Medicaid ACO Pediatric Quality Measures and Innovative Payment Models

Select States
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Introduction

Since the Medicaid program was implemented 50 years ago, it has undergone several evolutions and expansions—transforming from a cash assistance welfare-like program to a true health care coverage program that covers more than 1 in 5 Americans. Mirroring the commercial market, Medicaid's delivery system has also evolved over time, moving from fee-for-service (FFS) to risk-based managed care to increasing use of Accountable Care Organizations (ACOs), shared savings models, and other incentive payment arrangements based on quality measures.

This current evolution is driven by both state and federal initiatives, including the State Innovation Model (SIM) program,[1] which was launched by the Center for Medicare and Medicaid Innovation (CMMI) in 2012. SIM is a targeted effort to accelerate broad scale development and testing of new service delivery and payment models that have the potential to increase the quality of health care while lowering total costs. The majority of states that received SIM grants are implementing some sort of ACO model and/or alternative payment arrangement, and if those are successful, more states are likely to follow. Below are some examples of current state ACO initiatives.

Alabama

Alabama Medicaid implemented Patient Care Networks (PCNAs) in 2012, creating four community networks that assist primary care providers to become medical homes, coordinate care, and teach self-management skills. This program is now being expanded statewide as an interim step toward implementation of Regional Care Organizations (RCOs). RCOs are Alabama's version of ACOs.

RCO Model Overview

Approved Orgs: 6 in process of approval
Covered Lives: 800,000
Payment Model: Capitated payment to RCOs, which determine how to apportion that among providers in both fee-for-service and at-risk contracts.
Pay for Performance/Quality Approach: Still developing. A Quality Assurance Committee aims to complete measures when RCOs begin, Oct. 1, 2016.

Under the PCNA program, pediatricians have access to additional support to improve care quality. PCNA providers are paid on an FFS basis with additional care management payments. Providers are also eligible to participate in shared savings. The RCO initiative will utilize a payment model that includes capitation with care management payments (after an initial transition period that uses FFS). The state intends to implement value-based purchasing strategies and proposes to potentially include care coordination fees and quality and efficiency incentive payments to providers.

Metrics: A Quality Assurance Committee was formed to determine the metrics for the new RCOs. The committee voted on a set of 42 nationally recognized metrics, 10 of which will be used in an incentive program. Metrics related to children include: 1) medication management for people with asthma; 2) timeliness of prenatal care; 3) timeliness of postpartum care; 4) percentage of live births weighing less than 2,500 grams; 5) follow-up after hospitalization; 6) well-child visits; 7) adolescent well-care visits; 8)

[1] For full details on the SIM Initiative, see http://innovation.cms.gov/initiatives/State-Innovations/.

ambulatory care-sensitive condition admission; 9) transition record transmitted to health care professional; and 10) diabetes care.

Arkansas

AHCPII Model Overview

Program Approach: Payers designate a Principal Accountable Provider (PAP) who bears partial risk, in that certain episodes of care are included in the ACO program, but not all are.

Covered Lives: 243,000

Pay for Performance/Quality Approach: PAPs are required to report quality indicators which differ for each episode type; those not meeting quality targets are not eligible for shared savings.

Arkansas' Medicaid program utilizes an FFS payment system but is also engaged in a care bundled payment program titled the Arkansas Health Care Payment Improvement Initiative (AHCPII), in collaboration with two commercial insurers. Providers are designated as the principal for specific episodes of care. For the first wave of the program, five episodes were introduced: upper respiratory infections (URIs), total knee and hip replacements, congestive heart failure (CHF), attention-deficit/hyperactivity disorder (ADHD), and perinatal (pregnancy). Additional episodes that have been deployed or are under development since the first reporting period include: tonsillectomy, asthma, attention-deficit/hyperactivity disorder (ADHD)/ oppositional defiant disorder (ODD) comorbidity, neonatal care, and others.

Metrics: The Arkansas Medicaid program reports on 13 of the 24 core Medicaid/Children's Health Insurance Program (CHIP) Children's Health Care Quality Measures (see document for list of the child core set of measures). The episode of care initiative also measures the performance of individual practitioners for the defined episodes of care and provides gain share/loss based on meeting the procedure's defined metrics.

