

STATE STRATEGIES TO
PROMOTE VALUE-BASED
PAYMENT THROUGH MEDICAID
MANAGED CARE *FINAL REPORT*

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health care system performance.

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Executive Summary

Although the majority of Medicaid beneficiaries are enrolled in comprehensive managed care, most managed care payments to providers are still based on fee-for-service (FFS) methods. As part of state efforts to improve quality and reduce costs, many state Medicaid programs have begun requiring managed care organizations (MCOs) to increase their use of value-based payment (VBP) methods that are based on the achievement of quality goals and, in some cases, cost savings. Some states require MCOs to use specific payment models while other states set broad VBP targets and are less prescriptive.¹

To better understand how these contracting strategies are working in practice, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Bailit Health to conduct structured interviews with state officials, MCOs, and other stakeholders in five states (Minnesota, New York, New Mexico, Ohio, and South Carolina) that reflect a range of approaches to implementing VBP through managed care. This report reviews findings from these interviews as well as perspectives from national experts and staff from the Centers for Medicare & Medicaid Services (CMS).

The states we studied employed a variety of approaches ranging from prescriptive to flexible. Minnesota and Ohio are prescriptive with their MCOs. Minnesota requires MCOs to make shared savings payments to accountable care organizations (ACOs) referred to as integrated health partnerships (IHPs). Ohio requires MCOs to reconcile FFS payment to providers to a targeted spending amount for all services provided across specific episodes of care and also requires MCOs to make additional care coordination payments to providers participating in a comprehensive primary care (CPC) initiative. In contrast, South Carolina and New Mexico use a more flexible approach that requires MCOs to meet certain levels of VBP activity but allows the MCO flexibility in determining which payment models to implement for each provider. New York uses a hybrid approach, allowing for some MCO flexibility within a state-defined menu of payment reform approaches.

Five major themes emerged from our work:

1. *National VBP models have informed Medicaid strategies, but states and MCOs have adapted their strategies to local circumstances and have modified their approaches based on experience.*

Despite efforts to promote the use of VBP nationally in Medicare and commercial insurance, most of the Medicaid VBP approaches that we studied were unique to Medicaid. In many cases, states adapted national models to fit their local circumstances. For example, Minnesota modeled its IHP initiative on the Medicare Shared Savings Program framework. South Carolina's patient centered medical home (PCMH) approach is aligned with efforts of the largest commercial payer in the state. In Ohio, the state's episode-based payment program was designed with both Medicaid and commercial health plans in mind.

Many states have used the Alternative Payment Model (APM) Framework taxonomy created by the Health Care Payment Learning and Action Network (LAN)² to classify VBP arrangements

based on the method of payment and whether providers are taking on any risk, but they have adapted this framework based on state-specific goals. For example, since 2018 South Carolina has required its MCOs to make at least 30 percent of their payments in VBP models, counting LAN categories 2C and above (fee-for-service with some link to quality) plus allowing care coordination payments to PCMH to count towards this target. New Mexico has established a similar overall target that in 2020, 30 percent of managed care payments to providers are made through VBP arrangements that have some link to quality, but the state classifies payments using its own taxonomy that differs from the LAN framework. New York also utilizes its own taxonomy.

The MCOs that we interviewed frequently indicated that they tried to align their provider contracting strategies across different lines of business even if they weren't required to do so because of the potential for alignment to improve providers' willingness to engage in VBP arrangements if they are standardized across plans and lines of business. For example, MCOs operating in Medicaid, Medicare, and commercial lines of business in the same geographic region reported that they prefer to have a single, standard agreement with provider entities in these regions across all lines of business and minimize the differences across payers where feasible. Similarly, national plans that operate in multiple states noted that it was more efficient for them to adopt VBP models that they had used in other states rather than create new models for each market. MCOs noted that multi-payer alignment was beneficial to providers and plans, since they felt that providers would be more likely to engage in VBP arrangements if these arrangements were more standardized across plans and lines of business.

Interviewees noted that because Medicaid is a particularly large payer for some types of services, such as maternity and behavioral health, the program has a particularly important role in designing effective payment models for these services. Many interviewees also noted that states and MCOs are still learning from their early implementation of VBP models and are likely to continue to adjust their models in the future based on their experience. Interviewees underscored the importance of ongoing engagement with stakeholders as states and MCOs make these changes.

2. *Existing Medicaid authorities provide states with multiple tools to promote the use of VBP in managed care, but developing and implementing VBP initiatives still requires substantial state investment and stakeholder engagement.*

The states we examined were able to implement a variety of different types of delivery system transformation and VBP in managed care through existing authorities and did not cite federal policy as a barrier. Some states used the new directed payment option added by the 2016 revisions to the Medicaid managed care rule, while others used longstanding managed care authorities, such as the ability to withhold a portion of a health plan's capitation rate based on achievement of VBP milestones.

The current VBP approaches used in the states that we studied have evolved over time and required substantial upfront effort to design and develop. Three of the states that we studied

(Minnesota, New York, and Ohio) received State Innovation Model (SIM) testing grants from CMS to support their design efforts. In addition, New York also received significant Delivery System Reform Incentive Program (DSRIP) funds to support its VBP efforts. States that benefited from additional federal funding implemented more advanced payment models. In comparison, the states in our study that did not receive SIM testing grant funding (New Mexico and South Carolina) have adopted more incremental targets for VBP adoption.

