Value-based Payment Reform in a Managed Care Environment:
Innovator States' Experiences with Episodes of Care

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The North Carolina Medicaid program's transformation to managed care later this year means the state's Department of Health and Human Services (NC DHHS) will now delegate much of the administration of the health insurance program to five managed care plans [1]. This change does not mean, however, that NC DHHS will relinquish all of its control and responsibilities over Medicaid. In fact, it will maintain several levers to implement its policy agenda through the new system.

One of NC DHHS's stated policy goals for managed care is to improve the quality and value of care delivered to Medicaid members by promoting value-based payments (VBP) that link provider payments to quality measures and outcomes, and the Advanced Medical Home program is a key, statewide, VBP model that North Carolina is implementing as part of the transition [2, 3]. To better understand how the state might install such a broad-scale VBP model that impacts plans and providers across the state in a Medicaid managed care environment, we studied how three innovator states have implemented similarly expansive episodes-of-care VBP models.

State Background

Tennessee, Ohio, and Arkansas have each implemented a multi-payer, episode-based payment reform with support from the State Innovation Models (SIM) program facilitated by the Centers for Medicare and Medicaid Service (CMS) [4]. SIM is a state-federal partnership for developing and disseminating promising state-based payment and care delivery models, and as a high-profile innovation model program, the design and implementation experiences for participating states have been studied and reported publicly by CMS's independent evaluators, other independent analysts, and researchers [5-11].

We were also interested in these states because they aimed not only to implement payment reforms within their own Medicaid programs, but also to use Medicaid as a vehicle for promoting multi-payer payment reforms. Payment reforms introduced by a single payer in a given health care market may not sufficiently attract providers' attention because individual payers are often only responsible for a minority of the patient volume for which a typical practice delivers care. Multi-payer reforms, in contrast, aim to reduce administrative burdens for providers so the same model can be adopted across multiple payers, thus expanding the reach and potential impact of payment reforms.

We reviewed published academic and grey literature covering the SIM initiative evaluation reports and documents provided by the state agencies, such as their episode definitions and specifications. We also collected surveys from and conducted interviews with CMS officials who oversee the SIM program and with Medicaid and health and human services agency leaders from each of the three states who played roles in designing, implementing, and/or managing their states' episodes-of-care programs.

In contrast to a fee-for-service payment structure, in which payments are made for each individual health care service delivered, an episodes-of-care payment model defines an episode as a set of services delivered, often by multiple providers and in multiple settings, over a defined period of time to treat a condition or conduct a procedure [12, 13]. Joint replacements and maternity care are two common examples of episodes [9, 10, 14, 15]. These models function by setting a price target intended to cover the full set of services provided over the course of the episode and have been developed in response to research showing wide variation in costs across different providers treating the same conditions [16, 17]. Specific model designs vary, but by defining episodes and establishing a payment level to cover them, payers aim to contain the variation in costs, while providers—which typically have the opportunity to share in any savings for delivering care below the episode payment target while meeting required quality of care metrics—are rewarded for working collaboratively to deliver high-value care [13].

Implementation Experience

The top-level finding is that, although it takes significant stakeholder engagement and technical resources,

states can leverage their regulatory authority and purchasing power through Medicaid to implement multipayer payment reforms. The Medicaid programs in each of the states we examined, even if predominantly or entirely managed care like Ohio and Tennessee, respectively, implemented an episodes-of-care model and commercial payers adopted it as well. For example, in Tennessee the episodes-of-care model has been implemented by all three of the state's Medicaid managed care organizations, the state employee health plan, and multiple commercial insurers [18].

Although states can mandate the implementation of VBP reforms, this top-down directive approach is not sufficient to ensure successful enactment. States must also convene key health system stakeholders in the model design and implementation processes, make concessions as needed, and remain adaptable to ensure durable support for payment reforms. For example, the leaders we spoke with in all three states explained that commercial payers participating in their episodes of care programs have flexibility in regard to certain program features, such as which clinical episodes they choose to implement and how they set any financial incentives. In Tennessee, starting in 2014, the state set an ambitious schedule of launching over 70 episodes-of-care payment models in its Medicaid program in waves over the coming years [19], but the models have elicited concerns from providers, including the state's medical association, which has advocated for refinements and improvements to the program from the perspective of participating physicians [20]. Since the launch of the first models, the TennCare Strategic Planning and Innovation team that manages the episodes-of-care program has established avenues for stakeholders to discuss their concerns, including through monthly provider stakeholder group meetings and an episodes-of-care annual feedback session [21]. In response to stakeholder input, the state flexibly makes changes to the program that impact both payers and providers. For example, after receiving comments with concerns about low-volume providers being burdened by episodes-of-care administration and potentially being held accountable twice for patients with "overlapping" episodes, the state established new exclusions that will keep providers with very few patients in qualifying episodes out of gain- and risk-sharing calculations and prevent redundant accountability [22].

In addition to wielding Medicaid's regulatory authority and achieving stakeholder buy-in, successful implementation of episodes of care programs required states to draw on federal financial and technical resources, in this case through the SIM program. The episodes-of-care programs were constructed on a foundation of robust data analytics. Early in the design process, claims data analysis was required to identify which treatments and procedures were good candidates for the episodes program and for defining episodes. Once implemented, strong data analytic capacity is required to produce accurate and timely reports for providers and for fairly calculating performance. For states with managed care systems, this requires the construction and operation of data infrastructure that facilitates the agile flow of data between the state, the plans, and the providers.

Once this data infrastructure was established, it enabled the operation of episodes-of-care programs and facilitated greater transparency around performance on cost and quality measures that may be important for encouraging practice transformations. State leaders told us that before the launch of the program, providers were not typically receiving—and therefore were unable to review—much data about their performance on meaningful measures of costs and quality of care on a timely basis. With the regular reporting generated by the episodes-of-care programs, providers now have clear metrics they can monitor to improve the value of the care delivered, and they can compare themselves to peers along the same measures.

Conclusion

At the time we spoke to state leaders, approximately 80% of Ohio's and 100% of Tennessee's Medicaid enrollees were covered by managed care plans, but we found that these states were still able to leverage their regulatory authority and unique capabilities to design and implement a value-based change in the way providers are paid in their states. NCMJ

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