Achieving Cost Control, Care Coordination, and Quality Improvement in the Medicaid Program

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Abstract: As Medicaid spending rises quickly, controlling cost while coordinating care and improving quality is paramount. Payment method reforms should reward providers that deliver beneficial care but not care of marginal value. This article draws lessons from previous payment reforms and analyzes the potential benefits for Medicaid of 7 specific proposals. The most promising are paying for quality (especially rewarding hospitals that reduce rates of potentially preventable complications and readmissions) and moving away from fee-for-service payment for "medical home" providers. To achieve reform, the article recommends a process characterized by persistence, attention to outliers, consultation, and timing. Key words: access, cost control, evaluation, healthcare costs, healthcare quality, Medicaid, reimbursement mechanisms

For Medicaid, the challenges of cost control, care coordination, and quality improvement are, if anything, more pressing than those facing Medicare and other payers. Spending is expected to surge 8.1 percent per year in the next 5 years, notably faster than either Medicare (5.7%) or national health spending (5.5%) (Sisko et al., 2009). Even this growth rate does not reflect the expanded role for Medicaid contemplated by many health reform proposals. Meanwhile, the states' fiscal situation is "increasingly dire" and "nearly unprecedented," according to the National Conference of State Legislatures (2009). To be sure, federal matching payments help states afford Medicaid. But, unlike the federal government, the states must balance their budgets. With Medicaid representing 21% of state government spending, the squeeze is on (National Governors Association and National Association of State Budget Officers, 2009).

To control spending states have 3 options: reduce eligibility, eliminate covered services, or reform payments to providers. Payment reform is most palatable, but reflexive rate cuts can undermine the program itself. The preferred path is to reform payment methods with the simultaneous goals of controlling cost, coordinating care, and improving quality.

Averill et al. (2010), in distilling their many years of experience developing payment methods, suggest 7 specific reforms for Medicare. This commentary extends their analysis to Medicaid. In the current environment, reforms that maintain access to quality care while reducing the growth in spending will have particular appeal.

VALUE PURCHASING AND PAYMENT METHODS

Value purchasing is characterized by a focus on value received compared with payment made, in other words, more health for...
the healthcare dollar. With US health spending the highest in the world by every measure, including per person and as a percentage of GDP, room for improvement clearly exists. One major area of opportunity, outside the scope of this article, is administration cost, and in particular the many efforts by private and public insurers, providers and patients, and federal and state governments to simply shift costs to other parties. Another is the prices that Americans pay for health care (Oberlander and White, 2009). I focus on a third major area, namely inappropriate services that fail to meet the standard of “right care, right time, right way.”

Identifying inappropriate services is not easy. Standard lists of procedure codes include very few services that are useless always and everywhere. (Gastric freezing for ulcers, HCPCS code M0100, is a rare example.) Far more frequently, a service may or may not be useful in particular circumstances. Examples are the CT scan for head injury without loss of consciousness, the follow-up visit for infection, the expensive prescription, the nursing home admission for the patient who perhaps could live at home. Bright-line coverage rules are therefore problematic. Even elaborate prior authorization processes can be ineffective, especially as providers learn the magic words that authorizers wait to hear.

The people in the best position to decide useful versus useless are those delivering the care, provided they have appropriate financial incentives and good information. For developers of payment methods, the challenge is to get the incentives right. The work will never end, but practitioners can take heart in the improvements that have been made over the past 30 years.

Principal among those has been prospective payment for hospital inpatient care using diagnosis related groups (DRGs). Its implementation by Medicare in 1983 was arguably the most influential innovation in the history of healthcare financing, adopted since then by Medicaid plans, commercial payers, and even other countries. Its impact stemmed from its simplicity: paying a set price for a known product. The “product” was in fact about 500 products, that is, a manageable number of groups defined more by what the patient needed than by what the provider did. As Averill et al. (2010) emphasize, DRGs created a common language for clinicians and financial staff that enabled better management in both spheres. On the basis of the success of DRG payment (especially in contrast with previous methods of cost reimbursement), Congress in the 1980s and 1990s enacted a series of Medicare payment method reforms for hospital outpatient care, skilled nursing care, home healthcare, and acute psychiatric and rehabilitation inpatient care. The stated goal was to extend the principles of “prospective payment.” The term is often used loosely; I define it as fixed, case mix–adjusted payment for bundled sets of services defined in a clinically meaningful way.

