Paying for value, not volume, in health care

States are experimenting with innovative delivery and payment reforms focused on more-efficient, high-quality care

by Kate Tormey (ktormey@csg.org)

In most industries, consumers pay more for receiving more goods and services. But in health care, more isn’t necessarily better — sometimes it’s just more expensive, some policy experts say.

That’s why states around the country are currently testing new ways to deliver and pay for health care, with the goal of fostering quality, cost-effective services.

“Right now there is an effort in the states to get away from simply paying fees per service without linking payment to quality,” says Michael Stanek, a policy analyst with the National Academy for State Health Policy. “There is lots of inefficiency and fragmentation of delivery that can drive up health care costs.”

Such a dramatic shift from the fee-for-service system, which has been used for decades in the United States, won’t happen overnight, experts say. But they agree that states are the ideal laboratories for testing new delivery models that could transform health care.

‘Triple aim’ of health reform

Sometimes delivering more-efficient health care is simply about stepping back and thinking about what a patient needs to lead a healthy life.

Take the example of “Mrs. Johnson,” an anecdote that Illinois Department of Healthcare and Family Services director Julie Hamos uses to describe a significant change her state is making to its Medicaid program.

Johnson was elderly and had limited mobility after a hospital visit, so returning to her home without extra help would have been daunting, and potentially dangerous.

She was assigned to a managed-care company that handles Medicaid cases. The company made a home visit and found a host of potential health hazards and problems: unsteady front steps, unfilled prescriptions, and outdated glasses that limited her sight. Plus, her food stamps had been stolen.

“All of these issues are very typical for someone in Medicaid,” Hamos says. “She had no home support and was left to just sit in her house by herself.”

But managed care dealt with all of the various issues that were identified — right down to fixing those wobbly front steps — “not because they are a charitable organization, but because it was cheaper to do all of the above than to have [Mrs. Johnson] end up in the hospital or a nursing home,” Hamos says.

“That’s the theory behind coordinated care: treating all of a patient’s needs, including preventive and specialty care, chronic condition management, behavioral health treatment and social services. Experts and policymakers agree that this type of care helps achieve the “triple aim” of health care reform: improving patient satisfaction, achieving better outcomes, and reducing the cost of care.

But the current health care system doesn’t provide much incentive for providers to collaborate in this way and treat the whole patient, Stanek says.

“The goal [of value-based purchasing] is to tamp down on the payment-based motivation in the fee-for-service system and instead reward quality, not volume,” he says.

While the goals are not new, the federal government and states are trying out new approaches to rewarding value in health care.

New provider groups forming

Illinois, along with many other states, has long enrolled Medicaid beneficiaries in managed-care plans, which first became popular in the 1990s.

Proponents of these plans, commonly known as health maintenance organizations, or HMOs, offer price stability because states pay a flat fee per enrollee. This is often

State payment and delivery reforms in Medicaid, Children’s Health Insurance Program

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New types of provider networks will reward coordinated, cost-efficient care

referred to as a “capitated” payment, and in exchange, the HMO is responsible for covering the cost of a patient’s care, even if it exceeds the fee.

Critics, however, have argued that managed care has its faults: Patients have fewer choices of providers, they say, and quality is sometimes sacrificed in order to keep costs low.

In Illinois, serious budget constraints required a new and innovative approach, Hamos says. In 2011, lawmakers passed sweeping Medicaid-reform legislation that will significantly change the way Medicaid is delivered to enrollees and paid for by the state. By early next year, at least half of the program’s 3 million enrollees will be enrolled in either traditional managed care or three completely new types of provider arrangements.

“No one was sold on managed care being the best and only solution,” says Hamos, a former state legislator, “and Medicaid had to be redesigned.”

“We wanted to see if we could invent some different models and see what worked best.”

Unlike managed care, the new delivery systems in Illinois are being organized by groups of preferred providers themselves. They will provide an array of services for a Medicaid enrollee — everything from laboratory work to inpatient care.

One type of new provider network will be called an “accountable care entity.” The name comes from the fact that the network of physicians, nurses and other professionals agrees to be responsible for a certain number of patients’ care, eventually in exchange for a set fee per member. But it will be up to the providers themselves to find innovative ways to keep costs down, because if they don’t, they won’t be profitable.

