Medicaid Payment Reforms:
State Options to Avoid and Address Underservice

Medicaid is now the largest coverage program in the nation, consuming over a quarter of state budgets, and that share is rising[1] at a rate that policymakers agree is unsustainable. A consensus has grown among state and federal policymakers that increasing spending is not driving improved quality, and that lasting reform will require a shift from a volume-based system to one based on value. States are on the cutting edge of a transformation in how we pay for Medicaid.

Potential for underservice

Medicaid is unique in the American health system for a number of reasons. As an income-based, entitlement program run by states with federal support that serves members at risk for poor health due to social determinants, it carries both unique strengths and challenges. Unnecessary over-treatment has received a great deal of attention as a driver of rising health costs in the wider health care system, but inappropriate under-service is also a problem across payer sources.[2] As health care payment moves away from volume-based systems such as fee-for-service to quality and risk based systems such as shared savings, the potential for underservice grows. Federal regulations acknowledge, "Programs that include incentives to reduce costs for care may result in unintended consequences such as avoidance of at-risk patients, [and] "stinting" on care".[3]

State strategies

State Medicaid programs have included provisions to monitor and discourage inappropriate under-service or "stinting" on care in new payment models.[4] All states have some safeguards to prevent underservice, but several states, led by Connecticut, have implemented novel underservice provisions.

- New Jersey requires Medicaid Accountable Care Organizations (ACOs), provider networks that receive rewards for lowering the costs of care for members, to demonstrate they are not rationing care with specific metrics.
- In Arkansas Medicaid's bundled payment initiative, providers who fall below a "gain sharing limit' of spending are ineligible for shared savings payments.
- Medicaid law in Oregon requires that health care providers participating in their reform program must "advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances."
- All state Medicaid reform programs include quality standards that providers must meet to qualify for savings rewards, risk adjustments to prevent avoidance of

Council of State Governments/Eastern Regional Conference
www.csgeast.org
Health Policy Committee
June 2016

costly patients, and mechanisms for consumers to report inappropriate denials of care.

- In addition, many ACOs are internally monitoring and addressing underservice[5].
- Accreditation as an ACO by the National Committee for Quality Assurance requires a system for underservice monitoring[6].

Connecticut's underservice safeguards

Connecticut policymakers have taken significant steps to prevent, monitor and resolve underservice as alternative payment models are adopted. Policymakers have made specific commitments that savings generated by inappropriately denying needed care or selecting more lucrative patients in Connecticut will not be shared with the providers or networks that underserved members. That commitment covers both Medicaid members and the state's larger health system through Connecticut's multi-payer State Innovation Model (SIM) initiative.[7]

To develop policies to support SIM's underservice policy, an Equity and Access Council (EAC) of consumers, providers, insurers and government agencies was convened. In June 2015 the EAC published a set of twenty-eight recommendations for payers and the state to prevent, monitor and address underservice in new payment models[8]. While the recommendations apply to all coverage groups in Connecticut, the EAC was particularly sensitive to the unique needs of Medicaid members and the risks of underservice in that population.

Among the EAC's recommendations:

- Patients should have the option to choose their own providers, be notified when they are connected to a provider, and notified of their rights.
- Consumers and providers must be fully informed about the new payment model and what it could mean for them.
- Consumers should be linked (attributed) to their provider at the beginning of the contract time period, rather than the end. Ensuring that providers know up-front the group of people they are responsible for, reduces any incentive to drop difficult or less lucrative patients.
- When savings are denied an ACO due to underservice or patient selection, those savings should be invested back into improvements in care.[9]
- Providers and ACOs that improve quality should be rewarded even if cost savings are not achieved within the payment timeframe. This removes an overly strong incentive to achieve savings that could result in underservice.
- Shared savings payments should be paid only to the ACO level, to reflect the entire team of providers responsible for the savings. Directly paying providers

based on savings from only their panel of patients could be a strong incentive to reduce care inappropriately.

- Rewarding improvements in quality, rather than only meeting a single standard, gives every practice a reason to invest in care.
- Incentives should be tied to the level of quality improvement, removing an all-or-nothing, "cliff" effect that could encourage aggressive savings to reach.
- Insurers, employers and government should share in the initial investments to create an ACO, as they will share in the savings.
- Against the use of minimum savings rates (MSRs). Eliminating the MSR ensures that providers and ACOs benefit from all the savings they achieve, even modest ones. MSRs create another "cliff" effect that intensifies incentives to underserve.
- Provider payments should be adjusted for unpredictable, uncontrollable costs (i.e. bad flu season, costly new treatments), costs associated with social determinants of health, and exceptionally high cost patients.
- ACOs should encourage peer review of cases. Current ACOs report that peer review is a very effective check on both under- and over-treatment.

The EAC's recommendations are voluntary for payers in the state, but Connecticut's Medicaid program has adopted virtually all of them in developing alternative payment models. In a currently evolving, ambitious plan[10] to move all 750,000 Connecticut Medicaid members into a shared savings, accountable care payment model, Connecticut's Medicaid program has followed the EAC's recommendations[11].

In 2014, when planning a Health Neighborhood Pilot of shared savings to cover Medicare and Medicaid eligible members[12], Connecticut's Medicaid program enlisted an existing oversight committee to make recommendations for an underservice monitoring system including specific metrics relevant to the population. The committee included providers, consumers, and state agencies that serve Medicare and Medicaid eligible members. The committee reviewed the literature and best practices, surveyed state and national stakeholders, collected proposals and drafted recommendations.[13] Thirty-eight candidate metrics were considered from existing sources including claims data, risk scores, chart reviews, care plans, and patient experience of care surveys. By consensus, the committee developed priority recommendations to the Medicaid agency. Recognizing that the list did not cover all potential opportunities for underservice, the committee strongly urged the agency not to notify ACOs in advance which metrics will be used to monitor for underservice until the contract timeframe has closed.

Connecticut's Medicaid program has a strong commitment to improving access to high quality care and protecting members from unintended consequences of payment reforms, with special attention to under-service. Policymakers and stakeholders share this deep commitment which is likely to persist as the state continues progress toward paying for value in health care.

[1] The Fiscal Survey of States, NASBO, Fall 2015.

[2] EA McGlynn, The First National Report Card on Quality of Health Care in America, RAND, 2006; W van de Ven et. al., Risk Selection Threatens Quality of Care for Certain Patients: Lessons from Europe's Health Insurance Exchanges, Health Affairs 34:1713-1720, 2015.

[3] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, Federal Register Vol. 76 No. 212, November 2, 2011

[4] R Houston and T McGinnis, Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations, March 2013; The Role of State Medicaid Programs in Improving the Value of the Health Care System, Bailit Health for the National Association of Medicaid Directors, March 2016; OR Rev Stat § 414.651 (through Leg Sess 2011)

[5] Webinar: Measuring Quality and Value at CrystalRun Healthcare ACO, CT Health Policy Project, April 17, 2014

[6] Accountable Care Organization Accreditation, NCQA

[7] A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP), CT Department of Social Services, April 13, 2015; Connecticut Health Care Innovation Plan, December 30, 2015

[8] Connecticut State Innovation Model (SIM) Report of the Equity and Access Council on Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements, June 25, 2015

[9] Note: This was the only recommendation that did not reach consensus by the EAC. Only insurance company representatives objected.

[10] At this writing, a Request for Proposals for networks to participate in the program is being drafted.

[11] A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP), CT Department of Social Services, April 13, 2015.

[12] Due to budget constraints, this pilot has not been implemented.

[13] MAPOC Complex Care Committee Underservice Process, Recommendations, July 20 and October 8, 2014.