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THE ROLE OF STATE MEDICAID PROGRAMS IN IMPROVING THE VALUE OF THE HEALTH CARE SYSTEM

bailit health

NAMD
National Association of Medicaid Directors

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EXECUTIVE SUMMARY

Across the country, states, insurers, providers and consumers are driving value into the health care system by transforming the way care is paid for, with the goal of improving the quality and cost of the nation's health care system. Medicaid, the nation's largest insurer covering more than 70 million people, is playing a critical role in the effort to drive value into the health care system. This was revealed from our survey of state Medicaid programs (n=34), a sample of Medicaid managed care organizations (MCOs) (n=5), and supplemental interviews and research.

There is a substantial amount of value-based purchasing (VBP) activities happening among state Medicaid programs, broadly defined as any activity that a state Medicaid program is undertaking to hold a provider or a contracted managed care organization (MCO) accountable for the costs and quality of the care they provide or pay for (in the case of an MCO). This most often refers to activities that a state Medicaid program is doing to move providers away from the traditional fee-for-service (FFS) payment system, which rewards volume, to alternative payment models that reward value. These models are being implemented either directly with providers, or by requiring managed care entities to implement alternative payment models with their network and implementing quality and cost requirements into managed care contracts. The overall goal for pursuing alternative payment models among most states is to improve the value of the health care delivery system, meaning to improve the quality of the care provided while at the same time, reducing the costs. Today, a number of states are using wide-scale alternative payment models as a way to further change the incentives from volume to value and efforts range from statewide mandated payment changes to experimental pilot programs.

States that are implementing alternative payment models are doing so in a manner that makes sense for their local marketplace, their culture and their environment, and therefore, there is variability in the type of model used and vehicle through which the model is implemented. For example, a number of states are requiring their managed care organizations to implement alternative payment models with their networked providers, and a few are planning to do so in the future. Some states contractually require their MCOs to implement alternative payment models with providers and impose financial consequences if they fail to meet certain goals. Still others are contracting directly with providers.

The most commonly used alternative payment models in state Medicaid programs are:

- ***additional payments that support delivery system reform***, where providers (typically primary care providers) receive a per member per month (PMPM) payment to be used for a wide variety of purposes, in exchange for meeting performance expectations. The goal of this model, which has been implemented in at least 12 states, is to support infrastructure for health care delivery transformation efforts or traditionally unreimbursed services (e.g., care management). Typically, additional PMPM payment models are attached to Patient Centered Medical Home (PCMH) and Health Home delivery systems and usually the PMPM is designated for a particular activity. Often states couple these models with pay-for-performance (P4P) programs or an opportunity to share in savings.

- ***episode-based payments***, an approach where one provider is held accountable for the costs and quality of a defined, and discrete set of services for a defined period of time. The goal of this model, which is actively being implemented in four states and considered in at least three others, is to bring increased focus to identifying and refining clinical pathways that produce more effective and efficient care, including through improved coordination of care for a patient across different providers. The services that are delivered and relevant to the condition are included in the episode-based payment model, and services that are irrelevant (e.g., treatment for a sports injury) are excluded. However,

what specific services are included or excluded from an episode-based payment model can be negotiated between the payer and provider, leading to many different approaches to the same model. Generally, the episodes that are being pursued are acute or episodic in nature (e.g., acute exacerbation of asthma or tonsillectomy). Very few chronic episodes are being implemented in Medicaid, or in the Medicare and commercial markets, as it is more difficult to define the beginning and end of a chronic condition; and,

- ***population-based payments***, where one or more providers is held accountable for spending targets that cover the vast majority of health care services to be delivered to a specific population. The goal of this model is to align the incentives of the payer, the provider and the patient to improve the overall quality of health care and manage the costs. Population-based payment models require a provider to take on responsibility for care it delivers, plus consider the costs of downstream care, resulting in a focus on prevention. In some, but not all cases, population-based payment models are applied to accountable care organizations (ACOs), which are an organizations of providers that have voluntarily come together and agreed to be responsible for the cost and quality of a total population. These providers work together to coordinate the care of a population. At least nine states have implemented population-based payment models with at least two operating more than one. There are several different population-based payment models implemented by Medicaid agencies with providers: population-based payment models with spending targets, primary care capitation and full risk capitation.

States have committed significant resources to the implementation of alternative payment models. Successful programs require commitment and strong leadership, and the capacity at the state, plan and provider level to share data and readiness to actively manage beneficiaries' care using that knowledge. Medicaid programs believe in the promise of these initiatives to improve the health of their beneficiaries while reducing costs, and see great opportunities for alignment across health care payers, including with Medicare and the commercial market. In addition, Medicaid programs see significant opportunity to further pursue alternative payment models by expanding the focus on social determinants of health, behavioral health services and long-term services and supports.

As Medicaid programs move forward in these efforts, states can learn from the experiences of others. This experience can also inform Medicaid's federal partners as they seek to support successful strategies to implementing alternative payment models in Medicaid programs, including through technical assistance and other infrastructure support. Key considerations for both Medicaid directors and federal policymakers are discussed below.

CONSIDERATIONS FOR STATE MEDICAID LEADERS

- **There is great promise in value-based reform, though significant effort and resources are required to implement these models.** Medicaid directors who are farther along in implementing alternative payment models underscore the difficulty and intensity of this work and the amount of their own time, as well as the time of their staff, to design and carry it out. It is also extremely complex. States must maintain focus on improving the health of their beneficiaries and consider the impact of their work on the provider landscape and health care market broadly, which can be nuanced and result in unintended consequences. The difficulty of this work holds true regardless of whether the model is state-designed and implemented, or implemented through MCOs.

- **High-quality data are essential to all alternative payment models.** For Medicaid programs that are looking to expand existing alternative payment models or pursue it for the first time, Medicaid directors note that success hinges on the availability of high-quality, timely data. This data serves as the foundation for all alternative payment models, from

additional PMPM payment models to population-based payment models. In addition to being able to share data and report on performance, states and their partners need strong data analytic capacity so that data can be leveraged to appropriately focus care improvements.

- **There is value in bringing stakeholders into the planning process for designing alternative payment models early.** States have achieved success by engaging stakeholders in the design and development of alternative payment models, especially providers. While this may be time consuming, it is essential for Medicaid to work in partnership with its MCOs and providers in designing alternative payment models in the context of the state's particular marketplace.

CONSIDERATIONS FOR FEDERAL POLICYMAKERS

- **Implementing successful alternative payment models requires resources, which states often do not have readily available.** The appropriate staff, funding, and tools must be available for states to design, implement, and oversee this work over a number of years, considering this work takes time. Efforts like CMMI's State Innovation Model grants have provided vital support for this work and helped state efforts succeed. Likewise, the use of Delivery System Reform Incentive Payment (DSRIP) funds provide an additional mechanism for supporting system transformation. The future of such resources is unclear and could be an important factor for the pace at which VBP in Medicaid is realized through alternative payment models.

- **Multi-payer reform is a major opportunity to drive value, but federal efforts that are not coordinated with Medicaid could impede successful state innovation.** Medicaid programs see significant value in alignment across Medicare, Medicaid, and commercial payers in promoting VBP. However, states are concerned that Medicare, as a single national program, could complicate or even impede successful state reforms tailored to the local health care marketplace, if Medicare efforts take a different focus and direction than Medicaid innovations. Greater and ongoing coordination between programs at the state and federal level could provide a potential pathway to mitigate this challenge.

- **New and innovative rate setting considerations may be needed in managed care to support alternative payment models.** States are continuing to discuss the role of social determinants of health in improving quality and bringing down health care costs in their reform models. As part of these discussions, states are looking to determine how the rate setting process can allow states and plans to address social determinants of health, including reinvesting savings in these activities. In addition, as more care is value-based, there is a significant challenge with the development of actuarially sound rates not undermining efforts to incentivize MCOs and providers to reduce costs over time.

- **Aligning the federally qualified health center (FQHC) prospective payment system with value-based principles could enhance the impact of Medicaid VBP.** The prospective payment system for FQHCs remains a sticking point for a number of states pursuing VBP through alternative payment models that improve outcomes and contain costs. FQHCs are significant providers of primary care to Medicaid beneficiaries nationally and efforts to more closely align the prospective payment system with the principles of value-based innovation – particularly allowing risk-sharing – could allow states to maximize the impact of their alternative payment models to deliver high-quality, high-value care.

As state and federal policymakers continue to implement, refine and align alternative payment models, these key considerations should be a particular area of focus and attention. Leadership and commitment will be required at all levels to implement and sustain successful alternative payment models across the health care system and ensure providers deliver high value services to the nation's most vulnerable populations.

INTRODUCTION

Across the country, states, insurers, providers and consumers are trying to drive value into the health care system to improve the quality and cost of the nation's health care system. There is a substantial amount of this activity, often referred to as value-based purchasing (VBP), happening among state Medicaid programs. Broadly defined, state Medicaid VBP efforts consist of any activity that a state Medicaid program is undertaking to hold a provider or a contracted managed care organization (MCO) accountable for the costs and quality of the care they provide or pay for (in the case of an MCO). This most often refers to activities that a state Medicaid program is doing to move providers away from the traditional fee-for-service (FFS) payment system, which rewards volume, to alternative payment models that reward value. The FFS system is understood by many to be part of the reason for unsustainable cost growth increases in the US health care system, and consequently, states have been experimenting with different approaches to change the incentives so that the system helps providers focus on delivering high value services.

Medicaid's move away from FFS is consistent with changes in the Medicare and commercial markets. For example, Health and Human Services Secretary Burwell announced plans to move 30 percent of traditional FFS Medicare payments into alternative payment models that reward efficient and high quality care by 2016, and 50 percent of payment to those models by 2018. State Medicaid programs are experimenting with many different models and no two state value-based reform efforts look exactly alike. Instead of using a one-size-fits-all approach, Medicaid programs are designing payment reform and value-based purchasing that best fit their state landscape. This customization directly responds to the localness of health care and allows flexibility for Medicaid to respond to the market dynamics of the state, region, and readiness of MCOs and providers.

As state Medicaid programs seek to advance the use of alternative payment models, they are looking to learn from the work of other Medicaid programs that have implemented these innovations. This report documents the key activities that states are engaged in to transform the payment system at the individual provider level through the use of alternative payment models. While states are actively engaged in driving value through implementing alternative payment models with capitated managed care entities, this report specifically focuses on the alternative payment models that are directly affecting providers, including when a state encourages or obligates its managed care entities to implement provider-level alternative payment models. In exploring these activities, the report develops consistent terminology that can be used across state Medicaid programs. Ultimately, the goals of the report are to: identify the scope and nature of these alternative payment models in Medicaid, share lessons learned in standing up these alternative payment models across states, and fill a major knowledge gap of state activities, which can inform multi-payer efforts around alternative payment models. The report does not focus on the authorities for implementing these models, but rather, focuses on the models themselves.

The report is structured to provide this vital information and meet these goals. In Section II we describe the methodology used to gather the information included in this report. Section III provides a brief overview of the facilitators and vehicles for implementing alternative payment models within state Medicaid programs. Section IV is the primary section of this report, describing the details of the most popularly used alternative payment models in Medicaid. Section V describes the varying ways in which states are implementing alternative payment models in concert with Medicaid managed care entities. And finally, Section VI details the road ahead for Medicaid, including the challenges and opportunities for Medicaid agencies pursuing alternative payment models.

METHODOLOGY

With support from the Commonwealth Fund, the National Association of Medicaid Directors (NAMD) contracted with Bailit Health Purchasing, LLC (Bailit) to conduct a study of state Medicaid agencies and the activities they are undertaking relative to payment reform.[1] To conduct this study, Bailit used a mixed methods approach to gather information about payment reform strategies, including a combination of surveys, interviews and supplemental research.

Bailit surveyed all 50 states via email with a comprehensive survey tool (see Appendix A) that asked detailed questions about state implementations of payment reform at the provider level, whether administered through Medicaid Managed Care, or directly by the state through their FFS program. In addition, Bailit conducted telephonic interviews and web-based research on some states, and collected information that states had previously reported in the State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors.[2] Bailit was able to obtain primary or secondary information from 34 states through a combination of state survey responses and telephonic interviews. Non-responding states do not necessarily reflect a state's engagement or lack thereof in alternative payment models. States may not have participated in the study due to a variety of factors, such as capacity issues, time constraints, limited activity in this area, or other factors. Likewise, not all of the 34 states that responded had been pursuing alternative payment models. Last, Bailit conducted telephone interviews with five MCOs using a structured interview guide. A listing of the interviewed organizations and the interview guide can be found in Appendix B.