3. *States face tradeoffs in deciding whether to be prescriptive or flexible in their managed care VBP initiatives.*

Among the state officials and stakeholders we spoke with, there was not a clear view about whether to be prescriptive or flexible. On one hand, prescriptive approaches ensure consistency across the multiple Medicaid MCOs that providers contract with, but on the other hand, prescriptive approaches can limit an MCO's incentive and ability to adapt payment models based on the unique needs of each provider. Conversely, where states have a general VBP target with broad parameters, MCOs have the opportunity to target their efforts on providers that are ready to participate in alternative payment models and can use their experience with VBP in other markets to help design their payment models. However, because the different MCOs in a state are likely to pursue different models when given the flexibility to do so, providers may be burdened by having to negotiate and implement multiple VBP contracts, and it is difficult to evaluate which models are working best.

4. *Contract requirements are effective in changing MCO behavior, but do not address challenges with provider participation in VBP models.*

States reported that MCOs are adopting VBP models to meet contractual requirements and avoid financial penalties. While some MCOs began implementing these models prior to contractual requirements to do so, these targets have been effective at changing MCO behavior as whole. Interviewees noted that provider readiness and willingness to engage in VBP models are often a challenge. Compared to other types of health plans, provider-sponsored plans were less likely to report challenges engaging providers, but even these plans noted provider reluctance to adopt models that could put their payment at risk.

Interviewees noted several challenges for providers to be successful in VBP arrangements. First, providers need to develop their infrastructure for measuring performance on quality measures and managing population costs to be ready to participate in payment models that tie payments to these metrics. Second, even if providers are able to participate in these VBP models, the providers may not be willing to take on increased risk, especially for Medicaid services which typically have lower payment rates than other payers. Since providers generally have a choice about whether or not to participate in VBP models, they have additional leverage when negotiating with health plans that must meet state-imposed VBP requirements.

Through its Section 1115 demonstration authorizing DSRIP payment, New York is able to incentivize provider participation in delivery system reform efforts by Performing Provider

Systems, hospitals and other providers in the state. New Mexico also received approval for a smaller, DSRIP-like program to incentivize hospitals to meet quality improvement targets. Stakeholders in these states viewed these provider investments to be complementary rather than duplicative of MCO VBP efforts.

5. *Although states are monitoring MCO compliance with VBP requirements, plans to formally evaluate the effects of VBP efforts are limited, particularly in states with less prescriptive models.*

Despite the fact that the states we studied have been implementing VBP requirements for several years, there is limited data available to assess whether or not the increase in value-based provider contracting has led to delivery system reforms, improved quality of care or reduced costs.

States with prescriptive VBP models were able to share some early findings from their efforts. In Minnesota, the state estimates that between 2013 and 2017, the IHP model saved \$185 million after accounting for shared savings payments and reduced emergency department and avoidable hospital use. In Ohio, the CPC program has resulted in improved quality and \$78.1 million in net savings in 2017, and the episodes program has lowered the average cost per episode without any measurable reductions in quality. In these states, the SIM grant that the state received financed the external evaluations of these programs. It is not clear whether states plan to continue formally evaluating these programs absent federal funding.

In states with less prescriptive models, it is more difficult to assess the effects of the VBP efforts. In part, this lack of data is due to limited state monitoring efforts. For example, in the states we studied, health plans do not report data about the specific payment arrangements that they are implementing or the results of these efforts.

New York is evaluating delivery system reform efforts in the state as part of its DSRIP Section 1115 waiver evaluation and has found statewide reductions in avoidable hospital use. However, because of all the other changes happening in the state it is difficult to isolate the effects of the managed care VBP changes.

All Medicaid managed care programs are required to contract with External Quality Review Organizations (EQROs) to assess plan performance, but in the states that we studied, EQROs were not directly involved in assessing the outcomes of delivery system or payment reform initiatives. Similarly, while actuaries consider whether delivery system and payment reforms might affect the actuarial soundness of MCO capitation rates, the actuaries are not necessarily involved in reviewing the cost effectiveness of such reform efforts at the state or the provider level. They are also not required to assess performance on quality metrics other than as part of assessing whether withhold arrangements should affect MCO capitation rates.

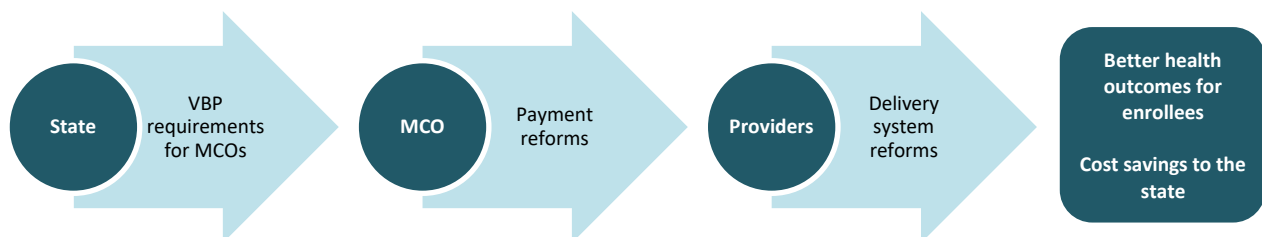
Introduction

In contrast to traditional fee-for-service (FFS) payment models that are based on the volume of care provided, value-based payment (VBP) models reward providers for the achievement of quality goals, and in some cases, cost savings. Because of the potential for VBP models to improve quality and reduce costs, there has been considerable attention to adoption of these models by state Medicaid programs, Medicare, and other payers. However, the use of VBP in Medicaid is lower than that of other payers: the Health Care Payment Learning & Action Network (LAN) estimates that 66.1 percent of Medicaid payments were made through FFS methods with no link to quality in 2018, compared to 55.7 percent for commercial insurance, 39.5 percent for Medicare advantage, and 10.2 percent for traditional Medicare.³

