MACPAC

# Use of Value-Based Payments in Managed Care

## Medicaid and CHIP Payment and Access Commission

Amy Zettle and Robert Nelb

# Overview

- Background
- Methods
- Key themes
- Next steps
- Discussant panel

# Background

- As part of efforts to improve quality and reduce costs, many payers are trying to increase the use of value-based payment (VBP) models
- MACPAC has previously examined a variety of VBP efforts in Medicaid, including:
  - Patient-centered medical homes (PCMH)
  - Accountable care organizations (ACOs)
  - Delivery system reform incentive payments (DSRIP)

# Share of Payments in Value-Based Arrangements by Payer, 2018

| LAN category | Medicaid | Commercial | Medicare Advantage | Traditional Medicare |
|---|---|---|---|---|
| **Category 1:** FFS with no link to quality and value | 66.1% | 55.7% | 39.5% | 10.2% |
| **Category 2:** FFS with a link to quality and value (e.g., incentive payments to PCMHs) | 10.6% | 14.2% | 6.9% | 48.9% |
| **Category 3:** APM built on a FFS architecture (e.g., episode-based payments) | 17.4% | 27.6% | 36.4% | 36.5% |
| **Category 4:** Population-based payment (e.g., shared savings payments to ACOs) | 5.9% | 2.5% | 17.2% | 4.4% |

**Notes:** LAN is Health Care Payment Learning and Action Network. FFS is fee for service. APM is alternative payment model. PCMH is patient-centered medical home. ACO is accountable care organization.
**Source:** Health Care Payment Learning and Action Network, 2019, *Measuring progress: Adoption of alternative payment models in commercial, Medicaid, Medicare Advantage and traditional Medicare programs*, http://hcp-lan.org/workproducts/apm-methodology-2019.pdf.

# VBP Requirements in Managed Care

- Directed payments
  - The 2016 revisions to the Medicaid managed care rule added a new option for states to require managed care organizations (MCOs) to pay according to specific VBP methods
  - Directed payments must be pre-approved by CMS
- Withholds and incentive payments
  - States can increase or decrease MCO capitation rates based on whether the plan meets specified VBP targets
  - Actuaries review whether withholds are reasonably achievable

# Methods

- MACPAC contracted with Bailit Health to conduct a study examining state strategies to implement VBP in managed care in five states
- We interviewed state officials, MCOs, external quality review organizations (EQROs), actuaries, national experts, and CMS officials

# VBP Requirements in Study States

| Managed care VBP strategy | Minnesota | New Mexico | New York | Ohio | South Carolina |
|---|---|---|---|---|---|
| Required VBP model | ACOs | None | None | PCMH; Episodes | PCMH |
| VBP target (2020) | None | 30% | 80% (35% downside risk) | 50% | 30% |
| Additional federal funding | SIM testing grant | DSRIP-like program; SIM design grant | DSRIP; SIM testing grant | SIM testing grant | None |

**Notes:** VBP is value-based payment. ACO is accountable care organization. PCMH is patient-centered medical home. SIM is state innovation model. DSRIP is Delivery System Reform Incentive Program.

**Source:** Bailit Health, 2020, analysis for MACPAC of state managed care contracts and related documents.

# Key Themes

1. States and MCOs are adapting national VBP models to local circumstances; multi-payer alignment is limited
2. Existing authorities provide states with multiple tools to promote VBP in managed care, but implementation requires substantial state effort

# Key Themes (Continued)

3. States face tradeoffs choosing between a prescriptive or flexible approach
4. Contract requirements are changing MCO behavior, but they do not address challenges with provider participation in VBP models
5. Although states are monitoring MCO compliance, plans to formally evaluate VBP efforts are limited, particularly in states with less prescriptive models

# Next Steps

- Seek Commissioner feedback
  - Draft report
  - Potential areas for additional work on VBP
    - Maternity care
    - Managed care rate setting
    - Multi-payer alignment

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