IMPLEMENTING ALTERNATIVE PAYMENT MODELS

Early Efforts

State Medicaid programs have been moving towards alternative payment models for a number of years. For example, starting in 1990, states began to adopt the Program for All-Inclusive Care for the Elderly (PACE) as a full-risk capitation model where providers receive an integrated payment from both Medicare and Medicaid to cover a comprehensive set of medical and social services for the frail elderly population. This program sought to keep elderly and disabled beneficiaries at home to receive long-term care services, instead of being institutionalized. While 32 states operate PACE programs, including Indiana which implemented a program in 2014, they remain small because of the limited population they serve. However, a number of states built on these early efforts to develop alternative payment models for dually eligible beneficiaries, including through dual demonstration programs.[3] The 2000s also saw many state Medicaid programs move to purchasing coverage through MCOs as a way to achieve more value in the program. While many states have been purchasing coverage through MCOs for several years, there are a number of states, including Florida and Louisiana that have recently implemented statewide managed care programs. For these states, this is a significant step in their strategy to drive value into the health care system.

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[1] NAMD conducts a range of technical assistance and dissemination efforts around delivery system and payment reforms. This project support is provided by The Commonwealth Fund. Other work by The Fund has been used to forward these efforts with Medicaid directors. For more information, go to www.MedicaidDirectors.org and to www.CommonwealthFund.org.

[2] National Association of Medicaid Directors. (2015). State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors. Washington, DC: National Association of Medicaid Directors. (Accessed December 18, 2015: http://medicaiddirectors.org/wp-content/uploads/2015/11/namd_4th_annual_operations_survey_report_-_november_2_2015.pdf)

[3] For more detail on state dual demonstrations, see Appendix C.

As a precursor to today's alternative payment models were pay-for-performance (P4P) programs. Many state Medicaid programs have implemented and still operate P4P programs that provide a quality bonus payment to providers based on their performance on particular quality measures or patient satisfaction targets. In many instances, states first provided pay for reporting, allowing providers to develop capacity for reporting on particular measures, and later states progressed to paying a bonus based on their performance of those particular measures. For example, Maryland provides a P4P for nursing facilities that meet certain quality and patient satisfaction measurement targets. Despite that many states continue to provide P4P, states were not asked to report these programs because historically, many P4P programs focused only on a few discrete set of measures and did not result in delivery system transformation or movement away from a volume-based payment system. Therefore, this report does not categorize P4P programs as alternative payment models and the survey design did not focus on this category of value-based purchasing.

Today's Efforts

Much of the focus of state efforts in alternative payment models today are focused primarily, though not exclusively, on primary and acute care services. A number of states are using wider-scale alternative payment models as a way to further change the incentives from volume to value. Efforts range from statewide mandated payment changes to experimental pilot programs.

States that are implementing efforts are doing so in a manner that makes sense for their local marketplace, their culture and their environment, and therefore, there is variability in the type of model used and vehicle for which the model is implemented.

States are implementing these models in three different ways. First, some states are designing their own alternative payment models and contracting directly with providers through the traditional Medicaid FFS delivery models or through their Primary Care Case Management (PCCM) programs. Second, some states are requiring their MCOs to implement MCO-designed alternative payment models, and, in some cases, are providing MCOs guidance on what the model should include. Lastly, other states are designing their own models and encouraging, requiring or incentivizing their MCOs to implement the state-designed alternative payment model. Today, states are choosing the implementation path and model that makes the most sense for their program, state environment and culture. Regardless of which approach or which model is used, significant work and resources are required on the part of the state, their plans and their providers to realize success.[4]

Facilitators for Payment Reform

There are multiple catalysts driving Medicaid agencies to implement alternative payment models. For some states, the desire to pursue these models comes from within the Medicaid agency as part of its strategic initiatives and annual imperatives to contain Medicaid cost growth. Other states have active governors that are driving broader value-based purchasing initiatives, and in some cases, legislatures have required state Medicaid programs to implement certain activities. For example, in 2012, the Massachusetts legislature passed a law requiring the state Medicaid agency to move 80 percent of its payment to providers into alternative payment models by 2015.[5] More often than not, however, the desire to improve the value in the system is a shared goal across agencies and branches of government. For example, in Ohio the governor's office created the Office of Health Transformation and the Governor's Advisory Council on Health Care Payment Innovation. At the same time, Ohio's Medicaid agency is pursuing health care coverage innovation.

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[4] See Section VII for a full discussion of the challenges that Medicaid programs face when implementing alternative payment models.

[5] The state has not met this goal, but is committed to implementing alternative payment models at scale across the Medicaid program and is currently developing new models to be launched in 2016.

An important additional facilitator for payment reform in Medicaid programs has been the additional funds states received in the form of grants from the Center for Medicare and Medicaid Innovation (CMMI). State Innovation Model (SIM) Model Test grants are enabling many states to advance payment and delivery system reform by providing large funding awards to support systems change, including across payers. In some states, SIM funding directly supports new delivery system and payment reform efforts, while other states align SIM activities with existing reform initiatives. For many of the six original SIM Model Test award states, including Minnesota and Vermont, programs predated the SIM initiative, but states are leveraging their SIM funds to support those payment reform efforts. While SIM Design grants are smaller, they too have provided states with resources to pursue payment reform initiatives. For example, the Virginia SIM Design grant was in part a catalyst for pursuing value-based payment initiatives in the state. Likewise, Pennsylvania has adopted many of the payment reform strategies laid out within its SIM Design strategy.

While additional federal funding has been an important facilitator for many states, there are some states that are strategically moving toward the implementation of alternative payment models without additional funding. South Carolina, for instance, worked with a national nonprofit, the Catalyst for Payment Reform, to improve its value-based contracting. As a result, it has implemented a requirement that its MCOs pay at least 20 percent of its contracted providers using an alternative payment model. Similarly, Texas is taking steps toward alternative payment models without SIM funds. The state requires its MCOs to report their usage of alternative payment models so that the state may begin to track MCO efforts.

Section 1115 waivers allow states more flexibility in designing innovative approaches that fit the needs of the state. For example, Massachusetts' current waiver indicates that CMS and the state will work together to set shared savings and shared risk targets for providers in its Primary Care Payment Reform Initiative. Likewise, Iowa, Virginia, and Washington reported implementing alternative payment models through their section 1115 waivers. However, a section 1115 waiver is not a requirement and some states, like Ohio, implemented alternative payment models without a section 1115 waiver. Whether or not an alternative payment model is implemented through an 1115 waiver depends on how a state currently operates its Medicaid program and what authority currently exists in the state plan vs. in a demonstration waiver, and whether a state is implementing the model statewide or for a targeted population or area.

A handful of states have also used a section 1115 waiver to create Delivery System Reform Incentive Payment (DSRIP) programs, which allow the state to reward providers for implementing successful delivery system and payment reform projects. New York, for example, is making broad, sweeping changes as a result of its DSRIP program and will be implementing a series of alternative payment models with providers through its managed care network as a result of DSRIP funds. Several other states, including Arizona and Massachusetts, are pursuing approval of DSRIP programs to provide technical assistance and transformation support to health care providers in the transition to alternative payment models.

THE TYPES OF ALTERNATIVE PAYMENT MODELS IN USE AMONG MEDICAID PROGRAMS

There is no national consensus on alternative payment model terminology, and states use different terminology for the same activity. This is because alternative payment model concepts are relatively new and only recently have efforts been put forth to set national definitions for models. This report seeks to identify consistent terminology for common alternative payment models in Medicaid.

There are a number of value-based purchasing strategies focused on provider accountability in use by Medicaid programs. This report focuses on the three most widely used payment models: additional payments in support of delivery system reform, episode-based payments, and population-based payments.

This section discusses the most widely used alternative payment models by Medicaid programs. They are: 1) payments in support of delivery system reforms; 2) episode-based payments; and 3) population-based payments. Each of these payment types are described below, including a discussion of the variations in which they are implemented among state Medicaid programs.

At the time this report was written, the Centers for Medicare and Medicaid Services (CMS) Health Care Payment and Learning Action Network (LAN) released a framework for alternative payment models. The LAN's framework is designed to help drive alignment of payment model approaches across payers and providers, and to track Secretary Burwell's goal of moving FFS Medicare payments to value-based payments. However, we conducted our research with states and plans prior to the release of this report, and consequently, state terminology may differ from LAN terminology. For this report we have created a framework through which we are categorizing alternative payment models in states, and much like the LAN, our framework considers payment to be value-based when providers have performance expectations. Going forward, NAMD intends to explore the linkages between the work of the LAN and Medicaid alternative payment models explored in this report.

1. ADDITIONAL PAYMENTS IN SUPPORT OF DELIVERY SYSTEM REFORM

Some Medicaid programs offer providers additional payments in support of delivery system reform where providers (i.e., typically primary care providers) receive a per member per month (PMPM) payment for an attributed population to be used for a wide variety of purposes, in exchange for meeting certain expectations. The goal of this model is to support infrastructure for health care delivery transformation efforts or traditionally unreimbursed services (e.g., care management). Thirty-five percent of state respondents (12/34) reported having implemented additional PMPM payment models, and in some of those states, they have implemented multiple additional PMPM payment models. For the purposes of this report, and consistent with Medicaid program efforts, we are including additional PMPM payments where the PMPM is tied to meeting specified practice transformation expectations (i.e., transforming a primary care practices to meet national standards for medical home accreditation, or for performing high-value services, such as care coordination) or more traditional quality, cost or utilization metrics as part of this framework. Many states that implement an additional PMPM payment model also utilize a P4P strategy that provides for a quality bonus in addition to the per member per month payment. As noted above, in this report, we have not separately categorized P4P initiatives.

Covered Services

Typically, additional PMPM payment models are aligned with Patient Centered Medical Home (PCMH) and Health Home delivery systems, and usually the PMPM is designated for a particular activity.[6] States with PCMH models typically provide a PMPM to primary care providers for provision of care management services and other support services offered to beneficiaries, or medical home transformation.

For states operating Health Home programs with the additional PMPM payment model, in exchange for the PMPM the Health Home must provide six statutorily required services: a) comprehensive care management; b) care coordination and health promotion; c) comprehensive transitional care, including appropriate follow-up from inpatient to other settings; d) patient and family support; e) referral to community and social support services; and f) use of health information technology to link services as feasible and appropriate.[7]

Application of Additional Payments that Support Delivery System Reform

There is wide variation in the application of PMPMs, including in how they are calculated and administered. PMPM fees can range from a few dollars (which is more typical in a PCMH model) to hundreds of dollars (which is more typical in a Health Home model) and typically vary based on what the practices requirements are (e.g., implement key patient-care related technology vs. administer a care coordination function). In the cases where the PMPM covers care coordination, the PMPM fees vary based on patient complexity. These PMPM fees can be applied in a uniform manner across all providers for all populations, and/or can be tiered to account for patient acuity, status of practice transformation or practice type (e.g., primary care physician vs. community mental health clinic). For example, in Iowa's Health Home program, PMPMs are graduated on a four tier payment ladder where patients with one to three chronic conditions have a $12.80 rate and additional chronic conditions increases the PMPM, to patients with 10 or more chronic conditions having a $76.81 rate. On the other hand, when states like South Carolina's and Oklahoma's PCMH offer primary care practices an additional payment tied to the practice's level of transformation, which is closely connected to the National Committee on Quality Assurance (NCQA) PCMH Recognition tiered program, PMPM rates are typically much lower and range from $0.50 – $9.00.[8]

Examples of States Using Additional Payments that Support Delivery System Reform Models:

- ARKANSAS
- COLORADO
- DISTRICT OF COLUMBIA
- IDAHO
- IOWA
- MAINE
- MARYLAND
- MICHIGAN
- MONTANA
- OKLAHOMA
- RHODE ISLAND
- SOUTH CAROLINA

Payment Models That Provide Additional Payments that Support Delivery System Reform

Sometimes coupled with additional PMPM payment models are other payment models, like bonus payments for quality reporting (pay-for-performance) or an opportunity to share in savings. This is a way of adding further value to the PMPM, more so than requiring practices to perform certain functions. For example, in the Colorado Accountable Care Collaborative (ACC), practices receive a PMPM and are also eligible for a quality incentive based on reductions in emergency

[6] While PCMH programs are typically paid using only an additional PMPM payment model, therefore fitting into this category, some PCMH delivery system models are coupled with population-based payments. For example see the discussion in section IV.3 on population-based payments.
[7] 42 USC 1800001 note. www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
[8] Bitton A, Martin C and Landon BE. "A nationwide survey of patient centered medical home demonstration projects." *J Gen Intern Med* 25(6):584-92, 2010.

department usage, hospital readmissions and medical imaging.[9] Colorado withholds a portion of the PMPM from practices and then uses those dollars to fund the quality incentive program. On the other hand, Iowa offers a pay-for-performance bonus valued at up to 20 percent of the PMPM based on quality measures. Likewise, Maryland gives primary care practices in their Multi-Payer PCMH program the opportunity to share in a portion of savings that a practice generates through improved care and better patient outcomes, in addition to an additional payment. Connecticut is planning a program similar to Maryland's.

