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# 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)*

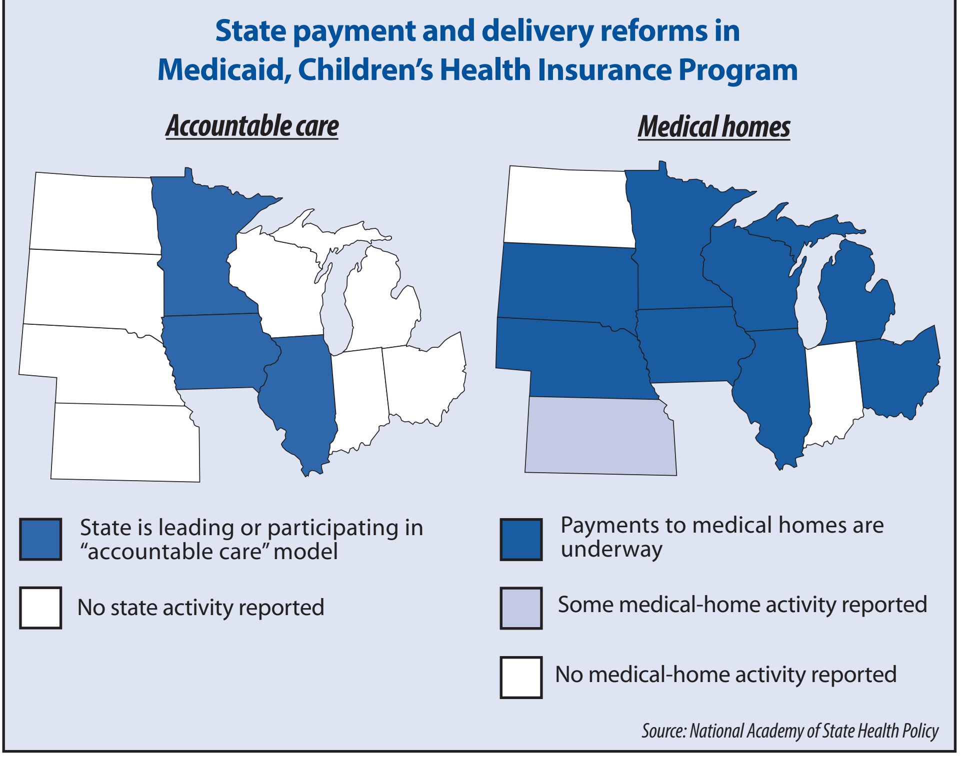
In most industries, consumers pay more for receiving more goods and services.

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.



Source: National Academy of State Health Policy

### '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home visit and found a host of potential health hazards and problems: unsteady front steps, unfilled prescriptions, and outdated glasses that limited her sight.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

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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.

"Not everyone 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 the best."

Unlike managed care, the new delivery systems in Illinois are being organized by groups of health 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. It, too, must find ways to offer the best care at the lowest price, because reimbursement is based in part on whether providers meet quality goals. If they don't, part of their fee is withheld.

All 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

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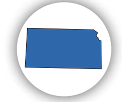
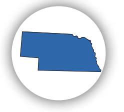
> "There is an effort in the states to get away from simply paying fees per service without linking payment to quality. ... There is lots of inefficiency and fragmentation of delivery that can drive up health care costs."
>
> Michael Stanek, National Academy for State Health Policy