By and large, the follow-on reforms have not matched the success of DRG-based payment. Medicare’s new hospital outpatient method, in particular, ranks among the great missed opportunities in the history of payment methods. It is therefore instructive to compare DRG payment with the outpatient method, which is based on ambulatory payment classification (APC) groups. For inpatient care, Medicare in FY 2010 pays $2823 for a patient with chest pain of uncertain etiology (DRG 313) and $4271 for a patient with uncomplicated acute myocardial infarction (DRG 282). The groupings speak the language of clinicians, and the bundled payment rewards efficiency. At the same time, higher payments for more complex DRGs protect patient access to care, as do outlier payments for cases that are unpredictably expensive.

Ambulatory payment classifications do not meet the definition of prospective payment. No patient characteristic affects payment, which instead depends entirely on procedure codes. Moreover, almost every service draws separate payment. For an emergency department (ED) patient with chest pain, the hospital receives separate payment for every laboratory test, chest radiograph, electrocardiogram, and intravenous catheter, with additional separate payment for most drugs. APC
descriptions, such as Level 1 Type A Emergency Visit, mean little to clinicians. Ambulatory payment classifications are better than Medicare's previous approach, which was an unsatisfactory stew of hospital-specific cost reimbursement, fee schedules, and even blends of cost reimbursement and fee schedules. However, in the years before APC implementation in 2000, hospitals were preparing themselves for “outpatient DRGs,” and that is not what happened. How the goal of clinically meaningful, bundled payment morphed into APCs is a story of payment politics, including the growing impact of lobbying, and of technical challenges in setting payment rates (Wynn, 2005).

As in the past, future payment reforms will occur at the intersection of policy decisiveness, technical feasibility, and political accommodation.

Policy decisiveness refers to a clear mandate from policymakers, who may be legislators, the Governor's office, or Medicaid managers. The Medicare APC experience underscores the importance of keeping focus, lest the goal become lost in the details of implementation.

Technical feasibility refers to the use of available data to pay fairly for the vast range of conditions and treatments seen in modern healthcare. More sophisticated payment methods are typically built on a computerized algorithm such as DRGs. Other algorithms are usually best known by their acronyms: APGs and APCs for outpatient care; ETGs and MEG for episodes of care; ACGs, CDPS, CRGs, and DCGs for capitation; RUGs for nursing facility care; and HHRGs for home healthcare.

Algorithms may be categorical (resulting in a fixed number of groups) or regression-based (resulting in an infinite range of “scores” from statistical models). They typically have the same goal and face the same challenge. The goal is to identify patients with similar clinical conditions who require similar amounts of provider resources. The challenge is to handle the characteristic dispersion and skewness of healthcare data. Overall, 5% of the population accounts for half of healthcare spending, and 20% accounts for 80% (Conwell & Cohen, 2005). The pattern of a few extraordinarily expensive patients repeats itself at less aggregated levels, such as physician care, hospital care, and prescription drug use.

As developers of payment methods embrace broader bundles of care, the importance of paying fairly for extraordinarily expensive situations rises. In a highly unbundled approach like APCs, payment easily tracks case mix as the number of services increases. In more bundled approaches, the accuracy of the computerized algorithm becomes critical. It is also possible to step outside the algorithm to pay for unpredictably expensive care; outlier payments for inpatient stays are an example, as are carve-outs for specific providers. In any case, the feasibility of a new payment method may depend on how it handles the 5% or 10% of situations that are extreme, regardless of how well it performs in the vast majority of situations.

Political accommodation reflects the reality that Medicaid is a public program in every sense. The politics of payment has little to do with Republican and Democrat and everything to do with the flow of funds. The constituency for more spending is always more focused than the constituency for cost control. Even the pursuit of higher quality suddenly loses support when it becomes clear that not every provider will benefit. In any payment reform, it is imperative to gauge support and opposition and to take the initiative in managing the politics of change.