Quality Measures

Quality measures for additional PMPM payment models vary across states and programs. Typically, quality measures for PCMH programs include clinical quality, cost and utilization, patient experience, process, and implementation. There have been some efforts from health policy experts to identify a core set of quality measures for PCMH, but quality measures across state programs continue to vary.[10] For Health Home programs, CMS has established a recommended "core set" of quality measures for state Health Home programs. This core set consists of eight measures and includes clinical quality measures (e.g., adult BMI assessment, follow-up after hospitalization for mental illness, initiation and engagement of alcohol and other drug dependence treatment), prevention measures (e.g., chronic condition hospital admission), and process measures (e.g., timely transmission of transition record). It is intended to inform an independent evaluation of the Health Home programs across the country. Many states have identified additional quality measures for their own programs. These measures vary based on the focus of the Health Home beneficiary. For example, Iowa's Health Home program, which focused on the chronically ill, measures performance on five key diabetes and two key asthma measures; whereas Maine's Behavioral Health Health Home has an additional focus on behavioral health measures, like access and adherence to antipsychotic medications. In addition, Maine also measures social determinants of health, for example, the employment status and residential stability for adults with serious mental illness.

Impact of Additional Payment Models that Support Delivery System Reform

Except for Colorado, most states have a limited portion of their Medicaid enrollees and providers involved in additional PMPM payment models that support delivery system reform. This is particularly true for Health Homes, which are often aimed at the beneficiaries who have the highest needs and the highest costs. Table 1 provides detail on the percentage of state Medicaid beneficiaries in their additional PMPM payment model.

While these models are often targeted at a subset of beneficiaries, many states reported positive outcomes of their additional PMPM payment models. Iowa experienced a reduction in the costs of emergency department (ED) visits by $12.30 PMPM, and a total reduction in costs of 20 percent.[11] Idaho reported a $22 PMPM average savings as a result of its Health Home program, totaling approximately $2.4 million in annual state savings. States also reported an improvement in patient satisfaction and outcomes. Colorado has experienced fewer readmissions, ED visits, and high cost imaging services, and lower rates of hypertension and diabetes exacerbations.[12]

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[9] Colorado reported that it plans to make significant changes to its ACC program, discussed in section IV.
[10] Bazinsky, K and Bailit M. "The significant lack of alignment across state and regional health measure sets." Buying Value, 2013.
[11] Summary Report of the Iowa Medicaid Medical Health Home: http://ppc.uiowa.edu/publications/summary-report-iowa-medicaid-medical-health-home-evaluation-health-home-program-those
[12] Colorado Medicaid Accountable Care Collaborative: https://www.pcpcc.org/initiative/colorado-medicaid-accountable-care-collaborative-acc

TABLE 1.

PERCENTAGE OF TOTAL BENEFICIARIES AFFECTED BY ADDITIONAL PMPM PAYMENT MODELS BY SELECTED STATE

STATE	PERCENTAGE
Colorado Accountable Care Collaborative	58% of all Medicaid members
Idaho Health Homes	3% (19% of targeted subpopulation)
Iowa Health Homes	1.3% of all Medicaid members
Iowa Integrated Health Homes (Community Mental Health)	4.2% of all Medicaid members
Maine (Health Homes State A – Chronic Conditions)	17% (38% of targeted subpopulation)
Maine (Health Homes State B – SPMI)	1% (14% of targeted subpopulation)
South Carolina PCMH	25% of all Medicaid members

A closer look at three states' use of Additional PMPM Payment Models in Support of Delivery System Reform...

The Iowa Health Home - *Additional PMPM payment plus pay-for-performance*: the program began in 2012 with a focus on patients with multiple chronic illnesses. Participating primary care providers receive a tiered PMPM payment ranging from $12.80 for individuals with 1-3 chronic conditions to $76.81 for individuals with 10 or more chronic conditions. Providers are also eligible for a bonus incentive (or pay-for-performance) based on their performance on key quality benchmarks across four domains: preventive care, chronic illness care, adult or pediatric-specific chronic care measures, and mental health. Each domain is weighted so that in order to receive the total bonus incentive payment (which is 20 percent of the PMPM) providers must achieve the performance benchmark across all domains. If a provider is not able to achieve all performance benchmarks, they are still eligible for partial bonus incentive payment. The program reported positive results, including that there was a significant decline in the number of patients reporting an unmet need, particularly after-hours, for urgent care, specialist care, and prescription medications. Overall, total costs savings was approximately $9 million during the first 18 months of the program.[13]

Maryland's PCMH – *Additional PMPM plus shared savings opportunity*: For this pilot program, the state requires the four largest state-regulated health insurance carriers to financially support the program by providing up-front and incentive payments to qualifying PCMH practices. Other state and federal payers, including Medicaid MCOs and Medicare Advantage, have voluntarily joined the program. There are 52 practices with nearly 250,000 attributed patients participating in the program overall, including approximately 60,000 Medicaid beneficiaries who are enrolled in Medicaid MCOs. Participating practices receive a fixed transformation payment (FTP) with a PMPM fee paid semi-annually, if practices are able to achieve National Committee for Quality Assurance (NCQA) PCMH recognition and invest a portion of their FTP in care coordination. In addition, participating practices can earn a percentage of savings generated through improved care and better patient outcomes. Shared savings calculations comprise all patient costs, including approximately 94 percent of costs that occur outside the primary care practice (e.g., hospitals, specialist physicians, laboratories, etc.). For FY 2016, Medicaid budgeted $3 million to PMPM payments to the participating MCOs based on the number of attributed participants. Shared savings payments to providers in the participating MCOs totaled nearly $350,000 in performance year 2012 and nearly $63,000 in performance year 2013. While Medicaid MCOs will continue to participate in the program through June 2016, it is important to note that this PCMH pilot project has largely concluded, as the pilot ran through December 2015.

Colorado's Accountable Care Collaborative – *Additional PMPM payment plus quality incentive based on withhold*: this is a managed fee-for-service (PCCM) model under which primary care providers receive an enhanced payment of $4 PMPM for managing patients' care, and Regional Care Coordination Organizations (RCCOs) receive a PMPM payment of $9.43 - $10 to provide care coordination services, network development, practice support and other functions on a regional basis. Both the primary care providers and the RCCOs have $1 of the PMPM withheld and earned through performance on Key Performance Indicators. Since implementing the ACC, Colorado has seen reduced readmissions, lower use of high-cost imaging and improvement in follow-up visits post-hospitalization. Moreover, Colorado reports net savings of over $77 million since the program's inception.

[13] Compared to a randomly selected group of matched non health home Medicaid members.

2. EPISODE-BASED PAYMENT

Episode-based payment is an approach where one provider is held accountable for the costs and quality of a defined, and discrete set of services for a defined period of time. Twenty one percent of responding states (7/34) indicated having implemented an episode-based program, or that they were considering implementing an episode-based program. In the three states that have implemented an episode-based payment program, the provider responsible for the episode is paid on a fee-for-service basis and a reconciliation process is conducted at the conclusion of the episode-performance period. The goal of episode-based payment is to bring increased focus to identifying and refining clinical pathways that produce more effective and efficient care, including through improved coordination of care for a patient across different providers. Arkansas, Ohio and Tennessee all have begun to implement episode-based payments on a widespread basis, and New York is actively engaged in developing a state-wide program. Connecticut, Oklahoma and South Carolina are also considering implementing episode models. These models have many similarities, but differ from one another in how they are being implemented. For example, Ohio, Tennessee and New York are implementing the episode-based program through their MCOs, and Oklahoma and South Carolina are considering doing the same. On the other hand, Arkansas directly contracts with providers.

Examples of States Implementing or Considering Episodes:

- ARKANSAS
- CONNECTICUT
- OHIO
- OKLAHOMA
- NEW YORK
- SOUTH CAROLINA
- TENNESSEE

Episodes and Covered Services

Episode-based payment can be used for acute or episodic care (e.g., acute exacerbation of asthma or pregnancy and delivery), or for chronic conditions (e.g., diabetes). Arkansas, Ohio and Tennessee are all implementing episode-based payments for similar episodes, as shown in Table 2 below. Tennessee plans to implement 75 different episodes of care by 2019, and is requiring its managed care entities to implement the state defined models. Generally, the episodes that are being pursued are acute or episodic in nature (e.g., acute exacerbation of asthma or tonsillectomy). Very few chronic episodes are being implemented in these states, although this is true of episode-based payment programs in the Medicare and commercial markets too.

The delivered services relevant to the condition are included in the payment model, and services that are irrelevant (e.g., treatment for a sports injury) are not included in the payment model. However, what specific services are included or excluded from an episode-based payment model can be negotiated between the payer and provider, leading to many different approaches to the same model. For example, Arkansas, Ohio and Tennessee each implemented a perinatal episode where all prenatal, delivery and postpartum services for the mother 40 weeks prior to delivery and 60 days post-delivery are included in the episode. New York is actively pursuing a different model that adds newborn care and services for the first 30 days of life as part of the episode. They hope to determine whether the incentives for a provider to deliver high-quality and evidence-based prenatal care might be greater if the outcomes of the newborn are included in the episode.

TABLE 2.

EXAMPLES OF EPISODES IMPLEMENTED OR PLANNED BY AR, OH, AND TN

	ARKANSAS	OHIO	TENNESSEE
Appendectomy	√	Planned 2017	
Asthma	√	√	√
Attention Deficit Hyperactivity Disorder[14]	√		
Cholecystectomy	√	Planned 2017	√
Chronic Obstructive Pulmonary Disorder	√	√	√
Colonoscopy	√	Planned 2017	√
Congestive Heart Failure			
Coronary Artery Bypass Graft	√		
Heart Failure	√		
Hysterectomy	√		
GI Hemorrhage		Planned 2017	√
Oppositional Defiance Disorder	√		
Percutaneous Coronary Intervention	√	√[15]	√
Perinatal	√	√	√
Pneumonia[16]	√		√
Tonsillectomy	√		
Total Joint Replacement	√	√	√
Upper Endoscopy		Planned 2017	√
Upper Respiratory Infection	√	Planned 2017	√
Urinary Tract Infection (IP & OP)	√	Planned 2017	√

This difference in episode definitions can also be seen in a chronic condition like asthma. Arkansas, Ohio and Tennessee have all taken an approach where an asthma episode is focused on services related to acute exacerbations. The episode begins during an asthma attack and includes all of the care following that asthma attack for 30 days, including any hospital admissions, readmissions and post-acute care. New York, on the other hand, is planning an approach where an asthma episode is included with other chronic pulmonary disorders. The provider responsible for the patient is responsible for all relevant services related to chronic condition management, including any acute flare-ups.

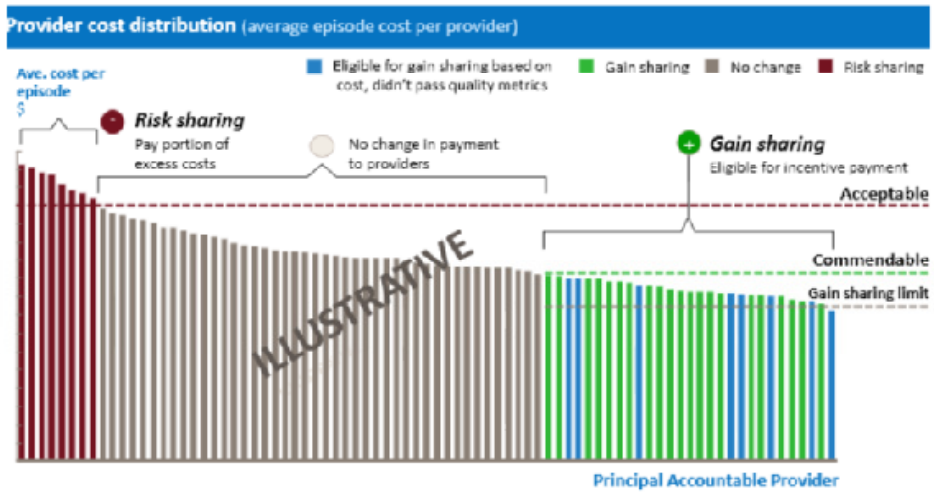
Risk Models

The three states with active statewide implementation of episodes have each adopted a shared risk model, where providers have some responsibility associated with costs that exceed the budget for the episode. Arkansas, Ohio and Tennessee each analyze the distribution of spending on a per-episode basis across all of its providers. Each state establishes "acceptable," "commendable," and "gain sharing limit" spending benchmarks that determine whether a provider may be at risk for cost overages and for where a provider may earn shared savings (see Table 3 on next page).