## Value over volume: Initiatives in Midwest aimed at better coordinating health care to trim unnecessary health costs

| | |
|---|---|
| | In 2011, the **Illinois** legislature passed HB 5420, a health reform bill crafted by a bipartisan committee of lawmakers. Among other provisions, the bill expands coordinated care in Medicaid by establishing three new types of provider networks. By early next year, at least half of all Medicaid beneficiaries must be enrolled in one of the new entities or in traditional managed care. The new provider-organized networks will be responsible for providing or coordinating most care for their patients, including primary care, diagnostic services, specialty care and mental health treatment. |
| | **Indiana** offers an insurance program to low-income adults called the Healthy Indiana Plan. Enrollees pay modest premiums, and preventive care is free. Other health care needs can be paid for with a health savings account, encouraging beneficiaries to explore the lowest-cost, highest-quality option for medical care. A recent state study found that Healthy Indiana Plan members were less likely to visit the emergency room (where they are charged a co-pay for non-urgent care) than the general Medicaid population. Enrollees were also more likely to use less-costly generic drugs. |
| | The **Iowa** Health and Wellness Plan was passed in 2013 as an alternative to simply expanding Medicaid under the Affordable Care Act; it was then approved by the federal government through a waiver. The program will incorporate the use of accountable-care organizations, which will tie providers' reimbursement to performance on quality measures and to reductions in the cost of care for the patients they treat. The state also received a State Innovation Model grant to implement integrated care models, with the goal of holding the growth in health costs to 2 percent statewide. |
|  | **Kansas** received a grant from the U.S. Centers for Medicare & Medicaid Services to establish medical homes for Medicaid beneficiaries with a chronic condition. The Kansas Division of Health Care Finance (formerly the Kansas Health Policy Authority) is working to develop a state medical-home model after legislation calling for such an initiative was passed in 2008. Kansas is one of 11 states nationwide (including Minnesota) that have an all-payer claims database, according to Kaiser Health News. These databases require all commercial insurers to submit claims and prices paid for procedures, which can be used to measure the performance of the state's health system and compare price and quality in different parts of the state. |
| | **Michigan's** Primary Care Transformation Project is the largest patient-centered medical-home project in the country. The three-year project is aimed at improving health in the state, in part by improving care for people with chronic diseases and preventing their illnesses from worsening, as well as better coordinating end-of-life care. Providers participating in the program have been receiving monthly, per-member performance incentives. The state has also received a State Innovation Model grant from the federal government to explore the use of new payment and delivery models in public insurance programs. |
| | **Minnesota** launched a Health Care Delivery Systems Demonstration in its Medicaid program in 2011. The goal of the program was to find innovative ways to improve quality and lower costs through care and delivery reforms. Under the program, Minnesota has set up nine accountable-care organizations within Medicaid. In the first year, the ACOs can share in the savings they achieve through better coordinating care for their patients. In year two, the ACOs begin sharing risk for losses. The state also has more than 350 primary-care clinics that serve as health homes and receive payments in exchange for coordinating patient care. |
|  | In **Nebraska**, a two-year, multi-payer medical-home project has been launched involving the state's major health insurers and Medicaid managed-care plans. The plans were convened by the Nebraska Legislature, which passed legislation in 2012 requiring private insurance companies to pay care coordination fees to eligible patient-centered medical homes. Under the agreement facilitated by lawmakers, insurers must contract with at least 10 medical homes this year and 20 medical homes next year. Insurers can also request quality data from providers, using a list of quality measures such as rates of screening for depression or hospital admissions for preventable conditions. |
| | Advanced-practice nurses in **North Dakota** are permitted to practice without the supervision of a physician. North Dakota is among the handful of states that have significantly eased restrictions on what advanced-practice nurses — or those with a graduate degree — can do in their practice, such as write prescriptions. Proponents of easing restrictions on non-physician providers say that doing so could decrease health care costs because, when appropriate, visits to an advanced-practice nurse are generally less expensive than seeing a doctor but offer a similar type of care. Advanced-practice nursing advocates add that these professionals are already trained in providing all but the most complex care, and that utilizing their expertise is getting the most value from their profession. |
| | **Ohio** received a federal grant of $3 million under the federal State Innovation Model program to design a payment and delivery system reform project. One goal was to expand the capacity and availability of medical homes, and to define and administer "episode-based payments" for acute medical events. These payments are based on the kind of medical event that occurs, not a series of interventions needed to treat the episode. And the state's Education Pilot Project offers technical assistance to convert primary-care facilities in underserved areas to medical homes and uses the sites for training in advanced primary care. |
| | Payments to medical homes are underway in **South Dakota** as the result of a Medicaid waiver granted to the state by the federal government. Medicaid enrollees are eligible to receive care in a medical home if they have two chronic conditions; one chronic condition and high risk for a second; or a serious mental illness. States that apply for this waiver (including Iowa, Kansas, Minnesota, Ohio and Wisconsin) receive a 90 percent match for medical-home services provided to Medicaid beneficiaries. |
| | In January 2013, the federal government approved a Medicaid waiver for the state of **Wisconsin** to assign beneficiaries to a medical home if they are HIV-positive and have a second chronic condition (or are at risk for one). The state has two specific goals for this initiative: to reduce the number of complications in HIV-positive patients and to better integrate oral health care with medical care. The state will track its performance in achieving these goals by analyzing claims, medical records and public health data. Wisconsin has also received a federal grant to test new methods of providing more-coordinated care to "dual eligibles," or people eligible for both Medicare and Medicaid. |

*Sources: National Academy for State Health Policy and CSG Midwest research*

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plan more if they don't take care of those needs early and provide preventive care."