Because many Medicaid enrollees are enrolled in comprehensive managed care, many states are seeking to use managed care contracts to promote the use of VBP in Medicaid. As of July 2017, more than two-thirds of Medicaid beneficiaries nationally were enrolled in comprehensive managed care plans.⁴ Today, thirty-nine states plus the District of Columbia contracted with managed care organizations (MCOs) to deliver care for their Medicaid beneficiaries.⁵ The use of managed care is particularly common for acute health needs of Medicaid-eligible adults and children who are not elderly or disabled, and so this report focuses on efforts to increase the use of VBP for acute care; the report does not review specific efforts to implement VBP in managed care contracts focusing on long-term services and supports.

In Medicaid managed care, states implement payment reform by incorporating VBP requirements into their managed contracts. The expectation is that these MCO requirements will result in new payment approaches that link provider payment to achievement of quality goals and, in some cases, greater efficiency and cost savings. These value-based payment approaches should in turn incentivize providers to improve the way they deliver care, thus leading to better enrollee outcomes. Figure 1 depicts how changes to contract requirements can theoretically affect MCO and provider behavior in ways that ultimately improve health outcomes and reduce overall health costs.

Figure 1: Impact of Value-Based Payment Requirement: Theory of Change



To better understand how these contracting strategies are working in practice, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Bailit Health to conduct structured interviews with state officials, MCOs, and other stakeholders in five states that reflect a range of approaches to implementing VBP through managed care (Minnesota, New York, New Mexico, Ohio,

and South Carolina). This report reviews findings from these interviews as well as perspectives from national experts and staff from the Centers for Medicare & Medicaid Services (CMS).

Background

Increasingly, health care purchasers are requiring or incentivizing the adoption of delivery system reform approaches that emphasize coordinated, team-based care and consider the whole spectrum of patients' needs over time, or for a specific condition or procedure. Box 1 presents terms used to describe payment and delivery system reform approaches included in this report.

Box 1: Select Payment and Delivery System Reform Models

Accountable Care Organization (ACO): This generally refers to a group of health care providers that agree to share responsibility – and be accountable to some extent – for the care, total cost of care, and outcomes of a defined population.

Episode-Based Payments: A value-based payment model that pays a group of providers a set amount for all services related to a particular treatment plan (e.g., knee or hip replacement). The payment is meant to support coordinated care across providers. Episode-based payments can be reconciled against a fee-for-service payment or can be paid through a capitated payment.

Patient-Centered Medical Home (PCMH): A model of delivering primary care that is patient-centered and focused on ensuring that patients receive appropriate care at the right time and place, and in a manner they can understand. PCMHs often receive a per member per month fee in addition to regular FFS payments. Generally, providers have recognition from organizations such as the National Committee for Quality Assurance (NCQA) to gain PCMH status.

