12-month budget lens through which state legislative bodies evaluate Medicaid rates. The broader economic pressures further exacerbate the challenge of reforming Medicaid's payment policies.

Finally, Medicaid payment reform has been impeded by a dearth of national information on Medicaid payment policies and their impact on patient access, quality, and outcomes. Far more robust data exists with respect to Medicare. In addition, since 1997, the Medicare Payment Advisory Commission (MedPAC) has provided independent analyses of Medicare payment methodologies and payment levels and their relationship to access and quality of care for Medicare beneficiaries. However, Medicaid is catching up. In 2009, Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) to play a similar role to MedPAC in providing analyses of Medicaid payment policies and spurring adoption of sound payment practices. In addition, under PPACA, the Department of Health and Human Services (HHS) is charged with collecting standardized information from states with respect to adult and child quality measures.

Medicaid Payment Policies – The Basics

Any discussion of Medicaid payment reform must start with a reassessment and potential recalibration of fee-for-service payment methodologies and payment levels. First, for the foreseeable future, fee-for-service will remain a primary payment option. Second, fee-for-service payment algorithms provide the metrics to measure outcome improvements and cost savings with respect to payment reform initiatives. Finally, fee-for-service payment methodologies and payment amounts are the building blocks for payment innovations from medical homes to episodic payments to accountable care organizations.

In reconsidering payment fundamentals in Medicaid, it is helpful to review the basic methodologies that the Centers for Medicare and Medicaid Services (CMS) adopted for Medicare. Prior to 1983, Medicare paid for inpatient hospital services based on each hospital's reported costs plus a profit margin. In 1983, Medicare abandoned its cost-based hospital reimbursement system and adopted a new pricing methodology paying hospitals a predetermined amount based on each patient's clinical condition or diagnosis-related group (DRG). Because payment does not turn on institution-specific costs, hospitals have incentives to improve efficiency; and, because payment is greater for sicker patients, hospitals are more willing and better able to serve all patients.[16] The shift to a DRG-pricing system was truly transformational and led to documented improvements in efficiency and patient outcomes.[17]

In 2007, Medicare adopted a new and more refined DRG system, Medicare Severity-Diagnosis Related Groups (MS-DRG), to better recognize severity of patient illness and more accurately capture the true cost of care.[18,19] Evidence that the previous DRG system, known as CMS-DRGs, systematically underpaid hospitals for the sickest patients prompted CMS to adopt a new algorithm.[20] MS-DRGs have resulted in an improvement in payment accuracy.[21] However, Medicare's new inpatient payment algorithm, developed based on the medical service needs and characteristics of its elderly and disabled enrollees, does not match well to the needs of the Medicaid population.

By comparison to its role in Medicare, the federal government has given states significant flexibility in selecting Medicaid payment methodologies and payment levels.[22] However, federal law requires states to adopt payment methods and payment levels consistent with "efficiency, economy, and quality of care" and sufficient to assure that Medicaid patients have equal access to the care and services available to the general population in the geographic area.[23]

States have selected, and CMS has approved, a wide range of inpatient and outpatient payment methodologies. Figure 2 breaks down the different methodologies used by states. Briefly, six states use hospital-specific costs to set inpatient rates and more than 20 states use cost-based outpatient rates.[24] Nine states pay for inpatient care on a per diem basis and 15 states are using CMS DRGs.

The wide variation in payment method for hospital inpatient services — Medicaid's single largest expenditure — should trigger some level of concern for those seeking to ensure that Medicaid buys value. For inpatient services, cost-based reimbursement and per diem reimbursement have perverse incentives encouraging more care and less efficiency; yet, more than a dozen states use one of these methods. In addition, more than 20 states rely on CMS DRGs or MS DRGs, both of which were developed for Medicare populations and fail to account for the disease burden or hospitalization patterns of the typical Medicaid population, including for example newborn birth weights, many pediatric illnesses, high-risk pregnancies, HIV, and serious psychiatric comorbidities.