[14] Including the variant of ADHD with Oppositional Defiance Disorder as a comorbidity.
[15] Includes acute and non-acute PCI.
[16] Arkansas is specifically targeting pediatric pneumonia.

TABLE 3.

EPISODE RISK SHARING MODEL FOR THREE STATES



Source: Arkansas Payment Improvement Initiative

Each vertical line in Table 3 represents the average cost for a provider (sorted from highest to lowest). Providers whose costs are higher than the threshold set for "acceptable" are responsible for a portion of the costs above that limit (e.g., the 75th percentile) (see red vertical lines in Table 3.) Providers whose average costs fall between the "acceptable" and the "commendable" threshold for episode spending are not at risk for loss, but are not eligible for savings (see gray vertical lines in Table 3). Providers whose average costs fall below the "commendable" threshold but are above the "gain sharing limit" threshold are eligible to share in savings, if their performance on quality measures is adequate. Lastly, providers who fall below the "gain sharing limit" are not eligible to receive any shared savings as a disincentive for providers to withhold services to achieve a lower per-episode cost average. Oklahoma is considering adopting a model similar to the one described.

Quality Measurement

In these episode-based payment models, quality measures are used for both tracking purposes and to affect payment. For example, in Arkansas's perinatal episode program, in addition to meeting cost expectations, in order to share in savings providers must meet three quality metrics: 80 percent of women in episodes must be screened for HIV, Group B streptococcus and chlamydia. In addition, providers are also required to report several quality measures like the percentage of women in episodes who were screened for gestational diabetes, asymptotic bacteriuria, and the Cesarean section rate. This allows the state to collect baseline performance data that will help it to set adequate benchmarks and consider these quality metrics for payment purposes at a future point in the state's program.

Quality measurement in episode-based payment programs focuses narrowly on the episode at hand because of the nature of implementing a payment model focused on a discreet service, like hip or knee replacement. Therefore, when looking broadly at an episode-based payment program for states that have implemented multiple payment models, there may be hundreds of quality measures in use that are only relevant for one or a small number of conditions. Some of the quality measures that are in use for one common episode, like asthma, include: rate of repeat acute exacerbation within 30 days post initial discharge, and percent of patients on an appropriate medication during or in the 30-day period following the acute exacerbation. Because most episode-based payment programs are focused on an existing condition or event, most do not measure prevention.

Impact of Episode-Based Payment

Because of the relative newness of this model, the only state that has reported outcomes on their episode-based payment program to date is Arkansas. Arkansas has experienced significant savings where each episode implemented in 2014 had an average cost between 2 and 39 percent under projections. The quality of care has also improved with a 17 percent drop in unnecessary antibiotic prescribing for non-specific upper respiratory infection and an improvement in perinatal screening rate, for example.[17] Ohio and Tennessee are too early in their program to assess outcomes, and New York plans to implement its program in 2016 and 2017.

3. POPULATION-BASED PAYMENT MODELS

Population-based payment at the provider level is an approach where one or more providers is held accountable for spending targets that cover the vast majority of health care services to be delivered to a specific population.[18] The goal of this model is to align the incentives of the payer, the provider and the patient to improve the overall quality of health care and manage the costs. Population-based payment models require a provider to take on responsibility for care it delivers, plus consider the costs of downstream care, resulting in a focus on prevention. In some, but not all cases, population-based payment models are applied to accountable care organizations (ACOs), which are an organization of providers that have voluntarily come together and agreed to be responsible for the cost and quality of a total population. These providers work together to coordinate the care of a population. A number of states have implemented population-based payment models with at least two (Minnesota and Oregon) operating more than one. There are several different population-based payment models implemented by Medicaid agencies with providers: population-based payment models with spending targets, primary care capitation and full risk capitation. Each one is discussed separately below, though they are not necessarily mutually exclusive.

Examples of States Using of Population Based Payment Models:

- CALIFORNIA
- COLORADO
- MAINE
- MASSACHUSETTS
- MINNESOTA
- OKLAHOMA
- OREGON
- RHODE ISLAND
- VERMONT

Population-Based Payment Models with Spending Targets

Population-based payment models with spending targets is a model that establishes a targeted expenditure, often based on the "total cost of care" to cover all of the expected costs for health care services to be delivered to a specified population during a stated time period.[19] Payers using these models continue to pay claims in the normal fee-for-service manner and reconcile payments to a spending target at the conclusion of the performance period. Oftentimes, these models are simply referred to as "shared savings" or "shared-risk" models. Several states use this type of population-based payment model, including Maine, Minnesota and Vermont, and Rhode Island has just launched a similar model. This approach can vary greatly in terms of what services are included in the model, what population is covered, and how shared savings or shared risk is calculated. Each of the states that have implemented a population-based payment model has done so differently, reflecting state agencies' unique environment and state culture.

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[17] Moving to a Value-based Health Care Payment System in Arkansas. National Academy for State Health Policy (NASHP) Annual Conference 2015.
[18] A Medicaid program's provision of a capitation payment to an MCO may also be called a population-based payment, but in the case of alternative payment models at the provider level, population-based payments refer to the attributed population of patients for a specific provider.
[19] Alternative Payment Models in the Massachusetts Commercial Market: Baseline Report (2012 data). Massachusetts Center for Health Information and Analysis, 2014.

Services Included in the Spending Targets

In large part, the services included within the spending targets cover care for acute and chronic medical conditions and certain behavioral health conditions. Long-term care and dental care are less commonly included in the spending targets, and some states leave the inclusion of those services up to the provider and vary the payment accordingly. While these spending targets are often called "total cost of care," it is a bit of a misnomer given the variation in what is included in the calculation of the spending target. However, this variation reflects the customization of Medicaid initiatives, which allows for greater participation by the Medicaid provider communities, expanding to more than just ACOs. It allows some providers that may offer expanded services, or have a larger network, to include services that other providers may not be able to (e.g., long-term care). Table 4 describes what services are included in the spending targets of select state models.

TABLE 4.

SERVICES INCLUDED IN POPULATION-BASED SPENDING TARGETS BY SELECTED STATE

	PRIMARY CARE	INPATIENT MEDICAL CARE	BEHAVIO-RIAL HEALTH	LONG-TERM CARE	DENTAL/ ORAL HEALTH	PHARMA-CY	OTHER
Maine	√	√			√ (optional)	√	
Minnesota (Integrated Health Partnership)	√	√	√	√ (optional)		√	√[20]
Vermont	√	√	√[21]				

Risk Models for Population-Based Payment Models with Spending Targets

Typically, providers begin to participate in a population-based payment model using a shared savings arrangement where they are eligible to keep a portion of earned savings. In some cases, a provider can stay in a shared savings arrangement for the duration of the contract, but in others, the state or health plan requires that the provider move into a shared-risk in the out-years of a contract. Shared risk arrangements require the provider to be responsible for a portion of costs incurred to them that are above the spending target. In most cases, states place some sort of cap on the amount of losses that a provider may bear, so as to protect the providers from outlier costs and the risk of individuals needing significantly more health care than expected, which is typically referred to as "insurance risk" and is the primary risk insurers cover. For example, in the Minnesota Integrated Health Partnership Program, there are two options: "virtual" and "integrated." In the "virtual" option, providers share in savings only and are not required to take on risk. In the "integrated" option, providers were eligible for shared savings in the first year of the program and are required to move to shared-risk during the second and third years of the program. However, participating providers take on limited risk in years 2 and 3, in exchange for limitations on the extent to which they can share in savings. In addition, providers have some protection from outliers and insurance risk.

A closer look at one state's use of population-based payment models with spending targets...

Rhode Island recently launched its Coordinated Care Pilot through which the state has certified four Accountable Entities (AEs) that will be responsible for providing and coordinating a comprehensive set of services to attributed Medicaid beneficiaries. The state's two managed care plans will contract with the AEs and negotiate a total cost of care methodology, how savings will be shared between the AE and the MCOs, and agree on required quality performance targets. The state retains the right to approve the MCOs' contracts with AEs. While shared risk is anticipated to be part of the model eventually, no entities are taking risk now. Additional organizations will be certified later this winter.

[20] Optionally included in Minnesota's model are intensive inpatient mental health and chemical dependency services, extended supports, transportation and DME.
[21] Some limited behavioral health services are included in the Vermont model.

While the federal Prospective Payment System (PPS) for FQHCs has historically protected FQHCs from being at risk for any services, states and FQHCs are beginning to look at ways for FQHCs to both share in savings above what can be earned under the PPS and also be at some limited risk. California recently passed legislation, with the support of its FQHCs, to allow for limited risk based on acceptance of a primary care capitation payment.

Primary Care Capitation

Under the primary care capitation model, a primary care practice receives a fixed amount of money for the entire set of services it provides to an attributed population. If quality is a component of the model, then it is considered to be a value-oriented alternative payment model. California, Massachusetts and Oregon are experimenting with primary care capitation. In the Massachusetts Primary Care Payment Reform Initiative (PCPRI), PCMHs, including some federally qualified health centers (FQHCs) receive a fixed dollar amount for a comprehensive set of primary care services, including integrated behavioral health services. In addition, primary care practices are also responsible for the spending targets of its attributed population. The Massachusetts PCPRI model was not included in the population-based payment models with spending targets category as its chief differentiating characteristic is the primary care capitation payment. Optionally included within the spending targets are long-term care services. If providers were under budget for the total cost of care measure, then they were eligible for shared savings in the first year of the program. In subsequent years, providers with a large enough attributed population are required to move to shared-risk during the second and third years of the program. However, participating providers take on minimal risk in years 2 and 3. They are only responsible for 15 percent of any costs above the spending target, giving them some risk, but protection from outlier costs and insurance risk.

While Massachusetts has implemented this model across primary care providers, California and Oregon are doing so specifically with their FQHCs. Nationally, FQHCs are paid using a prospective payment system (PPS) where the provider receives a fixed dollar amount for each office visit, regardless of what services are delivered during the office visit. This is sometimes called encounter-based billing. This incentivizes FQHCs to maximize the number of office visits that are delivered to patients and does not compensate for any care delivered outside of an office visit. In order to move FQHCs away from the incentive to increase volume of office visits, some FQHCs in Oregon and California are receiving capitation for primary care services. The FQHCs in both states are responsible for performance against quality measures, including process, prevention, clinical outcomes and patient satisfaction.

Due to federal requirements, under this model the FQHCs are not at risk if their PMPM payments fall short of what they would have normally received under the traditional encounter-based PPS model, and states are required to compensate the FQHCs to at least the level they would have received under the PPS model. Therefore, while the primary care capitation model can provide enhanced support allowing FQHCs the flexibility to perform services that do not require an office visit (e.g., telephonic care management), states are unable to fully hold providers accountable for high costs and poor outcomes. The reconciliation to the PPS payment rate creates a barrier for states to drive VBP at the provider level with FQHCs and to align models across providers in the state. Some states have sought ways to overcome this challenge. For example, California passed a law in which the Medicaid program would only repay the FQHCs if the capitation rate varied significantly (at a to-be-defined percentage) from the PPS model. However, such innovative strategies do not fully address the challenges with payment requirements for FQHCs and the barrier this creates to VBP in Medicaid.

The primary care capitation approach gives the FQHCs the flexibility to provide services that were traditionally not compensated, but that can improve the outcomes of the patient, like patient engagement and care management. The flexibility that FQHCs have in deciding how to use the payment they receive has yielded positive results in the outcomes of the delivery system for Oregon (the California program is just beginning). The state has reported that in the first phase of the program, inpatient hospitalizations were 20.3 percent below trend, and emergency department utilization was 5.6 percent below trend. Billable office visits decreased by 2.8 percent, while patient engagement activities increased by 142 percent.

Primary care capitation is also used by some Medicaid MCOs to pay their primary care providers. The scope and design of these activities is negotiated between the MCOs and providers, and differs across plans and the marketplace in which they operate.

Full Risk Capitation

Under the full risk capitation model, a provider receives a set amount of money to deliver a comprehensive set of services and is at full risk for any costs that may be incurred over the set budget. In exchange for this risk, the provider is eligible to keep all earned savings if it delivers efficient care. Assuming complete risk for costs incurred over the set budget is the primary feature that distinguishes this model from a population-based payment model with spending targets. Consistent with the LAN, our framework does not consider full risk capitation models to be considered value-based unless providers have some quality performance expectations.