Before turning to specific opportunities for payment reform, I offer a brief digression on the environment within which Medicaid programs set payment methods and rates.

MEDICAID PAYMENT FOR SERVICES

Medicaid is about three-quarters the size of Medicare (Fig 1). Before 2006, Medicaid had been approaching Medicare in spending, but a gap opened up with the implementation of the Medicare drug benefit. The gap is narrowing again as Medicaid grows faster than Medicare.

Managed care accounts for under 20% of spending in both programs, despite the
widespread perception that Medicaid is mostly managed care. While many beneficiaries do belong to managed care organizations, they tend to be the relatively healthy “moms and kids” population. Another reason for the misperception is that beneficiaries in primary care case management (PCCM) programs are counted as managed care, even though the PCCM model is firmly within the fee-for-service tradition.

Hospitals, physicians, outpatient drugs, nursing facilities, and home health providers (including personal care) account for another 60% of Medicaid spending and 68% of Medicare spending. The programs, however, differ in emphasis. Medicare focuses on acute care, and even the spending on nursing facilities and home health is for post–acute care. Medicaid, on the other hand, is the nation’s primary payer for long-term care. Well more than 30% of its spending is on long-term care, including nursing facilities, home health and other provider categories that are subsumed within the “other” category of Figure 1.

Medicaid tends to play one of two roles as a purchaser. For many services, especially acute care, Medicaid is “in the market” along with Medicare and other payers, representing 5% to 20% of provider revenue. For other services, however, Medicaid is the market in the sense that it may be the single largest purchaser in a state. These markets include personal care, adult day care, some mental health services, and services for people with intellectual disabilities. Medicaid also plays a prominent role in submarkets such as physician and hospital care for neonatal, pediatric, obstetric, and HIV/AIDS patients (Quinn, 2007a).
Federal law generally gives states wide discretion over payment methods and levels (Quinn, 2007b). There are upper limits on payment for some services, but few restrictions on the methods used to calculate those payments. (Exceptions include laboratory services, hospice, certain health centers, and disproportionate-share payments.) All methods do need federal approval through the state plan amendment process. Within states, the regulatory framework varies considerably. In some states, the legislature has given the Medicaid agency broad discretion. In others, literally any change requires legislative approval, with specific dollar figures sometimes enacted in statute.

With a few exceptions such as New York and Maryland, states have not been laboratories for change. Medicaid programs often emulate Medicare payment methods, for example in DRGs and APCs for hospital care, resource utilization groups (RUGs) for nursing facility care, and the Resource Based Relative Value Scale for physician care. Where states have gone their own way, these approaches have tended to be unsophisticated. For example, home- and community-based services (an area where Medicare has almost no presence) are usually paid using simple fee schedules. Other payment methods may include per diems, cost reimbursement, or even percentages of charges.

**POTENTIAL PAYMENT REFORMS**

This section discusses the potential applicability of the 7 payment reforms recommended by Averill et al. (2010) for Medicare. Other value purchasing suggestions for Medicaid, involving Medicare crossover claims, prescription drug pricing, and claim editing, among other topics, have been described separately (Quinn, 2009).

This section also makes 2 recommendations that might be considered prerequisites for the list by Averill et al. (2010), namely catching up to Medicare in some states and building analytical capability in almost all states.

**Catching up to Medicare**

Twenty-six years after Medicare implementation of prospective payment, only two-thirds of states use DRGs to purchase inpatient care. For most others, the payment method has been per diem or cost reimbursement since the 1970s (Quinn, 2008). Similarly, many states continue to pay for most hospital outpatient services at a percentage of charges, subject to a cost settlement process that plays out over several years. For nursing facilities, about 15 states do not adjust payment for case mix, as Medicare has done since 1998 using RUGs (Brown University, Center for Gerontology and Health Care Research, 2007).