Any discussion of Medicaid payment reform must include a reassessment and potential recalibration of fee-for-service payment methodologies and payment levels.

Similarly, for hospital outpatient services, states have selected several different payment methods with more than 20 states using cost-based reimbursement, which inherently rewards higher costs. State Medicaid agencies that use cost-based reimbursement are at the mercy of provider decisions about utilization and unit costs. More than 15 states use some type of fee schedule that likewise perversely incentivizes providers to maximize the number of services. At least a fee schedule, unlike cost-based reimbursement, does not reward high-cost providers. Fewer than a dozen states use a payment system that includes some packaging or bundling of services.

While selecting the right payment classification system or methodology is critical, equally important is the level of payment. There can be little doubt that Medicaid has improved access to care for low-income patients, however, low provider rates continue to plague the program, limiting physician participation and patient access in some communities.[25,26,27] In 2008, Medicaid fee-for-service physician payments nationally averaged only 72 percent of the rates paid

Figure 2: Hospital Inpatient and Outpatient Payment Methodologies by State

How Medicaid Pays for Hospital Inpatient Care *(April 2010)*	
Per Stay – CMS Diagnosis Related Groups (CMS-DRGs): CO, IA, IL, KS**, KY, MN, NC**, ND*, OH, PA*, SC, UT, VT, WI**, WV** **Moving to APR-DRGs, **Moving to MS-DRGs*	**Per Stay – AP (All-Patient) or Tricare DRGs:** DC, GA, IN, NE, NJ, VA, WA
Per State – Medicare Severity DRGs (MS-DRGs): MI, NH, NM, OK, OR, SD, TX	**Per Stay – Other:** DE, MA*, NV, WY **Casemix adjustment based on APR-DRGs*
Per Stay – All Patient Refined DRGs (APR-DRGs): MT, NY, RI	**Per Diem:** AK, AZ, CA, FL, HI, LA, MO, MS*, TN **Moving to APR-DRGs*
Cost Reimbursement: AL, AR, CT, ID, ME	**Other (Regulated Charges):** MD* **Casemix adjustment based on APR-DRGs*

How Medicaid Pays for Hospital Outpatient Care *(Draft March 2010)*	
Ambulatory Payment Classification (APC) Groups: IA, MI, MN, MT, RI, VT, WA, WY	**Ambulatory Patient Groups (APGs)**: MA, MD, NY
States that base their payment methods on Medicare's approach typically follow Medicare in using a fee schedule for lab services, an RBRBS-based fee schedule for therapy services, and APCs for all other services. States vary in how closely they follow the Medicare APC logic. Some (e.g., MT) very closely follow the Medicare model while others (e.g., RI) may not adopt Medicare payment policies such as conditional packaging and composite APCs.	Enhanced APGs are a software product developed and owned by 3M Health Information Systems. MA and MD use APGs indirectly to measure hospital casemix in setting payment rates. NY calculates payment for each claim based directly on APGs.
Primarily Other Fee Schedules: AL, AR, CA, GA, HI, ID, IL, IN, KS, KY, NV, OH, OK, OR, PA, SC, TX, WV	**Primarily Cost Reimbursement**: AK, AZ, CO, CT, DC, DE, FL, LA, NC, ND, NE, NH*, NJ, NM**, ME, MO, MS, SD, TN, UT, VA, WI **Moving to APGs, ** Moving to APCs*
This group of states covers a wide range of approaches, with more emphasis on fee schedules than on cost reimbursement. Nevertheless, some fee schedule states may use cost reimbursement for selected services while cost-reimbursement states typically use fee schedules for lab services and sometimes other types of care. Fee-schedule states may have developed their own fees or have based their payment methods on other approaches, such as Medicare's previous method for ambulatory surgical centers.	In a typical cost reimbursement method, Medicaid makes an interim payment for each claim based on a percentage of billed charges. Final payment is calculated after a cost settlement process that typically occurs one to three years after the service is provided. Although a state's payment method may be primarily cost reimbursement, states typically use fee schedules to pay for lab services and, depending on the state, may also use fee schedules for imaging services or other types of care.