Full risk capitation is a payment model that has been traditionally limited to managed care entities, and still today, most providers are not capable of accepting full risk capitation. However, some states are encouraging the development of integrated entities that share both provider and health plan characteristics. For example, Oregon has developed ACO-like entities that receive capitated payment to cover all the services a beneficiary needs (with some exceptions for long term care and/or behavioral health). In the Oregon model, which is sometimes referred to as a "global budget," the Coordinated Care Organizations are a network of health care providers organized by a former plan entity or by a new community-based organization. Colorado is experimenting with a similar model developed in coordination with two integrated health care entities that are both a plan and a provider. While these efforts are underway, others are beginning to develop this type of approach. For example, Oklahoma is in the process of developing their Communities of Care Organization model, and is closely following Oregon's approach. They also intend for their model to cover public employees in addition to Medicaid beneficiaries.

In these examples, the front-line provider receives incentives to deliver high value care. In other words, while the integrated ACO-like entity is receiving a capitated performance-based payment, the providers who are incorporated into the ACO-like entity are sometimes paid using an alternative payment model. This approach is sometimes called "payment within the payment," referring to the front line provider payment. In both the Oregon and Oklahoma approaches, their integrated entities are required to implement alternative payment models with providers. The Oklahoma model requires 80 percent of payments to providers to be value-based by 2020 and participation in a forthcoming episodes-of-care program. Similarly, in Colorado, two provider-based MCOs receive capitated payments from the state and use alternative payment models (i.e., shared savings and salary-based models) with their providers. In many ways, this approach is similar to state efforts to drive alternative payment models through their MCOs. The only difference is the entity receiving the full-risk capitation is a hybrid entity that acts as both a health plan and provider organization.

Colorado, Oregon and Oklahoma incorporate quality goals into their full risk capitation models. As a consequence for not meeting performance expectations under Colorado's model, the state medical loss ratio (MLR) applied to the organization, which is normally 85 percent, increases to 89 percent. This requires the ACO-like entities to spend more of its premium dollars on medical care. Oregon created a quality incentive pool funded through a four percent withhold of the capitated payment, which is distributed to the CCOs based on their performance on certain quality measures. Oklahoma has not finalized its quality model at this time.

Quality Measurement in Population-based Payment Models

Population-based payment models typically have a wider array of quality measures associated with the payment model than do additional PMPM payment models or episode-based payment models, in large part because the payment model has a wider focus on the total health of a population. States reported measuring patient and caregiver experience, care coordination and patient safety, prevention, specific measures around at-risk populations (e.g., behavioral health-focused measures), cost measures, and clinical processes for certain conditions.

THE ROLE OF THE MEDICAID MANAGED CARE ENTITY IN IMPLEMENTING ALTERNATIVE PAYMENT MODELS

About 72 percent of Medicaid beneficiaries across the country are enrolled in managed care organizations, with individual state populations ranging from about 10 percent to 100 percent.[22] Both national and locally-based Medicaid MCOs are also driving payment reform. This is true in states like California, Georgia and Indiana where MCO contracts do not contain requirements for payment reform but MCOs and their providers have developed their own value-based payment arrangements. However, many Medicaid agencies are actively directing their MCOs to expand their use of alternative payment models at the provider level. States are generally doing this through one (or more) of the following strategies.

- ***The state contractually requires MCOs to implement MCO-defined payment models.*** Twenty-six percent of state respondents (9/34) reported requiring MCOs to implement an MCO-defined alternative payment model or will be doing so in 2016. This approach gives MCOs flexibility to design approaches under broad definitional criteria, which may be set by the state. Many of these states, but not all, set specific percentages of payment that MCOs must have

Many state Medicaid programs have contractual requirements with their MCOs to increase implementation of alternative payment models with network providers. States require anywhere from 20-50 percent of providers to be paid through an APM by the end of the current contract period.

[22] Kaiser Family Foundation. "Total Medicaid Managed Care Enrollment." 2013. http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/

engaged in an alternative payment model. These targets vary from state-to-state and often reflect the variability in the MCO's starting points and provider landscape. For example, South Carolina's target is 20 percent of payments through alternative payments by next year, Iowa requires at least 40 percent by 2018, Arizona requires plans to have 50 percent by 2017, and Ohio requires 50 percent by 2020. Other states, like Hawaii, Michigan and Nebraska do not set specific targets, but do require plans to increase the use of alternative payment models, or in the case of New Mexico, require the implementation of alternative payment model pilots. Some states require a portion of the MCO capitated payment to be at risk for achieving these goals. For example, if MCOs in Arizona meet the threshold for use of alternative payments, they are then eligible to recoup a one percent withhold based on the quality performance of the plan.

- ***The Medicaid agency promotes the use of alternative payment models by its MCOs, but does not contractually require them to do so.*** Fifteen percent of respondents (5/34) noted that they encourage MCOs to implement alternative payment models, but have thus far not contractually obligated the plans to do so. In Illinois, for example, MCOs are encouraged to implement these models in order to meet their own performance requirements. Some of these states are asking plans to report the use of APMs or include placeholder language in their contracts indicating the desire for the MCO to participate in future reform efforts.

- ***The Medicaid agency designs an alternative payment model and contractually obligates MCOs to implement the state-defined model.*** Only four of the thirty-four states studied for this report contractually required its MCOs to implement a state-defined alternative payment model. Tennessee and Ohio are requiring their MCOs to implement episode-based payments; Minnesota requires its MCOs to participate in its Integrated Health Partnership; and Rhode Island requires its MCOs to participate in its Coordinated Care Pilots with state-certified Accountable Entities.

- ***The Medicaid agency provides financial incentives for MCOs to enter into alternative payment models.*** New York is the only state that reported this approach. New York is providing MCOs a rate enhancement to incentivize the adoption of the state-defined alternative payment models. The state is also providing significant data resources to both plans and providers through a Medicaid data portal that will allow providers and MCOs to access tools and analytics that are specific to the state-defined alternative payment models. The state is purposefully not discouraging MCOs from entering into MCO-defined alternative payment arrangements (i.e., "off-menu") with its providers, but these approaches need to be approved the state, and may present additional challenges when significant momentum is moving toward state-defined models.

Regardless of which approach the state takes, state Medicaid programs are working to implement alternative payment models in ways that are appropriate in the context of their state's program, culture and provider landscape. A number of Medicaid directors note that even while implementing alternative payment models through managed care, these efforts require significant resources and effort from both state staff and their MCOs. In particular, states must rely on strong relationships with their MCOs, mutual trust, and effective monitoring and oversight of the MCOs to accomplish this work.

To understand the alternative payment models being designed by MCOs, we also interviewed five MCOs for this report. The MCOs we interviewed for this study reported a plan-wide strategy to increase alternative payments to providers, while recognizing that providers are at different levels of readiness to take on alternative payment methodologies. For the most part, the MCOs designing their own models are using similar strategies as the ones discussed in the previous section. MCOs typically include pay-for-performance activities within their VBP arrangements for providers as it links the ability to earn additional money to quality performance. MCOs also look to encourage implementation of PCMHs and care management within practices, shared savings/shared risk arrangements, and

partial/full sub-capitation. The breadth of these models differed greatly based on both the provider capabilities and the general marketplace. For example, in California, MCOs have consistently entered into partial and full capitation arrangements with provider groups for years, though this is not either required or specifically encouraged under Medi-Cal's managed care contracts. Most MCOs were not implementing episode-based payments for their Medicaid lines of business, except in states where Medicaid agencies were requiring implementation of episode payments, though they did have experience on the Medicare and commercial lines with this approach. The MCOs all stressed the importance of using the appropriate contracting method with each provider, and that not all providers could or should move to population-based payment models.

While much of the focus of alternative payment methodologies is on primary care, MCOs that include coverage of specialized services or populations (such as behavioral health and long term care) have begun to implement alternative payment methodologies. For example, Beacon Health Options is actively working with both states and providers to develop alternative payment model strategies for those with serious mental illness, including providing technical support to providers to transform to a different clinical model. In a number of states, MCOs sub-capitate behavioral health services with community mental health centers, and these providers take on risk for delivering high quality care within a fixed budget. In Tennessee, MCOs are required to implement alternative payment strategies for nursing facility and home and community based services (HCBS) that reward providers that improve the member's experience of care and promote a person-centered delivery model. Specifically, Tennessee has developed an Enhanced Respiratory Care (ERC) reimbursement based on facility performance on clinical and technology measures that maximize independence & quality of life.[23] Through Minnesota's Integrated Care System Partnerships (ICSP) Special Needs Program, MCOs are required to enter into partnerships with providers, including primary care, behavioral health and long term services and supports providers, to implement alternative payment methodologies.

THE ROAD AHEAD FOR MEDICAID-DRIVEN ALTERNATIVE PAYMENT MODELS

While some states have actively been managing VBP initiatives and programs, many states are planning new activities – some for the first time, and others to broaden their existing programs, or in some cases, to completely revamp the program. A few states are well down the planning path and are putting the final touches on their programs before they are implemented in 2016 or 2017. For example, New York is nearly ready to launch a large-scale program to implement alternative payment models for Medicaid providers. It has spent more than a year developing four different alternative payment models, including episode-based payment, and population-based payment models focused on total and high-risk populations. It is also actively developing an analytics platform to the Medicaid data warehouse that will give providers and plans access to data to help them manage under alternative payment models. Similarly, Oklahoma is in the process of

[23] These measures include ventilator wean rate, average length of stay to wean, infection rate, unplanned hospitalizations, non-invasive open ventilation, alarm paging or beeping system, cough assist, and non-invasive ventilation (volume).

developing an episode-based payment model and a full-risk payment model with its providers. At the time of this report, Vermont is actively working to implement a model where one statewide accountable care organization would receive full risk capitation from state Medicaid agency, Medicare and commercial insurers. This "all-payer model" is intended to start in 2017, and at the time of this report Vermont is in negotiations between CMMI and the state. At the same time, other states, like Virginia, are in the early stages of planning new efforts. Virginia recently submitted a section 1115 waiver to request DSRIP funds to help change the delivery system to one that is more focused on integrated and coordinated organizations that are contracted under value-based arrangements. Similarly, South Carolina and Connecticut are working on episode-based payment programs.

While some states are standing up new models, other are making changes to existing alternative payment models to refine them and adapt to lessons learned. Examples include:

- Colorado is proposing significant changes to its Accountable Care Communities (ACC) program to include management of behavioral health services. These changes are aimed at building on the success of the current ACC program to better delivery of integrated care with one entity responsible for the physical health and behavioral health of a Medicaid beneficiary. Colorado is currently working with stakeholders to identify what payment models could be phased in over the course of the next contract period in order to better align incentives to promote high quality integrated care.

- California recently received approval of its section 1115 waiver, which includes new initiatives focused on improving the value of the system. Over the course of five years, California plans to move 60 percent of payments to safety-net hospitals into alternative payment models. California will also launch a dental transformation initiative that would encourage providers to focus on the early prevention of cavities and a county-based program focused on integrating health and human services together.

Regardless of where a state is in its planning or its implementation efforts, there is still much work to be done because these are large, complex and innovative projects. The majority of Medicaid directors reported spending at least 50 percent of their time on major reform efforts,[24] likely dealing with the multiple challenges and opportunities that are described in the next sections.

A. CHALLENGES FOR MEDICAID PROGRAMS TO ADVANCE ALTERNATIVE PAYMENT MODELS

States face many challenges in their quest to transition from rewarding volume to rewarding value in health care. Medicaid agencies provide services according to the authority granted to them by their state and by the federal government. Changes in the way states operate require approval at multiple levels, which can hamper their efforts and slow momentum. In addition, changes in leadership at the state and agency level impact the way states approach health care reform. These changes in leadership are a frequent occurrence, including among state Medicaid directors whose average tenure is less than a year and a half. Leadership changes at the federal level, especially the forthcoming change in Administration in 2017, could also impact Medicaid payment reform efforts over the next few years.

[24] National Association of Medicaid Directors. (2015). State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors. Washington, DC: National Association of Medicaid Directors. (Accessed December 18, 2015: http://medicaiddirectors.org/wp-content/uploads/2015/11/namd_4th_annual_operations_survey_report_-_november_2_2015.pdf)

Designing and implementing alternative payment models is a challenging task, particularly for the diverse and complex nature of the Medicaid system. Medicaid, unlike any other payer, includes many programs that assist the unique needs of the most vulnerable citizens. This has resulted in a number of challenges which this section describes in further detail.

1. Medicaid Agency Readiness

a) Staff Resources: Size and Skill Set

Many states pointed to resource constraints as challenging their payment reform efforts. State Medicaid directors reported needing additional positions in 2016 to meet the demands of payment and delivery system reform.[25] States indicated that limited staff resources are both sustaining current Medicaid operations and driving new and innovative payment reform efforts, causing a significant strain on existing staff resources. As noted above, these additional staff resources are required, although in varying numbers, depending on whether a state is implementing an alternative payment methodology directly, designing a model to be implemented by MCOs, or requiring MCOs to report on self-designed alternative payment models.