Colorado

Regional Care Collaborative Organizations (RCCOs) expand primary care medical home services to the Medicaid adult and pediatric populations. Each enrollee is linked to a primary care medical provider under the RCCO. The provider is responsible for assessing members' medical and nonmedical needs and helping them access services such as housing assistance, long-term care, behavioral health care, transportation, and food assistance. RCCOs receive $13 per member per month (PMPM), and primary care medical providers receive $4 PMPM for medical home services in addition to FFS payments. Once an RCCO shows cost neutrality, $1 PMPM is withheld from both the PCMP and RCCO, creating a shared incentive payment pool, which can be recouped by meeting specific performance goals.

RCCO Model Overview:

Approved Orgs: 7 RCCOs

Covered Lives: 352,236

Payment Model: Medicaid program pays $20 PMPM: $13 to the RCCO, $4 to the Primary Care Medical Provider (PCMP), and $3 to the Statewide Data Analytics Contractor (SDAC). The agency began withholding $1 PMPM, which RCCOs and PCMPs can earn back for meeting performance standards.

Pay for Performance/Quality Approach: The agency withholds $1 PMPM to create an incentive pool, which RCCOs and PCMPs can earn back quarterly for meeting performance benchmarks.

The Colorado Medical Homes for Children program offers primary care practices pay-for-performance payment for well-baby and well-child visits for children enrolled in Medicaid. The state is working to move the Medical Homes for Children Program into the ACC/RCCO Program.

Metrics: RCCOs track 4 metrics, 1 of which is well-child visits.

Massachusetts

In 2014, Massachusetts implemented the MassHealth Primary Care Payment Reform Initiative (PCPR). It is built off a patient-centered medical home (PCMH) model and provides primary care providers with risk-adjusted capitated payments, with the option to include some outpatient behavioral services as part of the capitation. The program also includes shared savings payments and incentive payments for meeting quality metrics. The state also has a Pediatric Asthma Bundled Payment Pilot that is designed to support integrated, preventive care for pediatric Medicaid patients with asthma.

PCPR Model Overview:

PCPs Approved: 30 physicians
Covered Lives: Planned 600,000
Key Facts: Jointly led by MassHealth's (state Medicaid) primary care case management program and Medicaid managed care organizations (MCOs). Three types of providers: Individual or Group Practices, Hospital Health Centers and Outpatient Departments, and Community Health Centers; each holds a contract with MassHealth.
Pay for Performance/Quality Approach: Annual incentive for pay-for-reporting year 1, and P4Q incentive for performance on defined primary care quality metrics in year 2 and 3. No weighting details released.

Metrics: A recent report indicates that there are 18 quality measures for both the adult and pediatric populations. In terms of pediatric quality measures, a preliminary list focused on National Quality Forum (NQF) metrics, including: 1) asthma medication management; 2) body mass index (BMI) assessment and counseling; 3) adolescent immunization; 4) developmental screening in the first five years; 5) well-child visits for <15 months, 3-6 years, and adolescents; 6) childhood immunizations; and 7) ADHD medication management for children.

North Carolina

North Carolina's Medicaid delivery system, Community Care of North Carolina (CCNC), is a community-based plan that involves primary care providers, safety net organizations, hospitals, social services, local health departments, and other community agencies. Networks and providers in the network receive a PMPM payment from the state. CCNC received a Health Care Innovation Challenge award from the Center for Medicare & Medicaid Innovation (CMMI) to implement the Child Health Accountable Care Collaborative (CHACC). The program aims to improve care for children with complex medical conditions. CMMI grant funds will allow CCNC to embed specialty care managers in hospitals and specialty clinics to work closely with primary care providers.

CHACC Model Overview:

Approved Orgs: 14 Community Care Networks, 5 academic medical centers, and 7 tertiary care hospitals
Key Facts: Built of the medical home model, CCNC embeds children's specialty care managers in hospitals and specialty clinics to work closely with pediatric subspecialists and PCPs. Patient Coordinators also provide additional assistance to families navigating complex medical services.

Metrics: CCNC's core Quality Measurement and Feedback (QMAF) program was expanded in 2009. Most measures developed under this process are not pediatric specific, but many include review for children's information. Quality measures are reported to the primary care practices to encourage improvement relative to benchmarks from the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and Improving Performance in Practice (IPIP). CCNC also conducts a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey every 3 years for both adults and children.

The Western North Carolina Pediatric Collaborative: The Western Collaborative is not a Medicaid ACO but serves as an example of how an ACO could develop. The Collaborative started when three pediatric practices in Western North Carolina joined with Innovative Approaches, Community Care of Western North Carolina, and the Mountain Area Health Education Center to pursue PCMH designation. That group then decided to expand to a patient-centered medical "neighborhood." Multiple practices (pediatric, family practice, and specialists) collaborate to improve community health.

