Part Six

Optimizing Payment Approaches to Support and Sustain High Performing Medical Homes
Part Six / Key Takeaway Messages

- Medicaid can and should play a lead role in advancing high performing medical homes for young children. Payment approaches should cover the costs of needed services, incentivize high performance, ensure that services meet standards of care, and result in improving outcomes for low-income young children served.

- This can be done through both direct, fee-for-service payment systems or under managed care arrangements. Regarding fee-for-service environments, a key step is to establish Medicaid reimbursement levels sufficient to finance and incentivize high performing pediatric medical homes. Appropriate billing codes, service definitions, provider qualifications, and measurement are needed.

- For Medicaid provided through managed care arrangements, states must incorporate into contracts with managed care organizations (MCOs) and accountable care organizations (ACOs) specific expectations and requirements for finance and delivery of high performing medical homes for young children and other services in line with the EPSDT benefit. This requires distinguishing services for young children from services for other populations in the Medicaid contract and establishing payment structures and distinct performance incentives. In particular, contracts and payment mechanisms should emphasize the preventive and developmental services needed to improve the health and well-being of young children in Medicaid in both the short and long term.

- Three specific payment approaches common to managed care contracts — per member per month payments, pay-for-performance, and use of “shared savings” — also can be used to advance the development of high performing pediatric homes, but they are not a substitute for the other actions described above.

- Medicaid administrative claiming can be used to cover administrative activities needed to maximize the effectiveness and efficiency of high performing medical homes. State Title V Maternal and Child Health programs often are in the position to provide or contract for administrative services related to Medicaid (e.g., related provider training, system coordination, measurement) and bill for administrative costs.

Financing Approaches to Support Practice Transformation and High Performing Medical Homes for Young Children

Children, and particularly young children, are not “little adults.” They need services and supports that address their unique health and developmental status. The focus should be on improving health trajectories to health and well-being during childhood and over a lifetime. This section discusses Medicaid financing specifically as it relates to high performing medical homes, with emphasis on primary, preventive, and developmental services for young children and their families.

As the insurer of a majority of young children, Medicaid can and should play a lead role in diffusing the implementation of high performing medical homes for young children and, eventually, making it the expected standard of care.1 To move from exemplary practices consistent with the description of a high performing medical home to the pediatric standard of care defined in Bright Futures will require states to develop Medicaid reimbursement systems, supported by clear and strong service definitions, billing codes, service provider guidelines, contracts, and measurement approaches.
Certainly there will be savings and returns on investment from the improved child health trajectories and therefore fewer medical conditions requiring treatment services, yet most of these will be realized well into the future and not in the timelines of current Medicaid expenditures (i.e., within an annual or biennial Medicaid budget or a Medicaid managed care contractual cycle). Savings can be expected, however, in reduced costs for health care of those with developmental and other disabilities, special education programs, and chronic health conditions from childhood to adulthood. Thus, while short-term savings may not accrue to contracting providers or plans, the public sector will have an overall return on investment in the long run.

In general, achieving improved outcomes will require increased investments in and or expenditures for effective primary, preventive, and developmental services for young children through high performing medical homes. State Medicaid financing systems must be structured to reimburse and incentivize the different services for young children described in parts two through five.

Whether operating under a fee-for-service system or a managed care system, the state has the same responsibility and legal requirements under Medicaid and EPSDT to provide necessary services to children. This may be operationalized through state rules regarding payments or contracts and enforcement provisions in those contracts. Moving to managed care does not eliminate the need for the state to promote and ensure that young children receive the services to which they are entitled, and particularly those governed under EPSDT.

Whether operating through a state fee-for-service system or a managed care system, every state is in the position to define and establish standards for services and set payment levels that support and sustain high performing medical homes for young children. In short, there are opportunities for promoting and advancing high performing medical homes for young children, but, to do so, state Medicaid agencies need to be explicit in expectations, oversight, and financing incentives to providers and/or MCOs/ACOs.

**Financing Through Managed Care and Accountable Care Organizations**

The term “managed care” is used to describe several different arrangements for delivering and financing health care services. Over 70 percent of all Medicaid enrollees — and more than 80 percent of young children in Medicaid — receive care in managed care arrangements, including comprehensive risk-based plans through MCOs, primary care case management (PCCM) programs, and limited-benefit plans. To date, 39 states have incorporated MCOs into their Medicaid programs.