The specific skills required to design and implement alternative payment models are varied from what are required to maintain existing operations. For example, one state noted the need for specific expertise in data analytics, which is necessary to adequately administer complex payment models and assess the performance of the health care system. This requires a significant amount of training, and staff with this skill set are in high demand from other payers. Another state suggested that staff were experiencing "initiative overload" with different units in the state working on different efforts and operating without a clear vision or comprehensive strategic direction. For some states with multiple initiatives, coordinating a vision and operations across SIM efforts, internal Medicaid strategic initiatives and legislative mandates can be particularly challenging. Many states, especially those that are choosing to design their own approaches are working with a variety of consultants to design and implement alternative payment models. One Medicaid director noted that in order to do this effectively, you cannot under-invest in the work, and while Medicaid programs have limited resources, it is important to have the appropriate individuals working towards implementation of a robust program.

b) Data

Both payers and providers require a significant amount of data when operating alternative payment models. The Medicaid program needs to both have and be able to share timely and accurate data in order to effectively administer an alternative payment model, and hold providers accountable for performance measures associated with those models. According to many states, data collection, exchange and integrity present significant challenges to holding providers and managed care organizations accountable under new reimbursement models.

Currently, many states lack adequate systems to operate new value-based payment programs. Some states reported that their current Medicaid Management Information Systems are not designed to respond to new reimbursement

[25] Ibid.

models and accountability structures. In particular, one state pointed to the complexities of modifying or enhancing existing systems without disrupting the functions that serve their Medicaid members. As a result, states must use already stretched staff and/or consultant resources to work around systems limitations.

In addition, existing administrative and claims-based systems do not provide adequate information about clinical outcomes, which many new payment and delivery system initiatives aim to track as part of their accountability structure. The MCOs interviewed for this report discussed the importance of having robust data and analytics capabilities as states moved further into VBP. The MCOs noted that detailed reports are an essential tool for providers to identify and address gaps in care that lead to improved health outcomes and reduced costs.

At least eight states are working to address some of these data issues by promoting HIT and interoperability through Medicaid waivers and demonstrations (which have either been approved or proposed).[26] For example, in Florida's section 1115 waiver, hospitals that wish to receive funds from the uncompensated care pool must participate in the state's event notification system that allows health plans to know when its members have been discharged from a hospital or emergency department.[27]

c) State Medicaid Budgets

State Medicaid budgets are under constant pressure, especially because they represent such a significant portion of many states' overall budgets. State budgets in 2016 are no different. State budget shortfalls often result in cuts to the Medicaid program that potentially set back programmatic changes and stifle innovation. In some states, payment reform is difficult to get off the ground because providers express concern about reimbursement rates already being too low, and are worried that any efforts would further reduce already low rates, similar to some of the models Medicare has implemented. Recognizing this issue, however, some state Medicaid directors have highlighted the main goal of their alternative payment initiative is focused on aligning incentives around better care, and is not singularly focused on the state's bottom line. One state Medicaid director noted that his state initiative was "not a back door way to lower Medicaid spending."

In addition, the state budget planning process and cycle do not lend themselves to longer-term investments in health care reforms. One state that is not currently pursuing payment reform noted that they would need significant resources in order to so. Those resources would be needed in the form of new and/or different staff, and new information systems to report on payment reform efforts. For many states that have pursued payment reform, federal grant dollars in the form of SIM or DRSIP funding have been significant catalysts for this reform. States without access to that funding have less ability to implement system-wide delivery system and payment reforms.

2. Provider Readiness

Many states have set specific goals to move a percentage of their provider contracts (either directly or through their MCOs' networks) into alternative payment models. But, doing so requires providers to be ready to enter into new

[26] Office of the National Coordinator for Health Information Technology. "State Health IT Policy Levers Compendium," Health IT Dashboard. December 2015. http://dashboard.healthit.gov/dashboards/state-health-it-policy-levers-compendium.php
[27] Florida Health Information Exchange Coordinating Committee. "Event Notification Service and Low Income Pool." August 15, 2014.

payment arrangements, both financially and clinically, and to be able to know what and how to make delivery system changes that achieve the goals of payment reform. States reported that payment and delivery system reform represent a culture shift for providers.

The Medicaid delivery system as a whole consists of providers that are at different points along a continuum. A provider's readiness depends on a number of factors, including staff, practice maturity, size, interest, geography and patient population served. Opportunities to improve care through data collection and analysis, care coordination, performance metrics, and service integration require financial, resource, and systems investments to shift the way providers practice. Some providers are well resourced and capable of taking on alternative payment models with shared risk, while others operate slim or negative margins and struggle raising the capital needed to invest in important changes necessary to operate under an alternative payment model. One state noted that providers require support and assistance with foundational elements needed to take on greater risk, including up-front infrastructure and data analytics.

Medicaid agencies recognize these problems and work to provide appropriate and meaningful levels of technical assistance and transformation support to advance providers along the spectrum of readiness. For example, some states have the resources to hire external vendors that provide technical assistance to providers. The District of Columbia is working with a vendor to provide practices with transformation support, change management, and quality improvement. They are using that vendor to help practices develop assessment reports, work plans, and to establish a quality improvement collaborative. Other states are specifically assisting providers with data analytics. Minnesota provides comprehensive reports through a web-based portal that includes aggregated and trended cost, risk and performance information, patient-level care coordination indicators, predicative risk and chronic condition indicators. New York is creating a similar data portal.

3. Unintended Impact on Provider Landscape

As noted above, states are cognizant of the effort alternative payment models represent to providers participating in Medicaid. Medicaid directors also recognize that these payment models may have unintended consequences on certain providers and the practice of medicine. This potential impact creates a challenge and adds complexity to state efforts to design effective models. For example, moving toward population-based payment models at the provider level may lead to provider consolidation, which can impact small independent practices and affect the health care market. One Medicaid director noted that even additional payments in support of delivery system reform require a certain case load for providers, which could leave behind many smaller providers. Medicaid programs must grapple with these complex issues to design alternative payment models that achieve quality outcomes and contain health care costs.

4. Quality

Aligning quality measures across payment initiatives and payers, to the extent possible, is both a challenge to states and a priority. Fundamental to value-based payment systems are performance measures that can assess the extent to which providers are improving quality and reducing costs; however, gaps persist in meaningful quality measures that are of significant interest to Medicaid agencies because of the populations they serve, including seniors, people with disabilities, and individuals who have unmet social support needs. Seniors and individuals with disabilities account for a

significant percentage of Medicaid spend, in particular in long-term services and supports (LTSS). Yet many measures of quality for LTSS are not as easily generated or benchmarked as traditional clinical measures defined in the HEDIS measure set, which is one limitation to states implementing more alternative payment models with LTSS providers.

Many states recognize the reporting demands on their providers across multiple payers and even across different reforms within the state. Some payment reform programs lend themselves to huge reporting demands. For example, in an episode-based payment program, each episode has its own specific quality measures, resulting in hundreds of quality measures being assessed in wide-scale episode-based payment programs. While one provider may not take on disparate episodes, another system may take on multiple episodes, resulting in the need for reporting numerous quality measures. One state characterized this as "reporting fatigue" and commented that there is too much fragmentation across payers (both locally and federally). In developing a measurement strategy, states must monitor providers to ensure that they are not only focusing on those aspects of care for which they are financially accountable.

Finally, states report difficulty in not only developing outcome measures that take into account the social determinants of health but also in obtaining the necessary data through the claims-based process that provide information on outcomes.

5. The Prospective Payment System and Alternative Payment Models

The federally-required prospective payment system (PPS) for FQHCs prevents states from fully leveraging alternative payment models to drive value. As previously mentioned, federal requirements do not permit states to pay below the encounter rate in the PPS for FQHCs. This prohibits states from designing models that hold these providers accountable for poor outcomes and high costs by having the provider take responsibility for a portion of excess costs. The PPS only allows for incentive payments above the prospective payment rate. This removes a key tool for states to drive VBP through alternative payment models. It also prevents Medicaid programs from aligning innovation efforts across provider types.

B. OPPORTUNITIES FOR THE FURTHER ADOPTION OF ALTERNATIVE PAYMENT MODELS

Payment and delivery system reforms in Medicaid programs across the country reflect the populations, geographies, market forces, political dynamics, and other state-specific needs and characteristics that states must consider when designing new programs. As described in this report, states, plans and providers are at different points along a continuum of reform. Some states have established payment reform models that affect a wide population. For example, Arkansas reports that nearly 80 percent of its beneficiaries are covered under one of its alternative payment models, whereas other states have fewer than 15 percent of its beneficiaries' care paid for through an alternative payment model. Medicaid programs are leading, evolving, and adapting to the changing health care environment at different paces and according to the environments in which they operate. States are balancing the responsibility of providing care to their Medicaid members with a desire to improve – and importantly, not disrupt – that care. Because of the complexity of the Medicaid program and the complexity of value-based purchasing efforts, states must devote significant resources to both efforts, which can be a challenge. State Medicaid agencies operate in vastly different markets, not only from one another, but even within states, with a range of forces impacting health care system innovations.

Despite the differences across states, there is a shared goal of getting more value out of the health care system and their health care purchase. While no two programs look alike, there may be opportunities to take lessons learned from other states and apply them more broadly. The opportunities are discussed in the sections that follow.

1. Multi-payer Alignment

States must be cognizant of the Medicare and commercial market dynamics and demands on their providers when contemplating value-based payment reforms for Medicaid. Medicaid agencies are not the only payers that are actively engaged in getting more value out of their health care purchase. While many states characterized multi-payer alignment as a challenge, they also acknowledged the value in engaging with other payers to advance successful and sustainable payment reform efforts. States see Medicaid's work on alternative payment models as a potential pathway for providers to incorporate the innovation into their practices and further include aligned incentives in provider contracts with commercial payers, Medicare, and state employee plans. Further, one state pointed out that this type of multi-payer alignment increases transparency across programs, something providers, members, policymakers, advocates, and others seek to improve.

States recognize the value of streamlining quality and performance measures across Medicaid, Medicare and the commercial markets, and reported bringing together commercial payers, providers, member advocates, and others to discuss measurement strategies and to ensure that payment incentives align appropriately with the care delivery system. To reduce the burden on providers, some states are aligning their efforts with existing alternative payment models implemented by other payers. Massachusetts, Minnesota and Oregon have established multi-payer forums to facilitate cross payer dialogue on potential areas of alignment on key payment reform design elements. Furthermore, some states reported modeling and aligning their payment reform initiatives with the Medicare Shared Savings Program (MSSP), Medicare Pioneer ACOs, or other Medicare or statewide payment reform initiatives.

Moreover, many states are establishing core measure sets for multiple initiatives and aiming to align them with other private and public payers. The legislature in Minnesota mandated that the quality measures included in its Medicaid ACO contracts (Integrated Health Partnerships) align with existing statewide quality reporting requirements. The state contracts with an independent organization to collect and validate a consistent set of measures used across health plans in the state, which informs the Medicaid ACO measurement strategy. Another example is New Mexico, which directs its managed care plans to use a core set of Medicaid quality metrics in the implementation of payment reform efforts. Finally, South Carolina reported that it is evaluating the success of programs across all payers.

Multi-payer alignment does not exclusively require Medicaid to conform to other payer standards. For example, in Vermont's Accountable Care Organization pilot, the state-based commercial plan aligned with Medicaid. Similarly, New York has a proposal under consideration by CMS that if a provider in its state participates in a Medicaid alternative payment model, that Medicare conform to the Medicaid quality metrics of that payment model to help the provider align their incentives. Likewise, if the provider was participating in a Medicare alternative payment model, the state Medicaid program would accept the Medicare quality measures.

2. Technical Assistance and Support

Many states reported the multitude of challenges that exist in health care system reform, especially as it relates to staff resources and knowledge. Several programs and organizations offer state Medicaid programs funding and technical assistance to support delivery system and payment transformation. For example, many states noted the value that federal programs like SIM and DSRIP have provided to their state to accelerate delivery system reform. These programs provided the infrastructure support states required to drive reform. More recently, the federal government established the Medicaid Innovation Accelerator Program (IAP) that seeks to support states' efforts with payment reform through technical assistance.

In addition to the federal government, private organizations and foundations have provided technical assistance to states as part of their mission to improve the health care system. For example, the Robert Wood Johnson Foundation established the State Health and Value Strategies (SHVS) program, which provides technical assistance customized for each state, in support of states' goals of improving the value of health care. Finally, the National Academy for State Health Policy (NASHP), the National Association of Medicaid Directors, as well as other organizations, provide various learning opportunities through webinars, conferences and learning collaboratives on key topics related to health care reform.