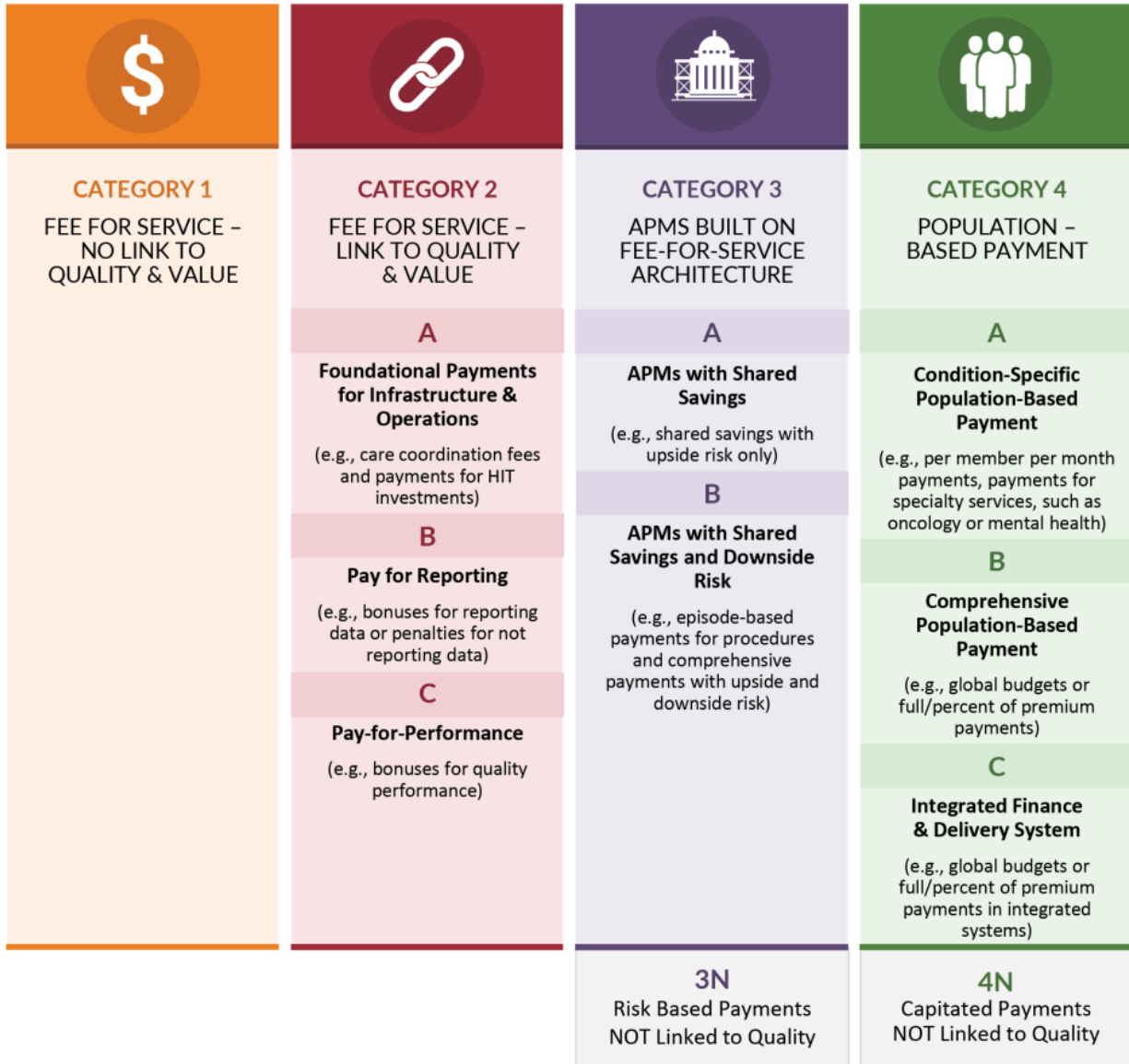
These reforms move away from FFS payment models that pay providers solely based on the volume of care they deliver, towards VBP models that link some portion of provider payment to achievement of quality goals and, in some cases, greater efficiency and cost savings in order to incentivize providers to change how they are delivering care. Many of these VBP models are built on top of a FFS payment that continues. The VBP models are not exclusive, and MCOs and providers often enter into provider agreements that combine models.

A. National Efforts to Promote Adoption of Value-Based Payments

At the federal level, the U.S. Department of Health and Human Services (HHS) has increased efforts to promote VBP by setting targets for the use of alternative payment models (APMs) by all payers, including Medicaid. In 2015, HHS set goal of tying 30 percent of payments to quality or value by 2016, and having 50 percent of payments in APMs by the end of 2018.⁶ At the same time that HHS announced these goals, it supported the creation of the LAN, a public-private partnership that aims to serve as a forum for providers, purchasers across all sectors, policymakers, and consumer groups to discuss how to make the transition to value-based payments in health care.

In order to measure progress towards these goals, the LAN developed an APM Framework to classify VBP payment models. The LAN APM Framework places payment models into four categories based on where they fall in the continuum of clinical and financial risk for providers as illustrated in Figure 2.

Figure 2: LAN Alternative Payment Methodology Framework



SOURCE: Health Care Payment Learning & Action Network, "Alternative Payment Model: APM Framework," 2017.

LAN Category 1 describes FFS payments that have no link to quality or value and are therefore not considered alternative payment models. Category 2 payment models include FFS payments that are subsequently adjusted based on the following: infrastructure investments to improve care (2A), providers reporting of quality data (2B), or how well providers perform on quality/efficiency metrics (2C). For example, PCMH models typically fall into Category 2A of the LAN APM Framework when

providers are paid a per-member per-month care management fee for example. Some more advanced PCMH payment models may also include additional payments to providers based on performance to pre-determined metrics which would be fall within Category 2C. This is one example of how one provider contract may include payment components that fall within different APM categories. In the LAN APM data collection approach, reporting plans are instructed to report these types of provider payments model in the highest applicable category, in this case Category 2C.⁷

Category 3 models hold providers financially accountable on a retrospective basis for performance on both quality and cost-efficiency measures. In Category 3A models, designated providers can share in a portion of the savings they generate against a cost or utilization target if they meet quality targets for their attributed patients. In Category 3B models, in addition to sharing savings when performance exceeds expectations, payers may recoup a portion of the losses that result when designated providers do not achieve cost or utilization targets. For example, ACO and episode payment models are classified as Category 3 in the LAN APM framework where providers are paid FFS with a reconciliation to a spending target. Models that include both shared savings and down-side risk arrangements are included in Category 3B, while models with shared savings only are in Category 3A.⁸

Category 4 payment models involve prospective, population-based payments that also require providers to meet certain quality of care measures. These may include ACO or episode payment models. The LAN APM Framework does not recognize capitated models at the provider level that lack a link to quality as an alternative payment model.⁹

B. Reporting of VBP Provider Payments to Assess Progress

Annually, the LAN asks payers to voluntarily report their use of payment models in order to track progress towards the LAN's goals.¹⁰ Participating plans and states categorize provider payments according to the APM Framework for the most recent 12-month period using the LAN survey tool, definitions, and methodology.¹¹ Despite significant movement towards VBP models, most provider payments are still FFS-based, with no links to quality or costs. For 2018, the LAN began reporting provider payment data by line of business – Medicaid, commercial, Medicare Advantage, and traditional Medicare and by LAN category and subcategory. The LAN's most recent data collection effort included data from payers that represent nearly 80 percent of covered Americans, including 51 percent of Medicaid-covered lives.¹²

