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DRIVING INNOVATION ON THE GROUND: *KEY ISSUES FOR STATE MEDICAID AGENCIES IN PAYMENT AND DELIVERY SYSTEM REFORM*

Executive Summary

State Medicaid programs have taken on a number of different reforms in order to improve quality and enhance program efficiency. State reforms span incremental changes in payment to large scale health system reorganizations and occur across a number of existing delivery system models. Driving innovation through fee-for-service (FFS) or managed care, or through accountable care organizations (ACO) or payment innovations like episodes of care, requires different functions and responsibilities on the part of the Medicaid agency during implementation. However, across different reform strategies, three elements stand out as major issues for state agencies designing and implementing reforms:

- Incorporating the perspectives and priorities of providers into reform design and implementation;
- Finding adequate resources – notably staff with the necessary skills – to develop and oversee reforms; and
- Supporting reform "infrastructure" at all levels that allows realigned incentives to work effectively.

While many facets of reform are determined by each state's specific circumstances, states in general have demonstrated a strong interest in pushing for change at the provider-level. These changes require a range of new capabilities, including the capacity to engage and support providers in delivering on these reforms.

Introduction

With the support of The Commonwealth Fund, the National Association of Medicaid Directors (NAMD) brought together staff from states over a period of a year to focus on data analytics, practice transformation, and multi-payer alignment. While states were organized into different workgroups to address these issues, reform proved to be a wide-ranging topic. As these workgroups discussed their respective state's work to drive innovation at the point-of-care for their beneficiaries, cross-cutting and coherent themes emerged. This brief reflects the discussions across the workgroups and all-state calls, and draws from state submissions to NAMD's *State Medicaid Operations Survey: Third Annual Survey of Medicaid Directors*.[1]

Across the board, states demonstrated a strong interest in supporting health care delivery improvements that would have an impact at the provider level across different initiatives and existing delivery vehicles. State agencies were interested in driving better care coordination and better health outcomes in both FFS and managed care

[1] NAMD. State Medicaid Operations Survey: Third Annual Survey of Medicaid Directors. November 2014.

environments, and across the range of potential innovative payment and delivery system models. The complexity of reform implementation in the design, roll-out, and maintenance phases often required a strong agency presence and a variety of supports for providers and other stakeholders in every delivery system model, whether the reform was focused directly on providers or on health plans.

State discussions also clearly demonstrated that payment and delivery system reform in Medicaid creates a new and quite different relationship with providers. Medicaid programs are moving beyond the historical norm of paying providers for discrete, uncoordinated services in favor of payment incentives and delivery innovations focused on quality. States are finding that they need new tools and resources to support providers and other stakeholders because of the changes necessary to meet new system demands. As states do more to facilitate change rather than just requiring it, state agencies are being transformed alongside providers.

Three themes emerged as cross-cutting factors that every Medicaid agency had to consider when adopting innovations focused on creating change at the point of care:

- First, Medicaid must incorporate the priorities of providers because of their essential role in bringing the reforms to fruition on the ground. Stakeholder engagement strategies in reform development put agencies in close proximity to providers and other stakeholders, even if there were buffers between the agency and providers in the form of a managed care organizations or other entities.
- Second, agencies faced strong resource and capacity demands in order to stand up payment and delivery system reforms. While some states were fortunate to have dedicated resources for new efforts, many states had to make due with flat budgets and rely on personnel with existing workloads to take on new duties and adopt new skills.
- Third, states were called upon not only to design or mandate change, but provide the crucial supports to ensure viability. This occurred even in reforms focused on health plans. Reform required information-sharing capabilities, reporting mechanisms, quality benchmarking, and other "infrastructure" that the state was either well-suited or necessary to provide for the sake of uniformity.

States Leverage the Stakeholder Process

"We have very healthy and organized groups of providers that have direct links to government… Many businesses built their practice on Medicaid."

- Workgroup Participant

A stakeholder process, which encompasses providers, is an integral part of Medicaid reform design and implementation. The reason is twofold. First, providers are the ones providing services and are the recipients of Medicaid dollars in a FFS system or downstream in a managed care environment. Second, the relationship between Medicaid and providers is more dynamic than just payer and collector. Medicaid's role as a social program creates opportunities for providers and other stakeholders to make their views known in the policymaking process to a degree that may not be seen in commercial markets.