In states that have not followed Medicare (or have not developed something better than Medicare), adopting Medicare methods would sharpen incentives for efficiency, increase Medicaid control over payments, and probably improve access when patients need expensive care but the payment method contains no case mix adjustment. Change may also reduce administrative burden for providers and the state, especially if the current method includes cost settlement.

**Building analytical capability**

No one knows how Medicaid programs compare with each other in payment levels for hospital care and many other services. Comparative data do exist for physician fees, prescription drugs, and nursing facility rates, but the availability of such useful evidence is the exception. More typically, states have little practical information available to them on comparative payment methods and rates, and little understanding of how payments affect access to quality care. Medicaid programs rarely have significant research and demonstration budgets, do not attract the attention from academic and commercial researchers that Medicare does, and do not benefit from the expertise of agencies such as the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office, or the Office of Inspector General.
Fortunately, the situation seems to be improving. The growing importance of Medicaid has drawn more research interest, especially from the Kaiser Commission on Medicaid and the Uninsured. Other sources include the National Academy for State Health Policy, the State Health Access Data Center, the Drug Effectiveness Review Project, and the New England States Consortium Systems Organization. The Medicaid Statistical Information System is much improved, with raw data available to analysts at http://msis.cms.hhs.gov.

**Pay for performance**

Pay for performance (P4P) has attracted considerable interest but also a gathering cloud of criticism. Objections include the following: P4P focuses on what is handy, not what is important; evidence linking payment and quality is thin; the data can be unreliable; the typically small bonus payments are disproportionate to the cost of providers achieving objectives; providers will avoid sicker patients; benchmarks based on averages are not appropriate for all patients; incentives reward providers for what they should already be doing; providers may be penalized for actions of other providers they don’t control; and P4P plans lack a business case to save money.

All true. Yet P4P exemplifies the adage that the perfect should not be the enemy of the good. In deciding how to spend $386 billion a year (2009 estimate) to improve the health of Medicaid beneficiaries, the alternative for policymakers is not perfection but rather the incentives in current payment methods. As many have noted, those incentives have almost nothing to do with clinical performance. In fact, many incentives reward quality problems if those problems result in more care being delivered. “Medicare has been paying for quantity and not for quality,” sums up Barry Straube, Medicare’s chief medical officer, in words that could be echoed in every Medicaid program (Winslow & Goldstein, 2009).

Although Medicaid programs have been leaders in setting P4P incentives for managed care plans, so far there have been few implementations on the fee-for-service side (Kuhmerker & Hartman, 2007).

Many P4P measures identify underutilization of healthcare, with immunizations and disease screenings being prime examples. Improving quality therefore often means more spending. To be sure, preventive care makes long-term sense, but in the long term many beneficiaries no longer have Medicaid coverage. Medicaid programs deserve credit for being in the forefront of payers emphasizing preventive care, but in tight budgetary times any P4P measure that costs money will be a tough sell.

Averill et al. (2010) identify 2 possibilities to improve quality and save money. Both potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs) address major concerns in hospital care, and both could save substantial sums of money.

In 2008, Medicare began reducing payment for individual inpatient stays that include a PPC such as a stage III pressure ulcer or an air embolism. To make sure the list of complications was defensible, Medicare kept it narrow. As a result, the expected impact of the policy was to lower FY 2009 payments by just 0.02% (Centers for Medicare & Medicaid Services, 2007). Unpublished analyses of Montana and Rhode Island data similarly show very low incidence of Medicare-defined PPCs in Medicaid. The low incidence stands in sharp contrast to the nationwide concern over complications. Klevens et al. (2007), for example, estimated that there were 1.7 million hospital-acquired infections and 99 000 associated deaths in 2002 nationwide. That implies that nosocomial infections developed in up to 4.3% of stays (author’s calculations based on Klevens et al. and AHA, 2009).

An alternative approach to reducing complications, advocated by Averill et al. (2010) and recently implemented by the Maryland Health Services Cost Review Commission (2009), would adjust payment depending on hospital-wide rates of PPCs, after appropriate risk adjustment. An analysis of California and Maryland all-payer data found that 7.8% of Maryland stays and 5.6% of California stays included a PPC, in each state adding 9% to 10% to the cost of care (Fuller et al., 2009). This approach recognizes that not all complications
are preventable but that hospitals with high PPC rates probably have opportunities to improve care and save cost.