3. Stakeholder Engagement

Reform efforts can fundamentally change the economic model in which stakeholders are accustomed to operating; therefore, states emphasized the importance of engaging a diverse set of stakeholders, and in particular the provider community, early in the planning process. An open dialogue among stakeholders facilitates the exchange of ideas and information. In addition, stakeholder engagement helps to build consensus and creates a shared commitment to see new initiatives succeed. One state underscored that stakeholder collaboration holds the potential to yield a better product. Many states reported involving stakeholders in the process of reforming their payment models but also indicated that a lesson learned was to bring providers into the discussions in the planning stages. States may wish to ensure provider participation in discussions of Medicaid payment and delivery system reform from the beginning. A strategic plan that includes goals for reform is one way to guide a stakeholder engagement process. This type of clarity around goals will set expectations and focus discussions on pathways to reform that acknowledge and respond to stakeholders' concerns.

4. Behavioral Health Integration

Medicaid is the largest payer for behavioral health services in the United States[28] and thusly, plays an important role in ensuring adequate access to high quality health care for the 20 percent of beneficiaries with a documented behavioral health diagnosis, and the countless more who are undiagnosed. This role has been an impetus for state Medicaid programs to increasingly focus on including behavioral health services in alternative payment models.

For example, the Massachusetts's primary care capitation model incentivizes primary care practices to deliver

[28] "June 2015 Report to Congress on Medicaid and CHIP. Chapter 4, Behavioral Health in the Medicaid Program – People, Use and Expenditures." MACPAC, June 2015.

integrated behavioral health and primary care in a patient-centered medical home. The dollars associated with the payment model vary according to the level of behavioral health services the primary care practice is able to deliver. In Minnesota's Integrated Health Partnership model, participating Medicaid providers are held accountable for the total cost of care of attributed beneficiaries, including a limited set of mental health and chemical dependency services. Further examples include episode-based payment programs that are active in Arkansas and being developed in Tennessee and New York focused on behavioral health episodes like oppositional defiant disorder, attention deficit disorder, schizophrenia, bipolar, substance use, and major depression. Some states are using value-based purchasing strategies with specialized behavioral health plans to further the efforts toward integration. Arizona has implemented a model where Regional Behavioral Health Authorities are responsible for both behavioral health and physical health care services for members with serious mental illness. Under its contract, Arizona requires these vendors to enter into value-based contracts with integrated providers.

A number of states are participating in SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) grant program. Through this program, several states are developing community-based behavioral health organizations that offer comprehensive services and the potential to share in savings. However, similar to the FQHC PPS, this model establishes a payment floor, which could create challenges in aligning this effort with other state alternative payment models.

States might also have an opportunity to change state-based laws that inhibit data sharing between providers for beneficiaries with behavioral health conditions and help providers integrate data. For example, Tennessee is building a shared care coordination tool between primary care providers and some behavioral health providers that will offer access to admission, discharge and transfer alerts from hospitals, as well as identify gaps in care for providers' attributed patients. In addition, states could work with the federal government to enable better care through enhanced ability within federal regulations for data sharing, while still protecting privacy of beneficiaries.

5. Long-term Services and Supports

While some states, such as Tennessee and Minnesota, have implemented alternative payment methodologies for long term services and supports (LTSS), and Arizona requires its health plans to increase alternative LTSS payments through it MCOs, many states identified LTSS as a next frontier for alternative payment models that drive value in the Medicaid program. Medicaid is the major payer nationally of LTSS, spending $123 billion on nursing facility and community-based supports in 2013.[29] While the majority of work to date has not focused on this set of services, Medicaid leaders see a major opportunity to pay for high quality care and value. This is particularly important as the number of individuals 65 and older will double by 2050.[30] Because the vast majority of Medicaid beneficiaries that are elders or persons with disabilities are dually eligible for Medicare, there traditionally has been limited benefit to Medicaid program to implementing VBP strategies whose savings accrue to the Medicare program without any potential of Medicaid to share in savings. With many states participating in duals demonstrations, and increasing alignment across the programs, Medicaid programs and Medicare will continue to experiment with payment and delivery system reform that improves health outcomes and reduces overall health care costs for the benefit of both programs.

[29] Reaves, E. and Musemeci, M; Medicaid and Long Term Services and Supports: A Primer, Kaiser Family Foundation, December 15, 2015.
[30] Ibid.

In order for states to design and implement alternative payment models in LTSS, ongoing work to develop meaningful quality measures in this area will be critical. Currently there is limited standardized measurement for LTSS outside of measuring nursing facility quality, but significant work is underway to expand the availability of performance measures for home and community-based services.[31]

6. Social Determinants of Health

Population-based payment models encourage providers to think more broadly about keeping their patients healthy. As health care providers assume risk for total cost of care, it becomes increasingly important for them to consider ways to address social and other non-medical drivers of health. Some states offer flexibility for their providers in delivering services not traditionally reimbursed by Medicaid and in developing care models that address social determinants of health. Many states are requiring their health homes to demonstrate how they are connecting and referring individuals to social and community supports to address needs that are unmet by the health care system but drive health care status, including housing, food, transportation, and employment services. Some states are considering ways to reinvest health care savings into upstream prevention programs.

Medicaid programs that deliver care through MCOs are particularly interested in how to appropriately set rates to help address social determinants of health. States are not only facing questions about how to build these rates, but also questions about the latitude under federal requirements to reinvest savings in this area.

[31] Ibid.

CONCLUSION

As described in this report, states are actively implementing delivery system and payment reform activities, and like each Medicaid program, these approaches to new delivery system and payment models are happening in different ways, at different paces, and according to the specific needs and characteristics of each state. Common however among states is the overarching goal to create a health care delivery and payment system that provides improved health outcomes for their Medicaid members while also ensuring that the care provided is cost effective. Wherever possible, states are seeking to align their programs with Medicare and/or commercial providers.

As Medicaid programs move forward in these efforts, states can learn from the experiences of others. This experience can also inform Medicaid's federal partners as they seek to support successful alternative payment models in Medicaid, including through technical assistance and other infrastructure support. Based on the findings of this report, key considerations for both Medicaid directors and federal policymakers around Medicaid alternative payment models are discussed below.

CONSIDERATIONS FOR STATE MEDICAID LEADERS

- ***There is great promise in value-based reform, though significant effort and resources are required to implement these models.*** Medicaid directors who are farther along in implementing alternative payment models underscore the difficulty and intensity of this work and the amount of their own time, as well as the time of their staff, to design and carry it out. It is also extremely complex. States must maintain focus on improving the health of their beneficiaries and consider the impact of their work on the provider landscape and health care market broadly, which can be nuanced and result in unintended consequences. The difficulty of this work holds true regardless of whether the model is state-designed and implemented, or implemented through MCOs.

- ***High-quality data are essential to all alternative payment models.*** For Medicaid programs that are looking to expand existing alternative payment models or pursue it for the first time, Medicaid directors note that success hinges on the availability of high-quality, timely data. This data serves as the foundation for all alternative payment models, from additional PMPM payment models that support delivery system reform to population-based payment models. In addition to being able to share data and report on performance, states and their partners need strong data analytic capacity so that data can be leveraged to appropriately focus care improvements. This is an area where there is significant opportunity for improvement in capacity across most states and providers.

- ***There is value in bringing stakeholders into the early planning process for designing alternative payment models.*** As noted previously, states have achieved success by engaging stakeholders in the design and development of alternative payment models, especially providers. While this may be time consuming, it is essential for Medicaid to work in partnership with its MCOs and providers in designing alternative payment models in the context of the state's particular marketplace.

CONSIDERATIONS FOR FEDERAL POLICYMAKERS

- ***Implementing successful alternative payment models requires resources, which states often do not have available.*** The appropriate staff, funding, and tools must be available for states to design, implement, and oversee this work over a number of years as this work takes time. Efforts like SIM have provided vital support for this work and helped state efforts succeed. Likewise, the use of DSRIP funds provides an additional mechanism for supporting system transformation. The future of such resources is unclear and could be an important factor for the pace at which alternative payment models are adopted.

- ***Multi-payer reform is a major opportunity to drive value, but federal efforts that are not coordinated with Medicaid could impede successful state innovation.*** Medicaid programs see significant value in alignment across Medicare, Medicaid, and commercial payers in promoting alternative payment models. However, states are concerned that Medicare, as a single national program, could complicate or even impede successful state reforms tailored to the local health care marketplace, if Medicare efforts take a different focus and direction than Medicaid innovations. This is because the provider community is often challenged when multiple payers have differing alternative payment program requirements (e.g., quality measures, patient attribution) or financial incentives (e.g., population-based or episode-based). This is particularly true of historically under-resourced safety-net providers, which are a large component of the Medicaid delivery system. Greater and ongoing coordination between programs at the state and federal level could provide a potential pathway to mitigate this challenge.

- ***New and innovative rate setting considerations may be needed in managed care to support alternative payment models.*** States are continuing to discuss the role of social determinants of health in improving quality and bringing down health care costs in their reform models. As part of these discussions, states are looking to determine how the rate setting process can allow states and plans to address social determinants of health, including reinvesting savings in these activities. In addition, as more care is value-based, there is a significant challenge with the development of actuarially sound rates not undermining efforts to incentivize MCOs and providers to reduce costs over time.

- ***Aligning the FQHC prospective payment system with value-based principles could enhance the impact of Medicaid VBP.*** The prospective payment system for FQHCs remains a sticking point for a number of states in driving alternative payment models that improve outcomes and contain costs. FQHCs are significant providers of primary care to Medicaid beneficiaries nationally and efforts to more closely align this payment model with the principles of value-based innovation – particularly allowing risk-sharing – could allow states to maximize the impact of their alternative payment models to deliver high-quality, high-value care.

As state and federal policymakers continue to implement, refine and align alternative payment models, these key considerations should be a particular area of focus and attention. Leadership and commitment will be required at all levels to implement and sustain successful alternative payment models across the health care system and ensure providers deliver high value services to the nation's most vulnerable populations.

APPENDIX A

STATE SURVEY QUESTIONNAIRE

For the purposes of this survey, "alternative payment model (APM)" refers to non-fee-for-service reimbursement of patient care services. This includes global payment, capitation, and bundled or episode-based payment.

NOTE: If you wish to include documents, presentations, white papers or other attachments that explain your health care system reform efforts in detail in lieu of completing some of the questions or augmenting your answers, please feel free to do so.

1. PAYMENT REFORM EFFORTS BY STATES

1. How many APM programs are currently in place, and how many providers are participating? How many APM contracts are currently executed?

2. Do you have goals that you're targeting for moving populations of beneficiaries into alternative payment models? If so, please describe the goals and whether the goals were set internally, by legislation, or other?

3. Generally speaking, what are / were the driving forces behind the Medicaid agency deciding to pursue payment reform initiatives in your state?

Legislative mandate ____
Governor's initiative ____
Medicaid strategic initiative ____
Other, please explain

4. How do your APM programs support the unique needs of the Medicaid population and the related social determinants of health (e.g., social support, transportation, language/literacy, availability of resources to meet daily needs, etc.) ?

5. If you're pursuing payment or delivery system reform, how do those efforts fit into the state's overall Medicaid long-term and short-term strategies?

i. Are your efforts included within an 1115 waiver?
ii. Are your efforts part of a SIM initiative?

6. To what extent are (or will) your efforts aligned with broader efforts in the state (e.g., multi-payer initiatives, etc.)?

a. How are you seeking to align payment model design with any other efforts (e.g., SIM APM if applicable, multi-payer initiatives, Medicare, commercial, etc.)?

b. Do you (or seek to) align quality measures associated with an APM or delivery system initiative with any other efforts (e.g., Medicare or a state-based quality measurement organization)?

7. If your state is not pursuing payment reform, what is needed to spur payment reform efforts (e.g., political will, provider support, time, resources, knowledge, etc.)

2. SPECIFIC PAYMENT REFORM ACTIVITIES

8. In the following table, please describe the current APMs you have in place. Include all payment models that the state has designed and is either contracting directly with providers, or mandates MMCOs to use. (In Section 3, there is an opportunity to detail payment models that MMCOs have designed).

