Medicaid value-based care: Should your practice take part?

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The Medicaid landscape is creating additional pressure on practices that are already relying on Medicaid payments that often fail to cover the full cost of care for this vulnerable population. Many state programs are making significant changes by combining payment and system-delivery reforms to introduce value-based purchasing initiatives that create new requirements for accountability, efficiency and quality.

The AMA offers extensive resources to help you navigate evolving physician payment and delivery models. Among these is “Evaluating Medicaid Value-Based Care Models,” which describes the new Medicaid models being implemented across the country, offers guidance for participation in these new programs, and identifies key elements that will affect physicians’ clinical practices moving forward.

Here are some essential points for your practice to consider regarding these various Medicaid reforms.

**Patient-centered medical homes (PCMH).** The PCMH places responsibility for patient care on a multidisciplinary team. The model is designed to coordinate referrals for specialty services, improve access and use of primary care services, and encourage effective management of beneficiaries’ chronic conditions.

A key consideration for practices exploring this model is whether the financial benefits will cover the extra resources needed to meet PCMH requirements and if the practice will need to grow or maintain a significant Medicaid beneficiary population to participate in their state’s PCMH program.

**Health homes.** These are intended to expand the PCMH concept and provide for more payment for patients with complex needs who may have multiple chronic conditions or a serious and persistent behavioral health condition.

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resources.

**Medicaid ACOs.** Most states that have implemented a Medicaid ACO program include quality measures that affect payment. They also rely on provider-led systems and use a shared-savings model that encourages those providers to take on risk.

A key consideration for physicians exploring this option is the required time, energy and resources required. Independent physicians may also need to find appropriate partners if they desire to fully participate in ACOs.

**Delivery system reform incentive payments programs (DSRIPs)** encourage systematic changes in the way Medicaid beneficiaries receive care and tend to target larger, institutional organizations. For example, Arizona’s programs for individuals transitioning from incarceration or individuals with behavioral health needs is an example of DSRIP efforts.

The program’s impact on practice affiliation is a key issue to consider. If a practice is affiliated with a large provider institution it may already be participating in a DSRIP—maybe even unknowingly. DSRIP participation may affect the practice’s interaction with these providers and may also make it subject to specific quality and performance-improvement goals.

**Pay-for-performance measures** are the most common mechanism used in all value-based payment programs, not just Medicaid. As a result, physicians are often subject to multiple sets of measures that may conflict with each other.

A key issue to be aware of is that some measures may unintentionally emphasize metrics such as patient satisfaction that are not tied to optimal health outcomes.

**Medicaid shared-savings arrangements** generally come in two flavors: Comprehensive, and episodic (or bundled) payments.

It may be difficult for small organizations or independent physicians to effectively participate in a comprehensive program that holds providers accountable for the beneficiaries’ full continuum of care.

A key issue is that the risk involved for a practice is that its payment may be affected by others upstream or downstream from where the practice is providing care. On the positive side, such arrangements provide an opportunity for physician leadership in regional improvement of care and reduction of costs.

For bundled payments, a key consideration is to pay attention to quality. While cost is naturally a focus of shared-savings arrangements, programs require physicians to hit specific quality targets “to ensure patient care doesn’t suffer in the name of efficiency,” the resource states.

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