Source: ACS Government Healthcare Solutions.

by Medicare.[28] While there are no complete data on payment amounts under Medicaid managed care, anecdotal information strongly suggests that its payments are closer to Medicare levels. As a result, Medicaid managed care plans have been able to attract physicians unwilling to participate in Medicaid fee-for-service. CMS, for the most part, has not addressed the issue of payment levels beyond its requirement that payment rates not exceed an upper payment limit tied to Medicare or reported costs.[29]

While payment levels may not be the only determinant of whether a provider participates in Medicaid, it is certainly a key factor.[30] In addition, providers respond to relative payment rates by delivering more higher-profit services and fewer money-losing services.[31] Both absolute and relative payment levels have implications for access to care as well as the cost and quality of that care. Medicaid fee-for-service methods and levels influence access, quality, and costs and are central components of payment innovations. It is virtually impossible to implement or evaluate most payment reforms on a base of poorly constructed fee-for-service payments. New York's experience is instructive.

While states have significant latitude in the fundamentals of Medicaid rate setting, there are several areas where federal law authorizes or requires particular payment mechanisms. Among them are:

- ***Disproportionate Share Hospital (DSH) Payments*** – Since 1981, federal law has required states to make additional payments for inpatient services to hospitals serving disproportionately large numbers of Medicaid and low-income, uninsured patients (DSH hospitals). States have considerable discretion in how they calculate and allocate DSH funds among hospitals.[33, 34] Notably, PPACA reduces states' Medicaid DSH payments by $14.1 billion from 2014 to 2019 with HHS to determine the methodology to effectuate the reduction.[35, 36]

- ***Upper Payment Limit (UPL)*** – By regulation, state Medicaid programs may not pay classes of providers more in aggregate than they would have received under Medicare payment principles. To the extent that aggregate Medicaid payments to a class of providers are below the UPL, states are able to make lump sum payments to providers in that class.

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New York State Payment Reform

In 2007, New York's physician fee schedule was the second lowest in the country. Reimbursement rates to hospital clinics and community clinics had been frozen for more than a dozen years and clinics were paid on a per-visit basis — the same amount for every visit. The inpatient payment methodology was similarly flawed and Medicaid inpatient rates actually exceeded Medicaid inpatient costs, thereby incentivizing expensive inpatient care and no doubt contributing to New York's last place ranking in a 50-state survey of avoidable hospital admissions.[32] Before implementing a medical home initiative, New York had to rationalize its payment levels and payment methods or the provider community would be unable or unwilling to participate. Further, the State would be unable to evaluate the results. Over a three-year period, New York, with the support of consumers and primary care providers, moved almost $600 million from hospital inpatient rates to outpatient rates for hospital clinics, community clinics, and physicians. It also provided additional payments for physicians practicing in underserved areas and maintaining weekend and evening hours. New York replaced its per-visit payment method with Enhanced Ambulatory Patient Groups (EAPGs), a system that ties payment rates to patient complexity and the intensity of the services provided. The State also replaced its inpatient payment method with APR-DRGs, which likewise capture hospital resource and patient variation for the Medicaid population. With these basic, but essential, upgrades completed, New York was positioned to take on additional payment innovations including, requiring hospitals to provide present on admission information; declining payment for certain hospital-acquired conditions and "never events;" and implementing a medical home incentive and requiring data on outcomes so that the effectiveness of the medical home in improving quality and containing costs could be measured.

An array of ideas for changing the way we pay for care is emerging – all seek value by linking payment to efficiency and better patient outcomes.

- ***Federally Qualified Health Center and Rural Health Clinic Payment Rates*** – Federal law establishes minimum facility-specific Medicaid payment rates for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). These rates are based on the facility's costs and must be paid on a per-visit basis unless the facility agrees to an alternative methodology that must generate at least as much revenue for the FQHC/ RHC as the per-visit methodology.

- ***Actuarially Sound Capitation Rates*** – Since 2003, federal regulations have required that Medicaid payments under risk contracts and risk-sharing mechanisms be "actuarially sound."