Most Medicaid provider payments are still FFS-based, with no links to quality or costs. Table 1 presents the results from the LAN's measurement effort which shows that approximately one-third of Medicaid provider payments occur within a provider contract that includes a VBP model. Shared savings arrangements (15 percent) account for the largest portion of payments within VBP models, followed by pay-for-performance models (9.5 percent). Outside of states with prescribed Medicaid episode payment models or VBP model risk requirements, there is limited use of shared risk or capitated models in Medicaid.¹³

Table 1: Percent of Payments in LAN APM Framework Categories by Health Care Market, 2018

LAN APM Framework Categories	Percent of Medicaid Payments	Percent of Commercial Payments	Percent of Medicare Advantage payments	Percent of Traditional Medicare Payments
LAN Category 1: Fee-for-service - no link to quality and value	66.1%	55.7%	39.5%	10.2%
LAN Category 2: Fee-for-service - link to quality and value	10.6%	14.2%	6.9%	48.9% ¹
2A: Foundational payments for infrastructure and operations	1.1%	0.2%	<0.1%	--
2B: Pay-for-reporting	<0.1%	0.1%	<0.1	--
2C: Pay-for-performance	9.5%	13.9%	6.9%	--
LAN Category 3: APMs built on fee-for-service architecture	17.4%	27.6%	36.4%	36.5%
3A: APMs with shared savings only	15.0%	19.5%	29.3%	22.7%
3B: APMs with shared savings and downside risk	2.4%	8.1%	7.1%	13.8%
LAN Category 4: Population-based payment	5.9%	2.5%	17.2%	4.4%
4A: Condition-specific population-based payment	1.9%	0.7%	1.4%	3.4%
4B: Comprehensive population-based payment	3.9%	1.4%	14.0%	1.0%
4C: Integrated finance and delivery systems	0.1%	0.4%	1.8%	0%
SOURCE: Health Care Payment Learning & Action Network (LAN), <i>Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs</i> (LAN, October 24, 2019). NOTES: (1) Reporting for traditional Medicare is not broken down into subcategories for LAN Category 2 payments.				

In 2019, the LAN announced new goals to increase the use of value-based payments generally, setting APM thresholds for Medicaid, commercial plans, Medicare Advantage, and traditional Medicare as detailed in Table 2. In addition to having half of Medicaid and commercial plan payments and all of Medicare payments be value-based by 2025, the LAN advocates moving more national health care spending into Category 3 and 4 payment models. This is because the greater financial risk associated with these models, when combined with appropriate quality measures, provides stronger incentives for providers to decrease costs while maintaining or improving quality. The prospective nature of

Category 4 payments, in particular, gives providers more flexibility to adjust their care to patients' needs and are more suited to a population health approach. While LAN advocates moving towards Category 3 and 4 payment models, it acknowledges that not all providers may be able to meet this goal. As noted in the 2017 refreshed LAN APM Framework White Paper, one key principle of the LAN includes: "...value-based incentives should be sufficiently meaningful for providers to invest in and implement delivery reforms, without subjecting providers to risk that is beyond their financial means and/or clinical scope of care."¹⁴

Table 2: LAN APM Goals by Health Care Market

Year	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	30%
2025	50%	50%	100%	100%

SOURCE: Health Care Payment Learning & Action Network Press Release, "While progress continues, the LAN launches new goals to increase reach and impact of value-based payment reform," October 24, 2019, <http://hcp-lan.org/workproducts/2019-APM-Progress-Press-Release.pdf>.

C. Mechanisms for Implementing Payment Reform in Medicaid

Compared to Medicaid FFS in which states set payment rates and methods, states have less direct control over Medicaid managed care payments to providers. However, states can and do affect managed care behavior through contract requirements, incentives, and penalties.

States managed care contracts must follow federal regulations that govern Medicaid managed care delivery systems codified in Section 42, Part 438 of the Code of Federal Regulations. In 2016, CMS finalized a comprehensive update of these Medicaid managed care rules, applying similar standards regardless of the authority that states use to implement their managed care program.¹⁵ The rule also applies standards more consistently across the type of managed care entity, e.g., MCO, pre-paid inpatient health plan or prepaid ambulatory health plans, consistent with the entity's contractual obligations. CMS must review each state's managed care contract annually to ensure compliance with federal requirements.

The 2016 revisions to the Medicaid managed care rule added a new option for states to require managed care plans to pay providers according to specified rates or methods, referred to as directed payments. CMS must approve directed payments in advance. A state's proposed use of directed payments must meet a variety of federal requirements, including a requirement that the state monitor the extent to which the payment advances at least one goal of the state's managed care quality strategy. Since 2016, the use of directed payments has grown rapidly. As of June 6, 2019, CMS had approved 121 directed payment arrangements in 34 states. About one-quarter of these directed payment arrangements require managed care plans to participate in value-based payment models.¹⁶

The 2016 revisions to the Medicaid managed care rule make few changes in the types of incentives or penalties that a state can impose, but the revisions did create new definitions and requirements for withhold arrangements and actuarial soundness of capitation rates. States can withhold a portion of the managed care plan's capitation rate but only the portion of the withhold requirements that is certified by an actuary as being reasonably achievable can be considered as part of an actuarially sound rate. Overall, the managed care capitation rate (after accounting for any unachievable penalties) must be sufficient to cover the reasonable, appropriate, and obtainable costs for services under the contract.

