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Value-Based Payment: The Role of Medicaid Programs

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In this time of political change and shift toward managed care, one thing seems certain: Value-based payment for healthcare will continue as a national priority to align healthcare payment with quality. The Medicare Access and CHIP Reauthorization Act (MACRA), for example, is heralded as bipartisan legislation that links payment to the quality of physician care. MACRA includes an all-payer variant, encouraging participation from both Medicare and Medicaid payers and providers.

What role will your Medicaid program play to emphasize more value in healthcare? Some states are delegating the measurement of outcomes to managed care plans (MCPs), but there are limitations to this approach:

- How do state Medicaid programs verify the accuracy of reported outcomes?
- Can you compare MCPs' or hospitals' performance with each other or to a benchmark?
- How do you measure improvement over time?
- How can you link hospital or MCP performance to payment?

Most large MCPs have measured outcomes for decades and have resources to do so credibly. However, this is not true of all MCPs. Even if there is agreement on a common set of measures, healthcare outcomes quantified by individual MCPs may not be comparable for many reasons. The programmer/analyst must understand the specific protocol for the measurement and be technically competent to produce the desired measure. (Healthcare Effectiveness Data and Information Set [HEDIS] measures often require programming and data analysis comparable to a mini-study with multiple analytical steps.) Many plans, highly focused on the daily routines of networks and claims adjudication, may have varying degrees of aptitude for the complexities of data maintenance, data cleanup and audit of the measurement, as well as varying levels of interpretation and statistical appropriateness.

Also, casemix adjustment of healthcare outcomes is critical for comparative analysis as the mix of patients can vary considerably by type of hospital and between MCPs. Also, many MCPs may not have access to casemix adjustment tools or to the statewide data needed to establish benchmarks and perform comparative analysis. Outcomes that are not casemix-adjusted are simply not sufficient as a basis for value-based payment.

Finally, an independent survey of Medicaid managed care plans in California found considerable variation in which outcomes are measured. In fact, only 25 percent of plans measure readmissions.[1] This is unfortunate considering readmission measurement is a critical cornerstone of healthcare performance measurement.[2]

A state Medicaid-sponsored quality healthcare outcomes initiative that informs hospitals and managed care plans of their performance compared to a benchmark will encourage improved health for Medicaid beneficiaries and ensure program dollars are spent wisely.

Leaders in the quality movement have reacted to the proliferation of quality measures by advising that payers "align with other payers on a smaller required set of high-impact and outcome-oriented measures."[3] The question is how best to drive true value-based care grounded in both quality improvement and cost savings given limited resources for both managed care plans and Medicaid programs.

Several states have already achieved double-digit decreases in inpatient complications and readmissions and saved hundreds of millions of dollars using a state-driven approach. Maryland,[4] Texas,[5] Illinois[6] and Minnesota[7] have all published improved healthcare outcomes. These range from Maryland's 26.3 percent reduction in potentially preventable complications between 2013 and 2014 to a 25 percent reduction in potentially preventable readmissions for the Texas Medicaid STAR program between 2012 and 2015. Others, such as New York Medicaid, have transparently published healthcare outcomes by hospital to encourage value-based care.[8]

How can state Medicaid programs help move value-based payment forward? One strategy that has proven successful in our experience is a state-orchestrated approach incorporating claims and encounter data.[9] When a state makes a reasonable investment of time and resources as a purchaser, it realizes benefits beyond self-reported measurement. In this scenario, the state controls both the methodology and the payment, ensuring that each measure is accurate and calculated similarly for each plan or hospital. This ensures that accurate comparisons of casemix-adjusted outcomes can occur at any level: MCP, hospital or region, for example. Plus, year-over-year monitoring of outcomes can be compared to a benchmark and tied directly to payment, providing a financial incentive for quality improvement.

Finally, a state is empowered to establish more pertinent healthcare outcome measures specific to a Medicaid population. Kevin Quinn, Vice President of Payment Method Development at Conduent, notes that "Medicare's focus on only three conditions for readmission – heart failure, heart attack and pneumonia – does not suit a Medicaid population."

Our Payment Method Development team has found that providers welcome a fair and transparent process that provides them with quality, actionable healthcare outcomes measures – information that can pinpoint areas of care that need refinement to achieve the triple aim of improving population health, reducing per capita healthcare costs and improving the patient experience.[10]

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References

1. Lally, S., Yegian, J. (2015). "California's Medi-Cal Managed Care Pay for Performance Landscape." ***Integrated Healthcare Association***, No. 18.

2. Quinn, K., Weimar, D., Gray, J., & Davies, B. (2016). "Thinking About Clinical Outcomes in Medicaid." ***Journal of Ambulatory Care Management***, 39(2).

3. Cassel, C.K., Conway, P.H., Delbanco, S.F., Jha, A.K., Saunders, R.S., & Lee, T.H. (2014). "Getting More Performance from Performance Measurement." ***New England Journal of Medicine***, 371(23), 2145-47.

4. Patel, A., Rajkumar, R., Colmers, J.M., Kinzer, D., Conway, P.H., Sharfstein, J.M. (2015, Nov 12). "Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model." ***NEJM***, No. 373;20

5. Dudensing, Jamie. "Medicaid Network Adequacy." Senate Bill 760 Public Stakeholder Forum. Brown-Heatly Public Hearing Room, Austin, Texas. 6 June 2016. Lecture. Presented by the Texas Association of Health Plans. Presentation slides available at http:// legacy-hhsc.hhsc.state.tx.us/medicaid/managed-care/sb760-docs/TAHP-Presentaation-Medicaid-Network-Adequacy.pdf.

6. "Hospital Inpatient Potentially Preventable Readmissions Information and Reports." Illinois Department of Healthcare and Family Services, n.d. Web. 06 Jan. 2017. <www.illinois.gov/hfs/MedicalProviders/hospitals/PPRReports/Pages/default.aspx>.

7. RARE is a campaign lead by the Institute for Clinical Systems Improvement, the Minnesota Hospital Association, and Stratis Health, which represents Lake Superior Quality Innovation Network in Minnesota which resulted in a 19 percent reduction in readmissions. More information available at www.rarereadmissions.org.

8. "Medicaid Hospital Inpatient Potentially Preventable Readmission (PPR) Rates by Hospital: Beginning 2011." ***Health Data NY***. New York State Department of Health, n.d. Web. 06 Jan. 2017. <health.data.ny.gov/Health/Medicaid-Hospital-Inpatient-Potentially-Preventabl/ckvf-rbyn>.

9. Texas Health and Human Services Commission (2013). "Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012" and "Potentially Preventable Complications in the Texas Medicaid Population, State Fiscal Year 2011." Public reports retrieved from www.hhsc.state.tx.us/reports/2013/PPR-Report.pdf and www.hhsc.state.tx.us/reports/2012/PPC-Complications-FY-2011.pdf.

10. Berwick, D., Nolan, T.W., Whittington, J. "The Triple Aim: Care, Health, and Cost." ***HealthAffairs***. Vol.27, no. 3. Pp 759-769.

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