In addition to those noted above, federal law also dictates Medicaid payment policies with respect to critical access hospitals and Indian Health Services. Much has been written on all of these provisions. The intent here is to simply flag areas where long-standing Medicaid policies can potentially advance or impede payment reform with respect to inpatient and outpatient payment policies. For example, there is no question that DSH and UPL are critical supplemental funding streams for safety net hospitals. However, at the same time, the amount and allocation methods of DSH and UPL tied to facility-specific costs and provided on a lump sum basis can distort payment reforms intended to incent care that is efficient and effective. Likewise, federal law requires states to pay FQHCs a cost-based amount using a per-visit rate methodology. The challenge going forward will be to reconcile these mandates with efforts to bundle payments that more accurately capture the complexity of the services provided and to use payment incentives to reward quality and outcomes rather than volume.

Payment Strategies to Improve Quality and Contain Costs

An array of ideas for changing the way we pay for care is emerging, in many cases with Medicare taking the lead. All seek value by linking payment to efficiency and better patient outcomes. These payment strategies generally involve some form of bundled payment that builds on and aggregates fee-for-service payments. The following brief review of reform options demonstrates areas of opportunity for Medicaid.

- ***Potentially Preventable Events (PPEs)*** – Health care costs can be controlled and quality improved by reducing unnecessary admissions, readmissions, complications, and emergency room visits. In 2007, CMS required that all Medicare claims include whether each complication diagnosis was present on admission (POA) in order to distinguish between complications that are hospital-acquired and those developed prior to admission. In 2008, CMS barred additional payments for certain hospital-acquired complications (HACs), including never events. Requiring POA information and reducing payment for HACs is intended to drive hospitals to take steps to minimize complications.[37] Some state Medicaid agencies have recently taken steps to reduce PPEs. A State Medicaid Director Letter in July 2008 encouraged states to adopt similar policies with respect to their dual eligibles as well as their Medicaid-only patients.[38] Maryland has taken the CMS approach further, expanding the list of HACs to a much larger set of potentially preventable complications.[39] Extending this concept of "potentially preventable" to potentially preventable readmissions (PPRs) presents opportunities for more significant and more immediate cost savings combined with both quality improvement and movement toward episode-based payment.[40]

- ***FFS with Bonus or Shared Savings/Patient-Centered Medical Home (PCMH)*** – While there is no one definition of the PCMH, core features include "physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high-quality, accessible care; and payments that recognize a medical home's added value for patients."[41] Payment policies generally provide FFS payments with add-ons for coordination and shared savings or bonuses for quality outcomes and reductions in emergency department and hospital utilization. Notably, payment incentives in the PCMH model remain grounded in FFS, demonstrating once again the importance of getting fee-for-service payments right even as we move toward more effective payment models.

- ***Bundled Payments/Episodes of Care*** – Bundled payments include all services associated with an episode of care such as an inpatient stay plus care required for a limited period of time post-discharge (e.g., 15 to 60 days). The payments to hospitals and physicians are combined into one patient severity adjusted amount that is shared among the providers. The idea is to create incentives for provider communication and coordination regarding the processes of care and their associated financial consequences.[42] The challenge here is to define the services to be bundled, risk adjust the payment to reflect patient health status, and determine the recipient of the payment.

- ***Global Payments/Accountable Care Organizations*** – Accountable Care Organizations (ACOs) seek to provide financial incentives for cost containment and quality improvement across multiple sites of patient care under a global or capitated payment for all health care provided to each patient over a fixed period of time.[43, 44] ACOs are entities or virtual entities that share responsibility for treating a group of patients. The capitated payment arrangement is directly with providers; there is no managed care organization or HMO between the purchaser and providers. Providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency. Providers in the ACO are held accountable for the care and outcomes of their patients and share in the savings generated through reductions in PPEs.