Ohio

Ohio does not have a Medicaid ACO; however, the Ohio Nationwide Children's Hospital: Partners for Kids (PFK) is physician-hospital organization that serves a significant number of Medicaid and other low-income children. PFK is jointly owned by Nationwide Children's Hospital, primary care physicians, pediatricians, and specialty care providers. It operates as a pediatric ACO-like network that receives capitated payments from Medicaid MCOs. As such, the contractual arrangement exists between the ACO and the MCOs and not between the ACO and the state.

PFK Model Overview:
Covered Lives: 300,000
Payment Model: Receives a capitated payment from the Medicaid Managed Care health plans. A contractual arrangement exists between the ACO and the plans that is not officially sponsored by any of the regulatory initiatives at the federal level.
Implemented: Since 2005, PFK has operated under capitated arrangements.

Metrics: Quality measures are derived from the Agency for Healthcare Research and Quality's (AHRQ) Pediatric Quality Indicators. Four additional measures PFK targets include neonatal intensive care days, emergency department (ED) visits for asthma, diabetes care management, and 3- to 6-year-old well-child visits.

Oregon

Oregon's Coordinated Care Organizations (CCOs) are a partnership of payers, providers, and community organizations that provide coordinated health care to children and adults enrolled in Medicaid. CCOs are given a global budget from the state, which gives them the flexibility to create alternative payment methodologies for providers and explore new strategies for care delivery. New payment methods are being developed that reimburse providers as well as nontraditional health care workers on the basis of outcomes and quality through shared savings and incentives.

CCO Model Overview:
Approved Orgs: 16 CCOs
Covered Lives: 627,000
Key Fact: Oregon is the first state to transfer its entire Medicaid population into CCO coverage. The CCO program is modeled on "hot-spotting," using ED and hospital admission records to identify highest-utilization patients.
Report Results: A June 2014 report also noted an increase of 58% in developmental screening for children under 2 years old and an 11% increase in PCP visits, with spending on primary care and preventative services up 20%, along with many other results.

Senate Bill 436 (2013) established guidelines for CCOs to focus on children's health in the development and adoption of their required CCO community health improvement plans. A 2014 report to the Senate stated that more than 80% of CCOs included plans for working with the state Early Learning Council or school health providers, and more than 90% included plans for coordinating effective and efficient delivery of health care to children and/or adolescents.

Metrics: Pediatric-specific incentive metrics for the CCOs include: 1) adolescent well-care visits; 2) developmental screening in the first 36 months of life; 3) follow-up care for children prescribed ADHD medication; and 4) mental and physical health assessment within 60 days for children in the custody of the Department of Human Services. Pediatric-specific performance metrics include: 1) appropriate testing for children with pharyngitis; 2) child and adolescent access to primary care practitioners; 3) childhood immunization status; 4) immunization for adolescents; and 5) well-child visits in the first 15 months of life.

Vermont

The Vermont Medicaid Shared Savings Program (SSP) is a performance-based contract that distributes financial incentives through shared savings. Two ACOs (OneCare Vermont and Community Health Accountable Care) participate. To receive shared savings, ACOs must meet a minimum savings rate, after which they are eligible to receive up to 50% of savings, depending on quality metric performance. Upon contract, ACOs may choose whether to participate in shared losses.

Metrics: Pediatric-specific quality metrics included in the program are: 1) adolescent well-care visits; 2) developmental screening in first 3 years of life; 3) depression screening by 18 years of age; 4) appropriate testing for children with pharyngitis; 5) childhood immunization status; and 6) pediatric weight assessment and counseling.

Medicaid SSP Model Overview:

Approved Orgs: 3

Covered Lives: 139,900

Key Fact: Vermont's SSP is 1 of 3 health care delivery and payment models that began in Jan 2014. The state is creating a statewide claims dataset (VHCURES) that maps key measures of utilization and a statewide health information exchange for continuity of care and other reports.

Payment Model: Two-track program: track 1 has no downside risk in the first year with a 50% savings rate, and track 2 has 2-sided risk with up to 60% shared savings and increased risk each year. Points are assigned on the basis of quality performance for earned savings eligibility. There is an option to expand the service spectrum in year 2 for a higher savings rate.