Many states have found that the stakeholder process is best used as an ongoing way to promote objectives and solicit feedback, rather than a sporadic process to satisfy procedural requirements or a way to push out information. The power of financial arguments for instituting reform were seen by some states to be secondary in importance to the stakeholder dialogue process itself. Some states reported substantial changes in their plans based on the suggestions and concerns or providers, but the more essential benefit of dialogue was engagement over the long term.

States also noted that it was important to realize the stakeholder process is limited in that it cannot itself change provider priorities. States engaged in large-scale reforms often found that two conditions were present when they developed and implemented their reform design:

- First, providers were dissatisfied with the present system, whether they contended that provider payments were too low, or found that expenditures were on an unsustainable path, or some other reason. Providers responded to something more than just the promise of greater opportunity under reform – there was usually dissatisfaction with the status quo.
- Second, providers generally believed that there was benefit to a change. States have found that providers are often wary of changes to payment because they do not know if new criteria will take their circumstances into account. Medicaid programs have to demonstrate that new designs will benefit providers and articulate a positive vision for provider success under their reforms.

The state-provider relationship is key because states are asking providers to reinvent themselves both in how they approach patients and in how they put their business model into place. This represents a sea change in how many providers have gone about their practice for decades. In order to alleviate apprehensiveness and confusion, states have found it beneficial to engage all parties in reform through a strong stakeholder process.

Agency work to develop relationships with providers may produce future dividends for the state. Providers may be wary to agree to changes in payment or delivery systems at the outset of reform planning or implementation, but they appreciate the dialogue with state officials and the opportunity to be heard. As a payment or delivery system reform becomes a more permanent feature of a state's Medicaid program, providers may come to appreciate the ensuing changes in their practice. With stronger relationships, some states found that subsequent initiatives generated more and stronger support.

States have also noted that other stakeholder groups – such as sister state agencies, vendors and contractors, and other groups and institutions – are important to work with in designing and implementing reform. While providers and provider organizations deliver many of the services encompassed by reform, other institutions have a valuable role to play as supports for reform or as service providers themselves. Furthermore, other stakeholders have influence over the policy process and with providers with which they regularly work. States have found that stakeholder processes that bring in the views of all participants in a health system affected by innovation can lead to greater success.

Resources and Capacity are Essential

States' foremost hurdle in standing up payment and delivery system reforms is capacity. In order to manage reform, Medicaid agencies must have the operational capacity to take on new functions. States develop that capacity through expanding or modifying staff resources, and/or employing contractors to meet the often intensive requirements. New functional roles like payment analysis and redesign, quality measurement and improvement, stakeholder relations, monitoring and program integrity, evaluation, and other areas are needed to transition payment from FFS toward value.

> *"The new design … requires a more skilled workforce (e.g., actuarial, data analytics, policy development and writing, financial oversight) than the fee for service system. To attract such workers we have had to offer significantly higher salaries than previously authorized by the Agency."*
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> *- Workgroup Participant*

States continue to face challenges in standing up reforms due to administrative capacity limitations. As

noted in NAMD's Third Annual Operations Survey, nearly three out of four states are engaged in the planning or implementation of four or more reforms, many of them focused directly on changing delivery systems, like health homes and accountable care organizations. Unfortunately, many states draw the bulk of staff capacity to plan and implement reform by adding to the workload of existing staff. When asked to describe their chief implementation challenge in the Third Annual Operations Survey, half of states that answered named administrative capacity – specifically limited staff. [2]

Medicaid programs must live within budgetary limits set down by state legislatures and Governors. Medicaid Directors may not always have the flexibility to reallocate resources internally to the degree needed to free up staff for reform efforts. To fill the gap, states have tapped Delivery System Reform Incentive Payment (DSRIP) program dollars, State Innovation Model (SIM) grants, and other federal opportunities to jump start their reforms. Some states have noted that even these resources are not always sufficient to avoid strain on already scarce state resources. Agencies will continue to need to access resources beyond pre-reform administrative expenditures in order to put innovative strategies into practice.