Reducing PPRs (a similar but separate concept from PPCs) simultaneously addresses controlling cost, encouraging care coordination and improving quality. Separate analyses, using alternative methods with different populations, have found that 10% to 20% of inpatient stays are followed by a PPR within 30 days (Goldfield et al., 2008b; Jencks, 2009; MedPAC, 2008). Under current payment methods, hospitals that reduce readmissions are penalized with lower payment. A 2005 study reported that 13 of 15 successful projects to reduce readmissions were canceled after special funding for them ran out. “These hospitals knew they had something that worked,” said the study’s author, Harlan Krumholz. “But they couldn’t come up with a business model that could afford it” (Winslow & Goldstein, 2009). Such a business model would materialize, however, if Medicaid and other payers began factoring risk-adjusted PPR performance into hospital payment. As with PPCs, this approach focuses not on the individual case but on the hospital-wide rate.

States may also have PiP opportunities in another big-dollar area, namely long-term care. Facility-specific results have been available for several years on measures such as use of physical restraints and the prevalence of pressure ulcers. Although a significant step in policy terms, technically speaking it would not be difficult to adjust payments to encourage quality care.

Medical home

For Medicaid, the “medical home” movement may be especially promising. Compared with Medicare and commercial populations, Medicaid beneficiaries experience more instability in coverage and visit the ED more often (Owens & Mutter, 2009; Short et al., 2003). The majority of Medicaid spending goes to beneficiaries with multiple chronic conditions, often complicated by a wide range of psychosocial needs (Kronick et al., 2007). By coordinating care, the medical home could both improve quality and control cost.

States have been quick to express interest. More than 30 Medicaid or SCHIP programs have initiated medical home projects (Kaye & Takach, 2009). Often, the medical home has grown out of primary care case management programs. Under these programs, a physician or other primary care provider receives a modest payment (eg, $2 to $5 per member per month) to coordinate services, including prior authorization of some services by other providers.

Medical homes will receive substantial impetus from the growing availability of health information, itself propelled by new federal funding. In Alabama, a Medicaid Web-based health information exchange gives any authorized physician access to claims-based medical records, including diagnoses, prescriptions, immunizations, ED visits, and hospitalizations. Called Qtool, the system also includes electronic prescribing capability, patient-specific reminders for recommended care, and alerts for drug interactions (ACS Government Healthcare Solutions, 2009). Similar functionality being developed in many other states will give primary care providers better information at the point of care than they have ever had before.

The medical home model, however, suffers from the same fundamental weakness as the PCCM model. So long as the basic payment method is fee for service, the rewards from reducing utilization and coordinating care will be modest indeed. The revenue to a PCCM clinic from one unnecessary radiograph can exceed a full year’s worth of PCCM fees, for example. As well, no reward exists for the extra effort to keep a beneficiary out of hospital if no CPT or HCPCS code is billable.

If medical homes are to achieve their full potential, financial incentives must be strengthened. At the same time, risk-sharing arrangements must be flexible. PCCM and medical home providers range in size from solo practitioners to large institutions, with varying capacity and interest in bearing financial risk for the cost of care.

One option is to keep a fee-for-service structure but pay significant incentives based on potentially preventable ED visits,
hospitalizations, and readmissions. (Potentially preventable ED visits and hospitalizations are those considered sensitive to ambulatory care, such as diabetes, heart failure, asthma, and depression.) A second option, proposed by Gorroll et al. (2007), would be capitation payment for primary care practices, with as much as 15% to 25% of payment in the form of P4P bonuses. However, this proposal excludes even partial financial responsibility for laboratory tests, imaging, specialist care, and hospitalizations. Potential savings are therefore sharply limited.