## Collaboration is key to savings

Illinois is not the only state in this region experimenting with new models of health care delivery and payment.

"States are moving in the same direction Medicare is moving: using shared savings initiatives, accountable care organizations and shared financial agreements," Stanek says. "These are strong carrots to promote collaboration."

Iowa, for example, included some value-based programs last year in a Medicaid reform initiative. The legislation was a compromise aimed at providing the state an alternative to simply expanding Medicaid under the Affordable Care Act; Iowa's plan was then approved under a federal waiver.

The Iowa Health and Wellness Plan will use three key delivery systems to care for low-income Iowans. In addition to using traditional managed care, the state will provide special "care coordination" payments to primary-care practices. These fees are in addition to reimbursement for actual care, and are designed to help reimburse primary-care practices for taking a more active role in their patients' overall care.

For example, these primary-care doctors would make sure patients are seeing specialists for chronic conditions or behavioral-health care, ensure that medications from multiple providers are safe and effective when taken together, and prevent duplicate tests from being ordered by different providers.

Under the Iowa legislation, too, Medicaid beneficiaries will be served by accountable care organizations, which will integrate clinical services with other social services.

Qualifying ACOs will receive bonuses, for example, in exchange for

- performing annual physicals on at least half of all patients;
- meeting expectations of quality primary care, such as providing a patient's first contact with the health care system and providing coordinated care;
- offering "after hours" care, which may help patients avoid emergency-room visits; and
- supporting patients in adopting healthy behaviors, such as encouraging them to complete preventive care.

These are just some examples of how one state is choosing to measure and incentivize quality.

"Value-based purchasing links payment in some way to the quality of care," Stanek says.

"For example, accountable care organizations are based on a shared savings approach: [the plan] has to show it achieved savings, but it has to prove that it hasn't harmed quality." But with so many different areas of health care, determining the definition of "quality" can be a challenge.

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 long 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.

Minnesota has had a statewide quality-reporting 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.

### % of Medicaid enrollees in managed care*

63.6%
65.7%
75.8%
63.7%
88.4%
91.1%
85.1%
67.8%
70.3%
75.4%
87.4%

* The U.S. average is 74.2%

*Source: Kaiser Family Foundation, "State Health Facts"*

### Medical homes: Trend in state policy stresses coordination, efficiency

The Affordable Care Act's requirement for most Americans to have health coverage is now in full force, and many previously uninsured Americans are having their first visit to a primary-care office in a long time.

Navigating the health care system can be overwhelming, but "medical homes" aim to serve as a single point of entry for their patients. And it turns out that they are not only more convenient for patients, but they can also result in healthier outcomes.

All but two Midwestern states (Indiana and North Dakota) have begun using the medical-home model in Medicaid and other public programs — sometimes with grants under the Affordable Care Act, the National Academy for State Health Policy reports.

Medical homes are primary-care practices that use a team approach to health care. A patient chooses or is assigned to a physician who agrees to coordinate all of the patient's health care. First and foremost, the provider ensures that a patient receives regular preventive care, such as physicals, immunizations and appropriate health screenings.

But medical homes go beyond typical primary care by also monitoring the care that patients receive in other parts of the health care system. The goal is to have a single entity tracking a patient's care instead of the often-fragmented current model, where patients may have multiple physicians keeping separate records.

Medical homes are also designed with the goal of improving patient access. Many offer extended office hours, for example, in an effort to encourage patients to visit their doctor's office instead of an emergency room.

In exchange for coordinating a patient's care, these practices receive enhanced fees — sometimes on a sliding scale according to the complexity of a patient's care. This funding is meant to help offset the cost of providing more-comprehensive care, such as hiring additional staff that can answer questions by phone or e-mail.

Proponents of the medical-home model say that in addition to improving the quality of care, it can also trim costs. When a patient has a single contact for all of his or her health needs, he or she is more likely to complete preventive care, which can identify health issues early and potentially avoid costly procedures later on.

Another key cost driver in health care is duplicative 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 tracking a patient's 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. 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.