Since most children in Medicaid are covered under managed care, it is important to understand the operational dynamics of managed care. MCOs are designed with the goal of simultaneously improving health care quality, improving population health, and containing or reducing per-capita health care costs (the “triple aim”). They are not, however, charitable institutions and the bottom line for them is achieving a reasonable return-on-investment (profit) through their Medicaid contracts.
In general, state Medicaid offices contract with MCOs in order to contain or reduce overall Medicaid costs, while still maintaining quality of care and population health. They must follow federal rules in doing so. States typically structure incentives for MCOs for achieving those cost savings or offsets. The rationale is that, by providing MCOs greater flexibility in what they cover and provide, particularly in “managing” care to maintain health, there is reduced need for and use of more expensive care and treatment. There are several strategies MCOs can use to achieve these ends.

1. One strategy is through managing care to better maintain health and therefore prevent the occurrence or re-occurrence of illness, injury, or acute episodes requiring medical intervention. This is often done through additional care coordination or case management, particularly for enrollees currently experiencing high medical expenses and having chronic conditions that can give rise to acute episodes entailing high-cost medical services (particularly hospitalizations and emergency room use). The major costs within Medicaid go to providing services to persons with disabilities and others with complex medical and chronic conditions requiring expensive care. Managing their care to minimize relapses and control their conditions to prevent avoidable hospitalizations or emergency room treatments can reduce overall costs, even if there are attendant costs for case management.

2. Another strategy includes negotiating lower payment rates for provided services and reducing, through prior authorizations or limits on the units of service provided or other means, provision of unnecessary, duplicative, or ineffective services. These also are the primary ways direct, fee-for-service Medicaid systems seek to contain costs.

3. A third approach is offering incentives (or sanctions) to direct are providers to find ways to better address their patients’ health needs. This can include per member per month (PMPM) payments for care coordination or case management services designed directly to either better maintain health or reduce overutilization of services or incentives (pay for performance bonuses or increased payments or even shared savings) for achieving certain goals with respect to the patients under care.

4. The 2016 federal Medicaid managed care regulation also permits states to use arrangements with MCOs and managed care contracts to substitute certain services for those normally covered under state plans. (42 CFR §438.3(e)(2)) They might, for example, to finance home visits for new mothers rather than in-office mother and infant care. This flexibility to provide other types of care in lieu of normally covered services has promise for addressing social determinants of health, increasing emphasis on developmental risk, and providing more intensive care coordination. Although no MCOs has yet developed “in lieu of” agreements with their states, some have expressed interest in doing so.

Select Approaches to Promote High Performing Medical Homes for Young Children

Three approaches often used by MCOs/ACOs have utility in financing high performing medical homes. First are payments to practices on a “per member per month” (PMPM) basis or prospective capitation payments. A second payment approach is “pay-for-performance,” with payments tied to performance on
specified process and outcome measures. A third approach sets aside of some “shared savings” achieved from containing or reducing health costs to be used, generally by the MCO/ACO with oversight by the state contractor, in innovation and continuous improvement activities. These are often through demonstration projects, to seek further health improvements (again, usually for developing alternative care approaches that achieve the “triple aim,” and particularly the third aim of lowering per-capita health care costs). Currently, these approaches are used primarily with complex, chronic, and high-cost patients—generally adults. They could, however, equally be used to promote the health and development of young children. They are discussed below.

PMPM or capitation payments to practices can be used to finance primary and preventive care for children. They also can be used to finance the more intensive care coordination outlined in part three. Financing as a case management service or as targeted case management on a fee-for-service basis has the benefit of providing funding at a level that is commensurate with the number of children who qualify and receive the service. PMPM or capitation payments provide practices with a known, predictable amount of funding that they can then deploy to add a care coordination staff person. This can add an additional resource to the practice without the practice having to establish an ongoing billing system to cover its cost. A practice with 800 children ages 0 to 3 that receives a PMPM payment of $8 per member per month, for example, will have new funding of $76,800 of a year, an amount that generally can provide for a full-time, on-site social worker or family specialist. That specialist’s time may be well spent and improve children’s health trajectories; but if there are 200 children who require such help, that staff person may only be able to effectively serve a portion of those in need. The investment may be sufficient to demonstrate high returns-on-investment, but it also may realize only a portion of its potential in reducing health disparities.