“This arrangement is sometimes called “full risk” because the provider or group of providers are responsible for not racking up more charges than the flat fee they receive; indeed, the more cost-efficient they are, the more they keep in revenue.

Another example is dubbed a “care coordination entity,” and it has the same basic purpose: to take on a set of Medicaid patients and manage their care. But, too, must find ways to offer the best care at the lowest price, because reimbursement is based on part on whether providers meet quality goals. If they don’t, part of their fee is withheld.

In all, these new models differ from fee-for-service, under which providers receive payment for every individual service, regardless of outcome.

The Illinois experiment will allow policymakers to look at the different models and gauge their strengths and weaknesses. Hamos says. Residents who receive Medicaid are already getting letters asking them to choose a plan; if they don’t, they’ll be assigned to a new plan.

Different populations will have varying options, depending on factors such as geography and enrollment category (seniors or children and families, for example).

Regardless of their details, all of the new plans will have the same goal: to better coordinate care for Illinois Medicaid beneficiaries.

“We believe that the financial incentives are aligned with quality health care,” Hamos says. “If Mrs. Johnson has a mental illness ... it is going to cost the...
it hasn’t harmed quality.” But with so many different areas of health care, determining the definition of “quality” can be a challenge for all of them.

In Illinois, the state built certain quality requirements into contracts with its new provider-led medical groups. Most of the benchmarks will be measured against claims data, which Hamos acknowledges isn’t a perfect method. These data explain which services providers are completing, but individual outcomes (such as whether a diabetic patient’s blood sugar was stabilized) are not available.

The state will convene a panel of experts and stakeholders to pare down the list of metrics and identify the indicators that give the most accurate picture of how providers are performing.

“The way to change the behavior of providers to have higher quality is to have fewer metrics and to be consistent [across the health system],” Hamos says. "Medical homes was the state’s first model in the health care system in place since 2009. One way the system is being used is to tie providers’ payments to their performance on a set of 10 quality measures. The initiative is a Medicaid pilot project and rewards physicians based on outcomes, patient experience and service delivery. A program in Michigan is taking a slightly different approach, using already-established national measures of quality. The Primary Care Transformation Project offers monthly, per-member incentives to providers and is largely based on the Healthcare Effectiveness Data and Information Set — a tool used by more than 90 percent of America’s health plans to measure performance on care and service.

Medical homes: Trend in state policy stresses coordination, efficiency

The Affordable Care Act’s requirement for most Americans to have health insurance has encouraged medical homes. "Medical homes is a new driver of costs in health care. It is an attempt to stabilize the cost of the health care — and when a single entity is keeping track of a patient’s chart, these issues can be flagged before the service is completed again.

Most Midwestern states have begun using the medical-home model in Medicaid and other public insurance programs sometimes with grants under the Affordable Care Act. The goal is to have a single entity coordinating the patient care instead of the often-fragmented current model.

Under the federal Affordable Care Act, states are encouraged to use the medical-home model in Medicaid through enhanced funding for patient-centered medical homes. States can receive a 90 percent federal match for the costs associated with creating medical homes for Medicaid beneficiaries.

This provision of the federal law aims to improve care for those with chronic conditions, a key driver of costs in health care.

Under the new initiative, health homes can coordinate care for people with at least one chronic condition and who are at risk for developing a second. States can also assign patients with a serious and persistent mental-health condition to medical homes eligible for the enhanced funding.

Minnesota’s Health Care Homes initiative was created through 2008 state legislation. Statewide, about 350 medical practices have been certified as health homes. These providers bill the Medicaid program for “care coordination” payments that are based on how many chronic conditions the patient has. Enhanced payments are also available for these providers in dealing with patients who have a language barrier or a mental illness.

Some states have targeted their medical-home initiatives for certain Medicaid populations. In Wisconsin, for example, received federal approval in 2013 to create medical homes for individuals who are HIV-positive and who have — or are at risk of developing — a second chronic condition.

In order to bend the health care cost curve, though, private insurers will need to use medical homes as well. To that end, Nebraska is conducting a pilot program that encourages private insurers and Medicaid managed-care companies to participate in the medical-home model.