These payment reforms are intended to link reimbursement to better outcomes, greater value, and improved patient experience. They may start with Medicare, and indeed most of the literature focuses on Medicare, but they will only be effective if they reflect the demographics of all populations and are embraced by all payers, including Medicaid. Providers simply cannot respond effectively to inconsistent payment signals.

Among the issues all providers and payers must address are the lack of robust information on utilization and outcomes. Data must be collected and disseminated to identify opportunities and to measure successful efforts at cost savings and quality improvement. With information, interventions — such as care management, prior authorization requirements, or incentives to reduce PPRs — can be targeted to high-cost patients and over-utilized services respectively; best practices can be identified; and return on investment can be documented.

Early Medicaid Payment Reform Efforts

States' reliance on managed care models dates back to the 1990s and Medicaid remains a leader in using capitated payment models. Until recently the focus has been mostly "moms and kids" and the extent to which the care and cost incentives inherent in a capitated model flowed down to providers remains unclear. Many states now have the experience and the encounter data to hold plans accountable for the quality of care

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Medicaid's success in achieving payment reform goals will be enabled to the extent it can work with local consumers and providers.

delivered to their enrollees and a number have initiated pay for performance programs with their managed care plans, albeit often focused on process not outcome measures. Given the breadth and depth of state experience with managed care, it would seem to be an opportune time to revisit carved-out of services (most notably behavioral health and certain long-term care services) and excluded populations (such as the seriously and persistently mentally ill) as well as extending managed care to dual eligibles. With strong performance requirements for care management and reducing unnecessary hospitalizations and institutionalizations, there is substantial potential for these organizations to improve quality and contain costs.

Recognizing that five percent of the Medicaid beneficiaries drive 50 percent of the costs, states are especially focused on innovations for high-need, high-cost populations with multiple chronic conditions, often with underlying mental illness and/or substance abuse.[45] Since 2006, more than 30 state Medicaid programs have adopted medical home initiatives with some level of enhanced payments, shared savings, and/or bonus payments; a subset of them focus on patients with chronic illnesses and disabilities.[46] However, only 11 states have embraced Medicare's approach to hospital-acquired conditions and never events.[47] The relatively small number is likely related to three factors: (1) state inpatient payment methodologies that are insufficiently granular to effectively capture the targeted complications; (2) claims systems that are not set up to capture POA data necessary for implementing a non-payment policy with respect to HACs/never events; and, (3) limited expertise and capacity that have been pushed to the edge by today's fiscal environment. Finally, several states are considering payment policies related to potentially preventable events as a payment reform that can produce relatively quick savings while improving care.

Payment and System Innovations Under National Health Reform

PPACA establishes a new Center for Medicare and Medicaid Innovation with significant funding and a broad mandate to support pilot programs that develop, test and expand innovative payment and delivery arrangements in Medicare and Medicaid.[48, 49] In addition, there are multiple demonstrations and payment initiatives targeted specifically to Medicaid, including higher payment rates for primary care; enhanced FMAP for health homes for chronically ill Medicaid beneficiaries; state demonstration programs for bundled payments and ACOs. Additional provisions bar state Medicaid programs from paying additional amounts for hospital-acquired conditions and authorize the integration of Medicare and Medicaid funding streams for dual eligible beneficiaries including options to do so via full risk or shared savings with state Medicaid agencies. These provisions roll out between 2010 and 2014.

Creating a Stronger Foundation for Medicaid Payment Reform

The goals of effective and sustainable Medicaid payment reform are to create a sound payment system that promotes access to care and incentivizes providers to adopt more effective and efficient delivery models, producing both immediate savings as well as long-term quality improvements. Medicaid's success in achieving these goals will be enabled to the extent it can work with local consumers and providers. It will also be significantly influenced by the degree to which it aligns with Medicare and other payers in advancing complementary payment systems.[50] Conflicting incentives across payers dilute the effort of every payer to contain costs and improve quality. As the nation's largest purchaser of care, Medicaid must take steps to ensure that its payment policies are sound and to the maximum extent possible align with Medicare and private payers. Indeed, as the dominant

payer for some services and in some markets, Medicaid can often lead payment and system reform efforts.