MCO withhold arrangements are subject to requirements at § 438.6(b)(3), and must be tied to meeting targets designed to drive plan performance in ways distinct from general operational requirements. In addition, the rate certification & documentation must describe:

- any incentives or withhold amounts in the contract between the state and the MCOs;
- the percentage of the certified capitation rates being withheld through withhold arrangements;
- an estimate of the percentage of the withheld amount through a withhold arrangement that is expected to be returned and the basis for that determination; and,
- any effect that the incentive or withhold arrangements have on the development of the capitation rates.

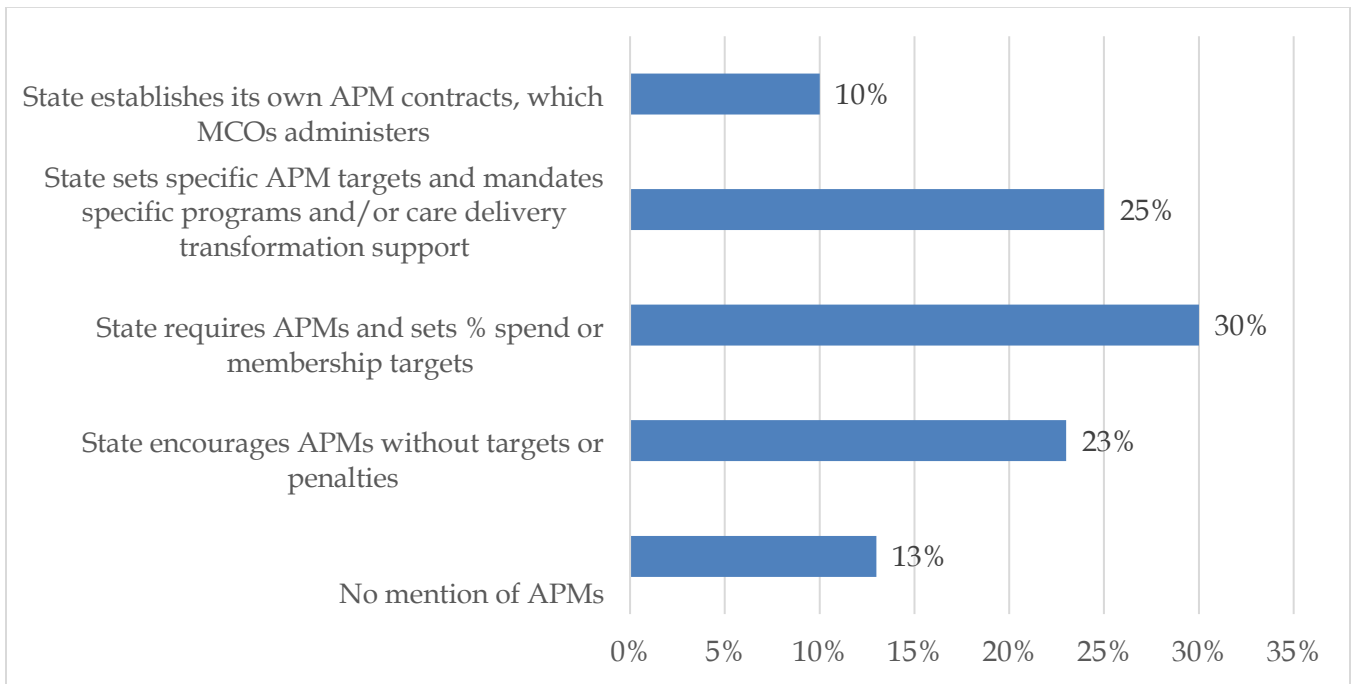
D. Payment Reform in Medicaid Managed Care

States are currently using a variety of strategies to promote the use of VBP in managed care. According to a recent review by Catalyst for Payment Reform (CPR) of Medicaid MCO contracts in 39 states and the District of Columbia, 12 states (30 percent) set general VBP goals and targets for VBP adoption and give MCOs flexibility on how to achieve them. Ten states (25 percent) use a combination of mandated programs and VBP targets, while 4 states (10 percent) required MCOs to administer state established APMs. Thirteen percent of states do not place payment or delivery system reform requirements on the MCOs.¹⁷

CPR's review also examined whether VBP requirements were specific to particular services, such as maternity care. Nine of the 40 MCO contracts reviewed included a provision for payment reform in maternity care. Strategies included: non-payment for early elective delivery before 39 weeks; uniform payment rates for c-sections and vaginal deliveries, maternity episode-based payments and incentives for meeting maternity-related quality targets. CPR also found that states commonly required MCOs to incorporate provider supports, the use of quality metrics, and care management in their delivery system reform efforts.¹⁸ For more information on use of maternity episodes, see Box 3 on page 24.

The Kaiser Family Foundation's annual state survey of Medicaid programs supports CPR's findings, and also found that nine states that did not set VBP targets planned to add them in the future.¹⁹

Figure 3: The Spectrum of Approaches to Payment Reform in MCO Contracting



SOURCE: Catalyst for Payment Reform, *Medicaid Managed Care Contracts as Instruments of Payment Reform, A Compendium of Contracting Strategies* (Catalyst for Payment Reform, Berkeley, CA, 2019).