A third option, proposed by Goldfield et al. (2008a), would calculate payment for primary care visits using Ambulatory Patient Groups, which are based on diagnosis rather than procedure codes. APG-based payment also includes bundling of ancillary services. Under Phase II of the Goldfield proposal, incentives would be extended to (partly) reflect use of hospital care.

Additional options, discussed in the next subsection, would be to pay medical homes by episode of illness, using algorithms such as Episode Treatment Groups (ETGs), Clinical Resource Groups (CRGs), or the Medical Episode Grouper (MEG). These algorithms capture the physician, laboratory, hospital, drug, and other costs for acute conditions such as arm fracture, chronic conditions such as depression, and preventive care. Especially when implemented across categories, episode payment has the potential to align incentives and tear down the notorious silos of healthcare. These silos have proven to be solidly built, however. Medicare demonstrations of bundled physician and hospital payment for coronary artery bypass grafts and cataract surgery did not gain traction, despite the success of the CABG demonstration in particular (Coulam et al., 2009). ETGs and MEG, although widely used in analysis, have found limited use in payment. New York Medicaid, however, recently implemented payment to its health plans using CRGs (which can also be used for capitation).

With episode payment, much of the challenge is in judging the art of the possible. As a next step, Averill et al. (2010) suggest expanding an inpatient episode first to include readmissions and then to include related physician services and other care. Building upon the P4P initiative on readmissions described above, this proposal has considerable promise. A Medicaid program with determination and resources could pilot such an approach, although if it goes forward it seems more likely it will do so as a Medicare demonstration.

Alignment of provider incentives

It is hard to imagine a worse job than being a hospital chief financial officer. On top of uncertain revenue, immense operational complexity, and the obligation to provide services to people who cannot pay for them (an obligation that no one else in our economy bears to the same degree), the CFO must control the cost of care without the ability to control the physicians who order that care.

As with episode payment, proposals to align physician and hospital incentives reflect the simple truth that people care more about cost when it pays them to do so. Physicians direct almost everything that happens in a hospital but have minimal incentive to think twice about ordering another test. Averill et al. (2010) propose eliminating current
federal prohibitions on gainsharing, that is, on arrangements for hospitals to share savings with physicians. This prohibition also affects Medicaid, so states that want to experiment with gainsharing would have to rely on waiver authority. Such an experiment is unlikely to make sense on its own, but may be worthwhile as part of a broader payment reform.

Price discounting and competitive bidding

Price discounting, competitive bidding, and selective contracting are closely related concepts that aim to bring an element of market pricing to the administered price regimes of Medicare and Medicaid. Under price discounting as advocated by Averill et al. (2010), Medicare would continue to do business with all hospitals but these hospitals could discount their prices (e.g., by DRG) to attract beneficiaries seeking to pay less coinsurance. This approach does not fit Medicaid, where beneficiary cost-sharing is already minimal.

Under competitive bidding, Medicare or Medicaid would do business only with low-price bidders. Selective contracting is similar but carries more of a connotation that quality plays into the selection process. For our purposes, the 2 terms can be considered synonyms.

Competitive bidding is an attractive idea that is very difficult to implement. The attraction is that Medicare and Medicaid would get a truer sense of the prices providers would accept. Durable medical equipment and supplies are obviously suitable for competitive bidding; numerous studies have shown that Medicare pays more than the market price for many of these items. Expensive, specialized, nonemergency services, such as many types of surgery and advanced imaging scans, are also candidates. When competitive bidding has been tried, results have been promising. A Medicare DME demonstration showed savings of 20% with no notable harm to beneficiaries, for example (Department of Health and Human Services, 2004).

The difficulty is that providers have demonstrated that they will do almost anything to avoid competing on price, including lawsuits, lobbying, and even accepting fee schedule cuts. An analysis by Coulam et al. (2009) of Medicare efforts to introduce market pricing makes for sobering reading. In some cases, Congress has bowed to pressure and cancelled demonstrations that it itself ordered. Administered prices, it turns out, are more popular than one might have supposed.