Payment redesign presents significant opportunities and challenges for state and federal Medicaid officials and calls into question whether the 40-year-old division of responsibilities still makes sense today as Medicaid moves inexorably from welfare program to major health insurer. Moreover, as the federal deficit moves to center stage and the federal government assumes a greater role in financing Medicaid, it will have an even greater stake in the success of Medicaid's payment policies and cost containment strategies. Although federal administrative resources are constrained, the capacity of state Medicaid agencies is arguably worse. States facing continued hiring freezes and staff furloughs barely have sufficient resources to maintain day-to-day operations much less to rethink and reform their payment policies and the claims systems that support them. If states were to try to individually reform their payment policies, they could spend months or even years explaining the changes to federal officials. For all these reasons, reconsideration of the respective roles of the federal and state government with respect to payment design may be warranted.

Potential Ideas for a New Partnership

Given the importance of payment methods in incentivizing providers to improve outcomes and reduce costs and the compelling evidence that some payment methods work better than others, CMS may want to provide support to states in crafting sound payment policies. States would benefit from development of national expertise on Medicaid payment systems at least comparable to what exists with respect to Medicare. Indeed, several states recently analyzed inpatient and outpatient payment methods and reached the same conclusions as to the most effective payment methods for generating accurate clinical data, assuring purchasing clarity, and advancing efficient and effective service use. One can readily envision a national effort to build on this knowledge base that would benefit both state officials seeking to implement sound Medicaid payment systems and CMS officials establishing payment reform metrics.

Establishing sound payment levels is, in some ways, even more complicated and certainly more sensitive to individual state differences. Several commentators have proposed analytic frameworks to measure patient access to quality care and to establish appropriate payment levels across services and with respect to patient characteristics.[51] With virtually unfettered discretion and little federal guidance, states are subject to the push and pull of budget pressures and politically powerful industry lobbies. Too often that means across-the-board rate cuts or targeted add-ons to appease the most powerful stakeholders. With thoughtful discussion and clear delineation about roles, responsibilities, and incentives, more proactive CMS involvement informing Medicaid's choice of rate-setting methods and payment levels could result in greater efficiency and effectiveness.

Once states have reasonably sound fee-for-service payment methods and levels, it will be easier to move to bundled or global payments or to craft primary care payment strategies that support patient centered medical homes as advanced by federal health reform legislation. Evidence-based payment reforms must be responsive to local markets and provider structures. Accordingly, here perhaps more than anywhere, states, working with their local consumers and providers, are positioned to lead. However, that does not preclude CMS from providing a common structure for states to use in designing their reforms, measuring outcome improvements and dollar savings, and guidance as to how and when states may share savings with providers and where states may integrate Medicaid and Medicare funding streams.

States would benefit from development of national expertise on Medicaid payment systems that is at least comparable to what exists with respect to Medicare.

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All states would benefit from clearer federal guidance and technical support with respect to Medicaid payment policies. For example, CMS could provide a framework to analyze payment methods or a list of payment principles along with a menu of specific methodological options noting the pros and cons of each. To the extent, CMS and its state partners develop a framework for making sound decisions about both absolute and relative payment amounts, it will be easier for states to make and defend payment decisions to state legislatures, in the State Plan Amendment (SPA) approval process and in court. Ultimately, both CMS and states will benefit from a partnership that relies more on states' ability to understand and adopt sound Medicaid payment systems than on the their ability to demonstrate compliance with complicated UPL calculations and awkward crosswalks to Medicare models developed for a very different patient population. Finally, CMS could encourage and facilitate certain payment reforms through expedited or streamlined SPA review or enhanced match, as occurs in the PPACA with respect to health homes for chronically ill patients. This revitalized federal-state partnership would make better use of scarce administrative resources at both levels of government and ensure that Medicaid becomes a more effective purchaser of coverage, access and care, and a more influential player in national efforts to purchase value.