Methodology

To gain a deeper understanding of how state Medicaid programs are developing and implementing payment reform initiatives through managed care, Bailit Health analyzed efforts in five states: Minnesota, New York, New Mexico, Ohio, and South Carolina.

We reviewed Medicaid managed care contracts and related documents and conducted stakeholder interviews to gather insights into the key questions outlined in Box 2. The following provides more details on our state selection process, document reviews, and stakeholder interviews.

Box 2: Key Study Questions

1. What are the drivers and barriers to promoting value-based payment through Medicaid managed care?
2. What strategies are states implementing through managed care and what requirements are they placing on MCOs?
3. To what extent are strategies to implement payment reform through Medicaid managed care designed to complement other delivery system reform efforts in the state?
4. How are MCOs changing their contracting and payment strategies with Medicaid providers?
5. How do states monitor and evaluate MCOs' progress in implementing strategies?
6. How do managed care delivery system and payment reform requirements affect beneficiary outcomes?
7. How are states planning to change their managed care delivery system and payment reform strategies in the future?

A. State Selection

In selecting states for the study, we considered those with at least two years of experience implementing payment and delivery system reforms within Medicaid managed care. Within this group of states, we then applied the following three criteria to further narrow the list:

- **Approach to payment and delivery system reform.** We included states that used a combination of the following approaches to improve value and support delivery system reform through their Medicaid MCO contracts:
 - Establishing a VBP target(s) for MCOs related to the percentage of payments, members, or providers to be engaged in APMs by a specified date.
 - Requiring and/or incentivizing MCOs to implement one or more delivery system reform models with providers but allowing health plans flexibility in how the models are designed and implemented.
 - Requiring and/or incentivizing MCOs to implement one or more delivery system reform models with providers as defined by the state, with little variation across MCOs.
- **Availability of some quantifiable results.** We sought to include some states that had measurement systems and data reporting structures to assess whether the Medicaid agency is obtaining the value that it seeks from the state's payment and delivery system reform requirements.
- **Application of rewards and/or penalties related to VBP.** We considered whether MCOs had clear consequences for failing to meet requirements around payment and delivery system reform and/or related quality measures. More specifically, we looked at whether the states withheld a portion of the capitation and allowed funds to be released based on MCOs meeting either quality requirements, or both quality and VBP requirements.

In addition to the three main criteria detailed above, we sought to include both states that have expanded coverage to the new adult group under the Patient Protection and Affordable Care Act and those that have not, states with different types of managed care plans (national, regional, or provider-based), states from different regions of the United States, and at least some states that received additional federal funding to support their delivery system transformation efforts, such as through Delivery System Reform Incentive Program (DSRIP) Programs and State Innovation Model (SIM) Grants. Table 3 presents basic information about key characteristics of the five selected states.

Table 3: Key Characteristics of Selected States

Criteria	Minnesota	New Mexico	New York	Ohio	South Carolina
Coverage Landscape					
Expansion state	X	X	X	X	
Managed Care Landscape					
Medicaid beneficiaries in managed care	76.4%	77.4%	74.1%	82.7%	63.5%
Presence of national plans		X	X	X	X
Presence of regional plans	X	X	X	X	
Presence of provider led plans	X	X	X	X	
Experience with Payment and Delivery System Reform in Managed Care					
2 or more years of experience with Medicaid MCO reforms (including 2017)	X	X	X	X	X
Quantifiable results related to VBP/reform efforts	X		X	X	
VBP Approach					
VBP payment target		X	X	X	X
Financial incentives related to VBP ¹		X	X		X
VBP directed payments	X			X	
Withholds related to quality	X	X	X	X	X
State required models	X			X	X
Provider-based incentives/DSRIP			X		
Multi-payer strategies			X	X	
Availability of External Funding					
SIM Test Grants	X	X ²	X	X	
DSRIP Demonstration Waivers		X ²	X		
<p>SOURCES: Bailit Health’s 2020 review of state managed care contracts and related documents. MACStats: Medicaid and CHIP Databook. MACPAC: Washington, D.C. 2019.</p> <p>NOTES:</p> <p>(1) Withholds related to VBP are those where an MCO may receive funding based on meeting VBP requirements. Payment of a withhold based only on an MCO meeting quality measures benchmarks is considered a withhold related to quality.</p> <p>(2) New Mexico received a SIM design grant but not a SIM test grant. New Mexico also received approval for a DSRIP-like program that is much smaller than other approved DSRIP programs, such as New York’s DSRIP. For more information, see the state profiles in Appendix A.</p>					

B. Review of State-Specific Medicaid Managed Care Materials and Related Documents

For each of the study states, Bailit Health reviewed Medicaid MCO contracts, focusing on provisions relevant to payment and delivery system reforms including:

- Requirements related to MCOs' use of specific delivery system reform models;
- Requirements for MCOs to meet certain VBP targets to transition provider contracts out of traditional FFS arrangement;
- Monitoring the MCOs' use of delivery system and VBP models; and
- Applications of rewards and penalties based on a MCO's success in meeting applicable delivery system reform and VBP requirements.

In addition, we reviewed publicly available materials such as Medicaid payment and delivery system reform strategic plans and roadmap documents, VBP and quality measurement sets and reports, Medicaid managed care external quality review organization (EQRO) reports, CMS submissions such as 438.6(c) direct payment pre-prints, and program evaluations, including for SIM and DSRIP, where applicable.