Competitive bidding and selective contracting continue to interest policymakers. The 2009 Rhode Island legislature, for example, included selective contracting under the state’s “global waiver” of federal Medicaid law. Implementing competitive bidding certainly requires considerable technical effort, especially in defining the unit of payment and ensuring that successful bidders do not stint on quality. However, history indicates that the biggest obstacles are political.

Best practice pricing

Rate setting—referring to both overall funding levels and payments for individual services—traditionally has been based on financial averages. For example, the Medicare Payment Advisory Commission, in making its annual recommendations to Congress, has always calculated the average difference between Medicare payment and hospital cost. In 2007, hospitals’ Medicare margin on inpatient care was negative 3.7%, which some people interpret as implying that Medicare pays too little (MedPAC, 2009). But MedPAC now also looks at payment compared with costs incurred by hospitals defined as efficient. For these hospitals, the 2007 Medicare margin was 0.5%—not great, but an indication that rates are adequate if the hospital is efficient.

There are various ways to implement best practice pricing, but they all take a tougher approach to purchasing than using averages as a benchmark. As an illustration, Averill et al. (2010) ranked hospitals by case mix–adjusted average cost per stay, then identified the
subset of hospitals that accounted for 75% of all stays. Rates could be set to cover the average cost of this “efficient” subset and then applied to all hospitals. Such an approach would reduce Medicare payments by 6.4%.

For Medicaid, the prerequisite question is whether payments are more than adequate, adequate, or less than adequate in relation to goals for access to quality care. A separate article proposes an evidence-based framework for states to use in making these technically complex and politically charged judgment calls (Quinn, 2008). If payments are to be reduced, best practice pricing creates some confidence that capacity will continue to exist to serve beneficiaries. The confidence stems from the finding that efficient providers can break even, on average, at the lower rates. The onus therefore falls on the remaining providers to improve efficiency.

Provider performance reports

Recent years have seen widespread interest in Web-published provider report cards, such as the Medicare Web site hospitalcompare.hhs.gov, HealthGrades.com and its competitors, and state Web sites such as floridahealthfinder.gov. Early results indicate that report cards at least improve performance on the measures being reported. Although the reports have little direct impact on care coordination and cost control, they are very much in the spirit of value purchasing.

Steps Toward Achieving Payment Reform

In retrospect, the most surprising aspect of DRG payment was its enactment in the first place. It came as a thunderclap, fundamentally changing hospital care for decades to come. Suddenly, arguments with regulators over allowable costs became moot, while length of stay and cost per day demanded urgent attention. Although the hospital industry ended up doing very well by DRG payment, that was not known in advance. Instead, the overriding emotion was fear that a worse alternative—tight caps on allowed cost—was about to be enacted. It also helped that in 1983 Congress was preoccupied by must-pass amendments to the Social Security Act. When DRGs were attached to the bill and the bill passed, hardly anyone noticed (Mayes & Berenson, 2006).

For Medicaid programs contemplating their own payment reforms, a few lessons can be drawn from experience. The first is simply the value of persistence. Very few major reforms happen on schedule. Yet truly good ideas—such as moving from cost reimbursement to DRG payment—will continue to make sense despite delays caused by technical challenges and political opposition.

A second lesson is the importance of moving carefully. When Medicare began publishing hospital-specific mortality rates in 1986 without sufficient adjustment for case mix, it probably set P4P back by a decade. As payers consider increasingly sophisticated payment methods, often based on highly complex algorithms, it becomes essential to test proposals on a state-specific analytical data set of historical claims. Exceptionally expensive patients must be thoroughly analyzed, as discussed above.

A related lesson is the importance of consultation. Consultation identifies issues that developers may not have thought of, enables providers and others to anticipate impacts on their operations, and removes the political argument that the Medicaid agency acted rashly. Considering its size, Medicare generally runs an impressive consultative process, including release of raw data and reasoned responses to thousands of comments. In consultation, Medicare has probably set the standard for states to follow.

The fourth lesson, exemplified by DRG enactment in 1983, is that a sense of crisis can lead to changes that might not occur otherwise. With Medicaid now facing perhaps the most difficult time in its 40-plus years of existence, payment reform may yet result in cost containment, coordinated care, and quality improvement.
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