Conclusion

Since its enactment in 1965, Medicaid has grown from an afterthought in the welfare system to the nation's largest health insurer. In the process, it may have outgrown aspects of the original state-federal partnership. In some areas, such as setting payment methodologies, a new relationship may be required; one that builds on the strengths of each partner and assures that scarce resources are used efficiently and effectively to advance health care reform. To succeed, that new partnership will ultimately need to include providers and consumers. As a pillar of the nation's health care system, Medicaid has the responsibility and the power to influence the cost of care and the quality of care. And, its payment policies are its greatest levers.

Appendix:
Participant List for CHCS Medicaid Payment Reform Small Group Consultation Meeting, April 20, 2010, Washington, DC

State Representatives	
California	Toby Douglas, Chief Deputy Director, Department of Health Care Services, Health Care Programs
Colorado	Sandeep Wadhwa, MD, PhD, Medicaid Director, Department of Health Care Policy and Financing
Massachusetts	Judy Ann Bigby, MD, Secretary of the Executive Office of Health and Human Services
Minnesota	Brian Osberg, Medicaid Director, Department of Human Services
Oklahoma	Lynn Mitchell, MD, Medicaid Director, Oklahoma Health Care Authority
Federal Government Representatives	
Centers for Medicare and Medicaid Services (CMS), Center for Medicaid, CHIP, and Survey & Certification (CMCS)	Cynthia Mann, Director Barbara Edwards, Director, Disabled and Elderly Group Dianne Heffron, Director, Financial Management Group Mary Kennedy, Senior Policy Adviser Kristin Fan, Deputy Director, Financial Management Group
United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation	Richard Kronick, PhD, Deputy Assistant Secretary, Health Policy
United States House of Representatives, Committee on Energy and Commerce	Andrew Schneider, Chief Health Counsel Andy Bindman, MD, Robert Wood Johnson Foundation Health Policy Fellow
Payment Reform Experts	
3M Clinical Research Outcomes	Norbert Goldfield, MD, Medical Director
Center for Healthcare Quality and Payment Reform	Harold Miller, President and CEO
Center for Health Policy Research and Ethics, College of Health and Human Services at George Mason University	Len M. Nichols, PhD, Director
Health Insurance Reform Project at George Washington University	Lynn M. Etheredge, Health Policy Consultant
Heller School of Policy and Management, Brandeis University	Robert E. Mechanic, Senior Fellow
Mercer Government Human Services Consulting	Mark Hoyt, Senior Partner
Health Policy Organizations	
Center for Health Care Strategies (CHCS)	Stephen A. Somers, PhD, President and CEO Melanie Bella, Senior Vice President Deborah Bachrach, Senior Program Consultant Julia Berenson, Program Associate
Robert Wood Johnson Foundation (RWJF)	Nancy L. Barrand, Special Advisor for Program Development Brian Quinn, PhD, Program Officer

Endnotes

[1] CHCS estimate for Medicaid and State Children's Health Insurance Program enrollment for FY 2009 based on the Actuarial Report on the Financial Outlook for Medicaid, Centers for Medicare and Medicaid Services, October 2008, and CHIP Enrollment: June 2008 Data Snapshot, Kaiser Commission on Medicaid and the Uninsured, September 2009. This number represents the number of Medicaid beneficiaries ever enrolled vs. average enrollment during the course of the year.
[2] Public Law 111-148, "Patient Protection and Affordable Care Act."
[3] Public Law 111-152, "Health Care and Reconciliation Act of 2010."
[4] Could trigger a review of DSH, UPL and GME payments.
[5] Could trigger a review of FQHC payment requirements.
[6] Could trigger a review of actuarial soundness.
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[23] 42 U.S.C. Sec. 1396a(a)(30)(A)—In addition federal regulations establish upper payment limits (UPLs) for aggregate payments to classes of providers and require a transparent and public process in the setting of payment rates.
[24] Charts 2 and 3 are based on data from Quinn, K. (2008). "New Directions in Medicaid Payment for Hospital Care." *Health Affairs*, Vol 27(1), pp 269-280.
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