Pay-for-performance payment approaches have gained popularity in recent years. In this case, regular payment rates or bonus/incentive payments may be tied to performance measures related to the clinical care process and/or outcome measures. For example, a state or MCO/ACO might pay higher rates or bonuses to high performing medical homes that perform well based on measures established to show impacts and the achievement of health goals (see part seven).

In addition, some Medicaid MCO or ACO contracts may seek to redirect some proportion of “shared savings” from successful MCO efforts — where MCOs show they have reduced costs for a specific population and deserve an incentive or bonus for doing so — into reinvesting in new efforts and innovations to produce savings. MCOs retain a share of the savings, but rather than the rest going back to the state in reduced costs, some are directed to additional MCO efforts to improve health care. There are a few instances where such “shared savings” may be achieved with a young child population, but in most instances they are achieved with adult populations. There is nothing to prevent state MCO contracts from designating a portion of any “shared savings,” from whatever population, toward advancing young child health. Again, this is a strategy that may accelerate innovation and its diffusion, creating a new focus on young children. It is only an adjunct, however, to other efforts to define and finance high performing medical homes for young children both in the state Medicaid plan and direct fee-for-service payment systems and within managed care contractual provisions.

* The young child population includes a significant proportion of children with presenting health conditions that can benefit from earlier detection and treatment, but it also includes a larger population of children, whether or not they have diagnoses, who have risks and conditions which, if they do not change, will result in future health problems.
Value-Based and Performance-Based Purchasing for Children

Medicaid financing is complex, and it is made more complex by the fact that Medicaid not only covers children, but also low-income adults ages 19-64, persons with disabilities, and seniors age 65 and older with varying needs. This means that many individuals with complex medical and chronic conditions involving a wide range of treatments and very high costs, particularly seniors and persons with disabilities, are a focus of Medicaid fiscal strategies. Many of the new and alternative payment models are focused on persons with chronic conditions and complex and high-cost medical needs, particularly those related to “value-based” and performance-based payment approaches. The ACO model, pushing provider networks beyond traditional MCOs, is designed to promote care integration and provide financial incentives (e.g., shared savings) for improved outcomes.

As they seek to develop alternative strategies and care and treatment options to meet patient health care needs with lower medical costs and involvement, states and contracting MCOs/ACOs generally focus on high-cost and medically complex populations, and not on children with health care needs and costs in the normal range. When it comes to children, a much larger share of Medicaid expenditures are for primary care services and relatively low-cost ambulatory treatment services for childhood illness and injury. However, since high-value health care is generally defined as that which produces the best outcomes at the lowest costs, people with medically complex conditions and high costs should not be the only focus. As described by Bailit in one of the first analyses of value-based care from a child health perspective, “The profound difference in health care objectives and services for children and adults and the strong link between childhood experiences and adult health and health care costs has not been recognized in the design and implementation of value-based payment models.”

The seminal work on value-based payments emphasized that “value” must not be measured in terms of equivalent or better quality of care and population-based outcomes and reduced or contained per-capita costs of care.). Still, much of the focus in payment systems innovations based on providing “value-based” care (paying for outcomes and not services) has been on achieving immediate cost containment or reductions. If further efforts in this field are to realize their potential with young children, they must emphasize that paying for value includes the value of long-term health benefits for young children apart from any immediate cost offsets to medical services.

Managed Care Contracts and High Performing Medical Homes for Young Children

As discussed above, most children covered by Medicaid receive services under state contracts with MCOs, with the contract providing state requirements and payment structures for the MCO. The MCO then contracts with providers to deliver services. Whether or not they are delineated specifically in the contracts, children must receive the EPSDT benefit and its full range of services. Medicaid also requires patient choice (e.g. more than one managed care plan, unless states secure a waiver for their contracting)

† The most commonly referenced opportunities for shared savings are reducing emergency room visits and hospitalizations with better management of conditions for children with asthma or high levels of medically complexity.
and a network of service providers capable of meeting the service needs of the covered population.