DETAIL REQUESTED	RESPONSE (SAMPLE ANSWER IN RED) *As noted above, if you have documents that describe this detail, please feel free to respond using those documents in lieu of this grid.*		*Please indicate whether you are attaching supporting documentation to help answer this question.*
a. Name of program	*Primary Care Payment Reform Initiative*		
b. Please describe what the payment model is and how it is designed.	*PMPM for a defined set of services and a shared savings / risk opportunity on total cost of care*		
c. What population(s) is covered?	**CHECK ALL APPLICABLE** ____ Dually-Eligible Adults ____ Pregnant Women ____ Medicaid-only persons w/disability ____ SPMI ____ Children	**INSERT RELEVANT DETAIL** *PCCM program, excluding pregnant women.*	
d. What population(s) is specifically excluded?	**CHECK ALL APPLICABLE** ____ Dually-Eligible Adults ____ Pregnant Women ____ Medicaid-only persons w/disability ____ SPMI ____ Children	**INSERT RELEVANT DETAIL** *Dually-eligible adults, SPMI*	
e. What services are included in the payment model?	**CHECK ALL APPLICABLE** ____ Behavioral Health ____ Pharmacy ____ Long Term Care ____ Primary Care ____ Dental/Oral Health	**INSERT RELEVANT DETAIL** *The PMPM services include all primary care services. Limited practice-based behavioral health services are optionally included.* *Shared savings / risk calculation includes all services, including inpatient medical care. Long term care is an optional service for the shared savings / risk calculation.*	
f. Are any covered services specifically excluded from the payment model?	**CHECK ALL APPLICABLE** ____ Behavioral Health ____ Pharmacy ____ Long Term Care ____ Primary Care ____ Dental/Oral Health	**INSERT RELEVANT DETAIL** *Inpatient psychiatric care is excluded.*	
g. What risk models are being used?	**CHECK ALL APPLICABLE** ____ Full risk ____ Shared risk (e.g.., upside / downside risk, two sided risk) ____Shared savings (e.g., upside only)	**INSERT RELEVANT DETAIL** *Shared savings for year 1 of the program, shared risk for year 2 and 3 of the program.*	
h. Is there a cap on risk or savings in any risk model?	*15% cap on risk only, no cap on savings.*		
i. Is the model risk adjusted and if so, how (e.g., yes, through 3M)?	*Yes, using a commercially purchased risk adjuster*		
j. Is there a minimum population size for providers to participate in the model?	*3000 for shared savings and 5000 for shared risk*		
k. Does the model include supplemental payments for activities (e.g., care management, medical home transformation, information technology infrastructure, community prevention, etc.)?	*No*		

DETAIL REQUESTED (CONTINUED)	RESPONSE (SAMPLE ANSWER IN RED) *As noted above, if you have documents that describe this detail, please feel free to respond using those documents in lieu of this grid.*	*Please indicate whether you are attaching supporting documentation to help answer this question.*
l. Which type of and how many providers (e.g., primary care, specialty care, behavioral health, hospitals, nursing homes, home health, etc.) are participating in the model?	*47 primary care practices (across 28 organizations)*	
m. Is the model associated with a delivery system reform initiative (e.g., patient centered medical home, home health program, DSRIP initiative, ACOs, HCBS programs, etc.)?	*The model is built of a PCMH initiative and supports primary care and behavioral health integration*	
n. When did the payment model start?	*2014*	
o. What is the contracting entity for this APM (the state Medicaid Program (e.g., PCCM) or the MCO, or both?)	*The state through the PCCM program*	
p. What % of total Medicaid spend is through this APM?	*22-23%*	
q. What % of total beneficiaries are included in this APM?	*20%*	
r. If the APM targets a subpopulation, what percentage of that subpopulation is included in the APM?	*N/A*	
s. How does performance on quality measures influence payment to providers (e.g., clinical care outcome measures, access measures)?	*Quality performance determines percentage of shared savings the provider is eligible for.*	
t. Please describe any penalties for poor quality performance in this payment model.	*Poor quality performance reduces the percentage of shared savings the provider is eligible for, and in the future we are considering lowering rates for those with poor quality scores.*	
u. Please describe whether you reduce or withhold payment for certain events in your payment models (e.g., certain hospital acquired conditions).	*We do not.*	
v. What are the key performance domains for which you create financial consequences for your providers in your contracts (e.g., preventive care, chronic illnesses care, patient experience, efficiency)?	*Behavioral health, patient experience, and financial effectiveness*	
w. What have the quality and financial results of the alternative payment arrangement(s) been to date?	*Program has been in operation for less than one year, but early results are positive.*	

9. Are the payment and delivery system reform initiative(s) described above meeting their goals? Why or why not?

10. Do you have any APMs that are in development? If so, how far in the process have you gotten? As noted above, if you have documents that describe this detail, please feel free to respond using those documents in lieu of this question.

a. Have you finalized a methodology for the payment model?

b. Are you waiting for a waiver from the federal government?

c. What time frame are you targeting for implementing the payment model?

11. What type of technical assistance and supports have you offered providers as part of participating in any of the payment and delivery system reform models? (e.g., learning collaboratives, provider registries, care management support, data, etc.)

12. Please describe the top 2-3 challenges and / or lessons learned in designing, implementing and operating under APMs.

3. PAYMENT REFORM EFFORTS DRIVEN THROUGH MMCOS

In this section, we seek to identify contract requirements that encourage (or mandate) the use of APMs, and any efforts that MMCOs may have implemented on their own for which you're aware. Please respond to the following section if you have risk-based contracts with MMCOs that require or encourage your plans to design and implement APMs. If you have a specific alternative payment model methodology that you have asked your MMCO to implement, please include that information in Section 2.

1. What percentage of the Medicaid population is covered by risk-based managed care?

2. Please describe generally, your managed care entities and what services they provide (e.g., three Medicaid managed care entities covering medical care, one behavioral health carve-out covering behavioral health services, and one pre-paid health plan for non-emergency medical transportation)?

3. Do you require your managed care entities to implement APMs? If so, please describe your requirements.

   a. Do you know what models are being implemented by MMCO contractors in your state or to what extent APM arrangements are being implemented? If so, please describe, including what services are included within the payment model.

   b. Have you given managed care entities any guidelines or contract requirements for implementing value-based purchasing arrangements?

      i. Do you contract with plans that commit to specific requirements for advancing alternative payment and delivery models with network providers?

      ii. Do you have financial incentives for plans to use alternative payment models?

      iii. Do you have non-financial incentives for plans to use APMs (e.g., auto-assignment)?

   c. Do you track the number of Medicaid beneficiaries or dollars that are in managed care-plan driven alternative payment arrangements? If so, please report.

   d. Do you track results or impact of the various APMs being tested by managed care plans (e.g., changes in utilization, changes in quality, cost-savings, etc.)? If so, please describe for which plans and any known results.

   e. Have you (or do you plan to) used RFPs to identify plans that have experience or are willing partners in advancing care delivery and payment reform?

4. Do you align (or seek to) managed care quality performance measures with any other efforts?

5. Are there any MMCOs in your state that you think are doing particularly innovative health care payment and delivery system reform that would be worthwhile for us to interview as part of this report?

APPENDIX B

MEDICAID MANAGED CARE ORGANIZATIONS

A. Interviewed Medicaid Managed Care Organizations

1. Aetna
2. Beacon Health Options
3. CareSource (OH)
4. Molina Healthcare
5. UnitedHealth Care

B. Interview Guide

Please describe the current alternative payment models you have in place in one or more state Medicaid plans designed to promote payment and delivery system reform efforts, starting with models that are in use in multiple states and moving to models that are unique to particular states. *[Note: Interviewer will use the table questions as prompts for more details or we need to break out the table into multiple questions.]*

DETAIL REQUESTED	RESPONSE
x. What is the name of the program / model?	
y. Please describe what the payment model is and how it is designed.	
z. Why are you implementing the models? Is this a Plan initiative or based on a state requirement or activity?	
aa. What state(s) have you implemented this model in?	
bb. What population is covered, including whether any particular subpopulation is excluded (e.g., dually-eligible adults, pregnant women, Medicaid-only persons with disability, SPMI, children)?	
cc. What services are included in the payment model (e.g., behavioral health, pharmacy, long term care, primary care, dental)?	
dd. What risk models are being used? i. Full risk ii. Shared risk (e.g., upside / downside risk, two sided risk) iii. Shared savings (e.g., upside only)	
ee. Include whether there is a cap on risk for shared risk or full risk models.	
ff. Is the model risk adjusted and if so, how (e.g., yes, through specific software programs such as 3M)?	

DETAIL REQUESTED (CONTINUED)	RESPONSE
gg. Is there a minimum population size for providers to participate in the model?	
hh. Does the model include non-risk supplemental payments for activities (e.g., care management, medical home transformation, information technology infrastructure, community prevention etc.)?	
ii. Which type of and how many providers (e.g., primary care, specialty care, behavioral health, hospitals, nursing homes, home health, etc.) are participating in the model?	
jj. Is the model associated with a delivery system reform initiative (e.g., patient centered medical home, home health program, DSRIP initiative, ACOs, HCBS programs, etc.)?	
kk. When did you first implement the payment model?	
ll. What is the % of Medicaid dollars to providers in this payment model (as a percentage of total Medicaid PLAN dollars to providers)	
mm. What is the % of beneficiaries in this payment model (as a % of total plan beneficiaries)?	
nn. How is quality or other non-financial performance measured in this model?	

2. Does your organization support contracted providers engaged in your previously stated payment reform efforts with reports, payment (e.g., PMPM supplemental payment), technical assistance or other resources?

a. If yes, please explain what types of supports are provided.

b. If not, please describe other ways in which providers may receive support to meet payment reform goals.

3. Has your organization encouraged (through contractual requirements or through financial or non-financial incentives) the following activities among providers? Please describe why you have or have not encouraged specific approaches.

a. Care coordination and continuity of care for members, especially for individuals with complex needs

b. Patient-centered models of care

c. Integration of physical health, mental health, and addictions services

d. Programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)

4. What is the overall quality strategy that you have in place for providers participating in APMs?

5. How do you measure quality of the providers participating in your APMs? Do you utilize a standard measurement set across states or does your set vary based on state requirements?

a. If more than one APM is in place, how does quality measurement different across payment models?

6. If quality measures are used, do you align your APM contract measures with those used by other payers (e.g., Medicare), those required or endorsed by the state and/or those adopted by national bodies?

7. To what extent have you seen improvements in contracted providers' quality or other performance measures targeted by the APMs?

8. In general, and to the extent known, have contracted APM providers generally been paid more, the same, or less than in the prior Medicaid payment arrangements in the terms of your value-based payment reform agreements with them? Does this answer differ by type of provider or provider characteristics? To what extent would you consider contracted providers to have been "financially successful" under these APM arrangements?

9. What are some of the challenges you see in Medicaid providers being able to successfully operate under APMs?

10. If you also provide coverage to non-Medicaid populations, how has implementation of APMs varied in the Medicaid market from implementation in the Medicare or Commercial markets?

11. Do you plan on expanding the use of APMs to any other Medicaid populations? To other types of providers? To more state Medicaid programs?

Questions about relationship(s) with state(s)

12. Where states are requiring implementation of payment or delivery system reform,

a. Do your contracts include financial penalties, sanctions or other incentives to implement a payment model?

b. Do states typically give you flexibility to implement a model as you see fit or are there specified requirements?

c. Are there factors in the state(s) in which you operate that make it more or less difficult to implement APMs?

13. [If operating in more than one state] How difficult is it for you to align your delivery system and payment models, including quality measurement, across the states in which you do business?

14. Are you engaged in any multi-payer payment reform efforts led by states? If so, which states and what are the reform efforts?

15. How do you see the role of the MCOs changing as more providers participate in APMs? What functions remain essential for the MCOs to provide?

16. Are there any states you contract with that you think are particularly innovative in health care delivery reform that we should be sure to contact as part of this project?

APPENDIX C

DUALS DEMONSTRATIONS

Twelve states are testing ways to integrate the financing and delivery of Medicare and Medicaid services to improve the quality of care for individuals who are dually eligible (e.g., Medicare-Medicaid beneficiaries.) States are jointly administering either fully capitated models or managed FFS models with CMS based on opportunities created by the Affordable Care Act to allow states to share in savings to the Medicare program generated by Medicaid initiatives. The states must meet established quality and performance thresholds in order to receive a share of savings achieved. Managed FFS models, which are being tested in Colorado and Washington, continue to reimburse providers on a FFS basis for Medicare and Medicaid services but allow the state to benefit from investments that reduce Medicare spending.

The other 10 states (CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA) have a signed Memorandum of Understanding with CMS to implement a capitated model to improve the care and control costs for dually eligible beneficiaries. Under the capitated model, managed care plans receive two PMPM payments (one from Medicare and one from Medicaid) to provide Medicare and Medicaid services to eligible individuals. States may target different dually eligible populations in their demonstrations and may include a different set of services in the covered benefits. Contracts between states and health plans include provisions for plans to demonstrate how they are implementing alternative payment models with their provider networks. In addition, Medicare and Medicaid withhold a portion of the capitated payment that health plans can earn back for meeting certain quality and performance thresholds.

Minnesota is testing a model to align administrative functions through the state's existing model of care to Medicare and Medicaid beneficiaries.