Payment and delivery system reform often relies on carefully designed, data-driven decision-making applied to reimbursement. States can supplement some of the technical and policy development with consultants or other entities, but some states prefer to build the capacity in house. Technical assistance and other resources can help states fill the gaps, but the resource demands remain substantial. Technical assistance cannot supplant the need for financial and staff resources.

Data analytics staff expertise, in particular, is notoriously hard to recruit and retain for states. This capacity is crucial as data analytics processes and results is shared with providers under many reform designs. For innovation to succeed, providers need timely information that is either best provided by states, or by contractors with substantial state direction and oversight.

States Supply the Infrastructure for Reform

> *"We are interested in enabling access to the right data at the right time at every level of the health care system, from payer to practitioner. But we struggle with knowing what data and analytics are important and actionable at each level. How do we ensure providers and care managers have the right actionable data? What data is actionable and meaningful? How do we engage the clinical workflow? How do we encourage data sharing across delivery systems, if it isn't happening already?"*
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> *- Workgroup Participant*

As noted above, additional state capacity is needed because state agencies can be called upon to build at least some of the crucial infrastructure that is used by providers and other stakeholders to engage in new payment and delivery systems.

As described in NAMD's *Data Analytics for Effective Reform: How State Medicaid Agencies are Leveraging Data for Payment and Delivery System Innovation*, states have worked to develop and deploy the tools that providers and plans use to participate in payment and delivery system reforms. These efforts include: provider and plan portals for quality reporting, which in turn can be used as a way for providers to assess their performance in comparison to others; contracting language for health plans to design provider-focused payment incentives that reward quality outcomes; and establishing statewide clinical data networks that enable electronic health record (EHR) sharing across provider systems. Infrastructure can also

[2] Id.

include the design of uniform quality metrics as many states have had to define and benchmark quality measures for providers and/or plans. [3]

The infrastructure role has arisen as states have realized that while reimbursement is a major driver of change, it must be paired with data that can be shared and standardized across providers. In order to succeed, providers need to see the context of their performance, i.e., the results of their work and how it compares to their competitors. While some states have been able to delegate the design and implementation of the information-sharing and reporting portals to managed care organizations or large provider systems, many have taken on that function themselves for the sake of uniformity across systems, or to play a more direct role in how reform is undertaken at the point of care.

Developing these tools have also led states to new conclusions on what motivates high performance. Some Medicaid programs have found that many providers believe they are among the best practitioners in their area of medicine. When confronted with data that demonstrates that this is not the case, providers will make adjustments in order to be favorably compared to their peers. States cite this professional drive to be high performing as a powerful incentive to make reform successful. However, to tap into it, states must present the right data in the right format to the provider, which can be a significant undertaking.

These critical supports are not ancillary to reform, but integral to the enterprise. As the new arrangements are often complicated and require Medicaid programs to push out information to providers, infrastructure becomes more important and this becomes another meaningful way that states engage with providers directly. This is true even in multi-payer reform initiatives. While some design and implementation efforts can be handled by other entities or state agencies in a multi-payer initiative, at a minimum, Medicaid programs have to align with other payers. States have consistently noted that large multi-payer reforms require substantial work on the part of Medicaid programs even when led by other institutions.

Conclusion

Many Medicaid programs—because of the unique and changing relationship the state has with providers, and because of the particular priorities and responsibilities that reform places on an agency—are focused on driving innovation at the point of care. In many circumstances, the state itself is designing new payment and delivery arrangements with providers. However, many states continue to leverage their existing managed care delivery systems to operationalize reforms but still retain an interest in how reforms will impact providers and beneficiaries.

There are certain commonalities across states. First, states generally have had to engage with providers in a robust stakeholder process in order to move forward successfully. Second, reform requires significant investment above an agency's existing administrative expenditures; every state engaged in significant reform impacting providers has confronted resource challenges. Finally, states are interacting with providers through infrastructure supports for reform that are essential to implementation, even if the financial incentives and other aspects of reform are operationalized by other entities.

Payment and delivery system reform represents a new era in Medicaid–provider relations. The major changes that have a significant impact on the agency and providers alike require new tools, more engagement, better data, and generally sustained effort on the part of state agencies to see successful implementation of new incentives.

[3] NAMD. Data Analytics for Effective Reform: How State Medicaid Agencies are Leveraging Data for Payment and Delivery System Innovation. April 2014.