Most current state Medicaid contracts with MCOs provide incentives to contain or reduce health care costs—through capitated payment rates, performance-based (or value-based) payments, or rate negotiations with service providers and prior authorizations for or limitations on services (to reduce overuse of services). MCOs also can in turn create incentives to providers. These relationships are illustrated in Figure 13.

Increasingly state contracts with MCOs are based upon a capitation rate for at least some services and populations, based on historical use and cost for the population being served. Depending on how the contract is structured, the MCO assumes some or all financial risk if its payments exceed the capitated payment — and the MCO retains at least a part (shared savings) of the amount below that capitated level. Federal law allows states to provide up to 5 percent above the capitated rate for incentive payments, which can be used to reward plans for meeting specified outcomes and priorities. Managed care contracts often offer greater flexibility in providing alternative services than is allowable under direct fee-for-service payment systems.

With respect to high performing medical homes for young children, the state Medicaid contract with the MCO requires specific state direction for advancing high performing medical homes and state oversight for doing so, as shown in Figure 13.

**Medicaid Contract Language to Ensure Coverage under EPSDT**

As discussed above, in managed care and accountable care arrangements, the state must establish contracts that specify the scope of services covered, the diagnoses, and authorizations required to cover the services, the duration and intensity of the services eligible for payment, the documentation required to receive payment, payment rates, and terms for any incentives based on performance or quality. Thus, state Medicaid managed care contracts must specify and provide financial incentives for the MCOs/ACOs to increase the proportion of children who are provided primary, preventive, and developmental services under a high performing medical home.

Today, most Medicaid managed care contracts set out requirements for securing an adequate number of providers of care, providing core covered services in the Medicaid plan, and reiterating the requirements under EPSDT for children. Often, they do not go much further in setting expectations and requirements for child health, and particularly for primary and preventive health services for young children.

This starts with Medicaid managed care contracts distinguishing the financing of primary and developmental services for young children from other parts of the managed care contract and developing financial incentives to MCOs to increase their expenditures/investments in such care, not reduce or contain them. State contracts with MCOs also should specify performance and reimbursement terms for high performing medical homes for young children, as well as additional services. As described in part two of this sourcebook, this

---

State Medicaid managed care contracts must specify and provide financial incentives for MCOs/ACOs to increase the proportion of children who are provided primary, preventive, and developmental services.
would include well-child visits that identify and respond to early childhood developmental, behavioral, and social determinants of health and offer some level of care coordination to address them. Key elements to address in MCO contracts include:

- Performance goals and incentives for increasing the proportion of well-child visits, which meet the *Bright Futures* guidelines in terms of content and timing.
- Definitions for high performing medical homes for young children, with performance expectations and measures.
- For designated high performing medical homes, structuring of payments and incentives to cover the cost of augmented well-child visits, additional screening, practice staff focused on development, and/or intensive care coordination. This may be built into the managed care contract as part of or beyond the capitated payment for other services.
- Measures and quality improvement/performance improvement projects designed to increase the quality of well-child visits and the availability of high performing medical homes.
- Opportunities for MCOs to use a portion of shared savings from other efforts that reduce Medicaid costs to make further investments in primary practices engaged in providing enhanced well-child care and to advance other strategies to improve healthy development for the young child population.
- Language specifying that “medical necessity” is defined for young children to include preventing, ameliorating, and addressing risks and conditions related to child development. Based on individual determinations of medical necessity, this might include services such as developmental interventions, parent support programs, parent-child dyadic mental health therapy, and other early childhood mental health interventions.

Contract purchasing specifications proposed by the George Washington University describe considerations in making coverage and medical necessity determinations about treatment under EPSDT. The model purchasing specifications were designed to guide Medicaid agencies in developing strong and
effective contracts under managed care arrangements. They suggest that in making a coverage determina-
tion, Medicaid managed care contracts should require contractors to consider the following evidence and
type of the enrolled child:

- Recommendations of the provider treating the enrolled child for whom the coverage determination
  must be made;
- Clinical evidence of the health status and needs of the child;
- Evidence and information that is provided by the child or child's family or caregiver;
- Opinions of medical, dental and other health care practitioners who are experienced in the treatment
  of children with similar mental or physical illnesses or conditions;
- Professional standards of medical, dental and other health care practice related to the care of children,
as reflected in: 1) scientific literature published in peer-reviewed journals; 2) the results of clinical tri-
als relevant to pediatric care; 3) government-sponsored studies; 4) professional consensus statements;
and 5) other sources of valid and reliable evidence regarding the pediatric standard of care;
- Opinions of, and evidence supplied by, qualified individuals who are involved in the care of the en-
rolled child and who are affiliated with publicly-supported agencies, programs, or providers deliver-
ing health services to children residing in contractor's service area; and
- Provisions of an Individualized Education Program (IEP) or an Individualized Family Services Plan
(IFSP) under the Individuals with Disabilities Education Act (IDEA).

Consistent with the purposes and design of the EPSDT benefit for children, the model purchasing spec-
ifications also recommend that state Medicaid managed care contracts specify that the contractor shall
not deny, terminate, reduce or exclude coverage in part or in whole of an item or service covered for an
enrolled child because the item or service sought is: 1) required to treat a condition rather than an illness
or injury; 2) not expected to result in the restoration or achievement of normal functioning; 3) experi-
mental, unless the service is available only through a clinical trial, or is not a generally accepted practice
or procedure among pediatric specialists; 4) identified in a plan of care developed by another public
agency, in an IEP or IFSP, or provided in a school setting; or 5) mandatory because of a failure of the
family or caregiver of the enrolled child to ensure that the child has complied with a recommendation or
prescription of the child's treating provider.

**Medicaid Administrative Claiming**

In addition to financing services to eligible recipients, Medicaid also provides federal matching funds
(i.e. federal financial participation-FFP) for certain administrative activities related to Medicaid.12 This
includes field staff time in eligibility determinations, outreach, claims processing, reporting and docu-
mentation, and overseeing contracts, including managed care. Most administrative claiming is not at the
states' FFP rate for medical care (which varies for states between a 50 percent and 70+ percent federal
match, based on a formula that reflects the state economy) (42 CFR 1007.19) but at a 50-50 federal-state
matching rate. (42 CFR 433.15(b)(7)). For a few activities, matching is 75-25 federal-state. (See 42 CFR
433.15(b)(1)-(6) for higher matching rates).

Medicaid administrative claiming can be used for implementing new Medicaid operational approaches,
training and supporting practitioners in their use, and establishing the infrastructure necessary for service providers to operate. It is mandatory to cover primary, preventive, and developmental services as medical services and not under administrative claiming, but there are some features that can be financed best through administrative claiming (e.g. monitoring the effective implementation of policy, training providers in Medicaid-specific knowledge and skills, and data and information systems). This includes training and supporting practices in converting to becoming high-performing medical homes and developing the reporting and management capacities to do so. It also includes the work in identifying and training and supporting other community service providers so medical homes make effective referrals to services available in the community. For example, this might involve training for case managers, individuals who develop and coordinate person-centered care planning, and primary care practitioners. (Costs incurred by providers to meet continuing education and advanced professional training requirements cannot be claimed as a Medicaid administrative spending.)

Notably, administrative claiming may not include: funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, the overhead costs of operating a provider facility, duplicate payment for activities that are already being offered or should be provided by other entities or paid through other programs, and/or supplantation of funding obligations from other federal sources. Best practices for administrative claiming through contracting include: strong memoranda of understanding between agencies, clear documentation of services provided, and justification as being “proper and efficient” for the state’s administration of its Medicaid state plan. (Section 1903(a)(7))

To move to the pediatric standard of care defined in Bright Futures will require states to develop Medicaid reimbursement systems, supported by clear and strong service definitions, billing codes, service provider guidelines, contracts, and measurement approaches.

State Title V Maternal and Child Health Block Grant programs often are able to provide or contract for administrative services related to children in Medicaid (e.g., related provider training, system coordination, measurement) and to bill for administrative costs. A number of states have developed specific contracts with their Title V agencies and/or other community entities to engage in such activities. Federal law requires interagency agreements (typically memoranda of understanding) between Medicaid and Title V programs, particularly to ensure proper administration of the EPSDT benefit. Administrative claiming is one element states may include in such agreements.
References


