Guiding principles: Innovative Medicaid delivery system and payment models

Introduction

States have been struggling with rising Medicaid spending for several years. In FY 2013, Medicaid consumed 24.4 percent of total state spending, the largest portion of total state spending, and 19.0 percent of general revenue fund spending, second only to elementary and secondary education.[1] As a result of budgetary pressures, state lawmakers and policymakers have implemented a series of cost cutting measures to the Medicaid program, including cuts to provider payments and optional benefits such as prescription drugs.[2] Unfortunately these short term "fixes" have been unsuccessful in bending the cost curve as they fail to address the underlying pressures of rising health care costs and, in fact, have harmed the program as lower payments result in fewer physicians accepting new Medicaid patients.[3] These flawed policies have also resulted in reduced access to care, a decrease in the overall health of Medicaid members and an increase in spending for other Medicaid benefits.[4]

To protect the viability of Medicaid as a safety net provider, the AMA encourages lawmakers to implement long-term policies that facilitate innovative health care delivery system and payment models that promote improved access to high-quality, cost-effective care. In fact, state Medicaid programs have been and will continue to be laboratories for innovation and will continue to play a key role in establishing innovative delivery and payment models across the country. The establishment of the Center for Medicare and Medicaid Innovation (CMMI) has further spurred reform by funding innovative projects at the state, regional, and local level that are focused on improving the quality and reducing the cost of care for Medicaid populations. As examples, CMMI has funded numerous such pilots through the Health Care Innovation Awards program and the State Innovation Models Initiative. While varied, these and other efforts strive to reach the same goal – to provide high quality, better coordinated, cost-effective care to Medicaid members. The AMA supports this goal and recognizes it can be achieved through a broad range of reforms. Successful state efforts have a few common elements discussed below that we believe have helped ensure their success.

- **Physician led.** Physicians have been actively involved in the development and implementation of the new delivery system and/or payment model. In many cases physicians have led the reform efforts.

- **Community based.** The delivery system is community based, meets the unique needs of the community and involves community partners where appropriate.

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[1] National Association of State Budget Officers, State Expenditure Report: Examining Fiscal 2011-2013 State Spending (November 21, 2013).
[2] *Id*.
[3] Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 Health Affairs 1673 (August 2012).
[4] Benjamin D. Sommers, et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, New England Journal of Medicine (August 28, 2012). Allen H. Baiker, et al., *What Oregon Health Study can tell us about expanding Medicaid*, 29 Health Affairs 1498 (2010); Amy Finkelstein, et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, National Bureau of Economic Research (July 2011).

- **Care coordination through physician-led health care teams.** The delivery system focuses on improving the health of Medicaid members through physician-led health care teams that promote care coordination. These teams are often multi-disciplinary, including both health care providers and community stakeholders.

- **Robust collection and sharing of data.** Successful new models feature a robust data collection system in which information is compiled and shared with the provider community for internal cost and quality monitoring and improvement. In addition to helping facilitate care coordination, these data systems also often help physicians and other providers self-assess how they provide care. A robust data system is critical to help monitor and evaluate the success of a new payment and/or delivery model.

- **Flexibility and adequate payment.** The new delivery and/or payment model allows various practice sizes, patient mixes, specialties and locales to participate and provides adequate payment rates to cover the full cost of a sustainable medical practice.

Implementation of the Patient Protection and Affordable Care Act (ACA) and state and federal budgetary pressures has provided the impetus for historic changes to the Medicaid program. While the overall fiscal situation in the states has improved, Medicaid continues to be one of the fastest growing portions of state budgets. State Medicaid directors, legislators and policy makers across the country have been challenged to implement policies to bend the cost curve, while improving the quality of care and access to care for Medicaid beneficiaries. We urge state lawmakers and policy makers to implement policies that facilitate innovative health care delivery systems and payment reforms that promote improved access to high-quality, cost-effective care.

Following is a set of guiding principles based on AMA policy that can be used as a guide when reviewing new state Medicaid delivery system and payment models.

Guiding principles

The AMA supports the following Principles when developing innovative Medicaid delivery system and payment models.

1. The AMA supports physician led reforms that enable practice innovations, best serve the needs of patients, and enhance the value of health care delivery. (CMS Report 8 A-11)

2. AMA policy supports a broad range of reforms that improve patient access to high quality, cost effective care for Medicaid beneficiaries. (H-390.849)

3. Physicians must be actively involved in the development of reforms to modernize Medicaid's delivery and payment system. AMA policy supports reforms that are designed with input from the physician community. (H-390.849)

4. Innovations must meet the unique needs of the community and involve community partners where appropriate. (D-390.961)

5. New payment models must be based on payment rates sufficient to cover the full costs of a sustainable medical practice. (H-290.980 and H-290.976)

6. Physicians must have the freedom to choose whether to participate in Medicaid. (H-275.994 and H-285.989)

7. New delivery system and payment models should be monitored and evaluated on an ongoing basis to determine whether the reforms are achieving the goals of improving patient care and increasing the value of health care services. (H-390.849)

8. Delivery system and payment reform must be implemented within a reasonable time frame. Physicians must be given sufficient notice prior to implementation and adequate support throughout the implementation process. (H-390.849)

9. Delivery system and payment reforms must provide options that allow various practice sizes, patient mixes, specialties and locales to participate in the program. (H-390.849)

10. The AMA supports delivery system reforms that include a physician-led team approach to patient care. (H-360.987[1,2,6], H-200.994 and D-35.985[6])

11. Delivery system and payment reforms should include a patient education component and mechanisms to incentivize patients to become active participants in their own care. (H-373.994 and H-373.997)

12. The AMA supports case management and disease management approaches to the coordination of care in the Medicaid managed care and fee-for-service environments. (H-290.982(17))

13. New payment models must use adequate risk adjustment methodologies.

14. New payment models must include robust, clearly delineated data sharing mechanisms that allow the physician and/or his or her practice to accurately evaluate the adequacy of the payment and to identify opportunities to achieve savings and quality improvement goals.

15. The AMA encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches. (H-290.982[3])

16. The AMA supports Medicaid beneficiaries' freedom to choose whether they would like to participate in a Medicaid managed care plan. (H-290.984)

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