C. Structured Interviews

Bailit Health conducted a series of interviews with state Medicaid officials and MCO representatives in each of the five study states, as well as interviews with select providers, EQRO representatives, actuaries, national experts, and CMS officials (see Appendix B for a full list of interviewee organizations). We developed and used structured interview guides designed to elicit interviewees' perspectives on the following issues:

- **State officials:** rationale behind Medicaid managed care delivery system and payment reform approaches; progress to date; initial impacts on cost and quality; and future directions.
- **MCO representatives:** how state delivery system and payment reform requirements are being put into practice; the effect on MCO capitation rates and provider networking; alignment with multi-payer initiatives.
- **Providers:** how delivery system and payment reform requirements are affecting care processes; perspectives on challenges in getting providers to engage in downside risk arrangements.
- **EQRO representatives:** monitoring and evaluation of managed care quality initiatives related to delivery system and payment reform strategies.
- **Actuaries:** state delivery system and payment reform requirements; progress to date; initial cost effectiveness results and interplay with MCO capitation rates and future direction.
- **National experts:** national trends around delivery system and payment reform; and state Medicaid efforts in relation to commercial and Medicare products.
- **CMS officials:** federal monitoring of state delivery system and payment reform efforts, Medicaid managed care initiatives and MCO directed payments to providers; sustainability; and future directions.

Findings

The following section presents our findings, which highlights information that provides insight on the key questions outlined at the beginning of the study. This section is organized as follows:

- States' payment and delivery system reform goals
- Contracting strategies to promote payment and delivery system reform in Medicaid managed care
- Integration and alignment with other delivery system and payment reform strategies
- States' monitoring and evaluation of payment and delivery system reforms
- Challenges to implementing payment and delivery system reforms in Medicaid managed care
- Future state payment and delivery system reform approaches

A. *States' Payment and Delivery System Reform Goals*

Perceived opportunities for quality improvement and cost-savings drove state decisions to pursue payment and delivery system reforms. Due to state budget pressures, the state officials that we spoke with noted that they are constantly exploring ways to get more value for their Medicaid dollar by improving quality while reducing cost. While states have taken varying approaches to payment and delivery system reform, we consistently heard that states' interest in reducing the use of FFS payment methods at the provider level because of its potential to reduce cost growth in their Medicaid program and improve quality outcomes for Medicaid beneficiaries. As one interviewee noted, the concept of value-based payments enjoys strong support among state legislators regardless of party affiliation, and a broad range of stakeholders view it as simply "the right thing to do."

State Innovation Model (SIM) grants provided important incentives and supports that catalyzed states to engage in payment and delivery system reform. Three of the states we studied received SIM grants through the Center for Medicare and Medicaid Innovation (CMMI) to help support payment reform efforts. These grants provided additional resources and technical assistance that enabled states to increase their focus on payment and delivery system reform efforts. For example, Minnesota used its SIM test grant to advance the state's ACO model, the Integrated Health Partnership (IHP) program. In Ohio, state officials credit the SIM test grant with the state's ability to develop and implement both a statewide PCMH initiative and over 40 different episodes of care. New York leveraged its SIM test grant to expand its PCMH model across the state.

National groups focusing on VBP influenced states' strategies. CMS's national goals of increasing use of VBP models encouraged state Medicaid programs to further develop VBP strategies. States also indicated that the LAN's activities were instrumental in advancing their thinking on VBP and in developing a framework and strategy for the state. Some states noted that national experts and consultants helped shape their approaches. For example, South Carolina's early and ongoing participation as a member of CPR helped the state better understand payers' use of the LAN APM Framework and resulted in the state introducing VBP targets for Medicaid MCOs. Similarly, their involvement with the PCMH efforts of a local commercial payer and other stakeholder contributed to

the state's ongoing commitment to MCO support of PCMHs. New Mexico received technical assistance from a national organization to develop a strategy to increase the use of more advanced payment models that require shared financial risk, while allowing MCOs flexibility in how to meet those requirements. Large multi-state plans also brought models and approaches from other states and markets, helping to increase the knowledge and use of VBP.

B. Contracting Strategies to Promote Payment Reform in Medicaid Managed Care

States employ a mix of strategies to promote VBP in Medicaid managed care. The five study states take varying approaches to payment reform. Table 4 presents a high-level overview of the payment reform activities in each state, including VBP targets and requirements, state-directed payment models, related financial incentives, and additional funding support through SIM or DSRIP.

States generally relied on two approaches to contracting with their Medicaid MCOs: (1) setting value-based payment targets; and (2) prescriptively directing MCOs to adopt a specific payment model. While states may elect to primarily focus on one or the other approach, some states have aspects of both approaches in their delivery system transformation strategies. In determining their approaches, states consider a variety of factors including available resources and expertise, provider and MCO engagement, other payment reform activities in the marketplace, and alignment with the state's overall strategy and approach to Medicaid managed care.

- **VBP Targets:** Four of the five states (New Mexico, New York, Ohio, and South Carolina) require their MCOs to have a certain percentage of their payments flow through value-based arrangements with providers. The VBP targets for 2020 across these states range from 30 to 80 percent. In addition, New Mexico and New York establish tiered VBP targets for different payment reform approaches within the overall VBP target. All study states were at least generally aware of the CMS and LAN targets for increasing VBP and many indicated that their strategy was informed by the CMS target. However, most states we interviewed did not articulate precise rationales for how they identified the specific levels to use for VBP targets, other than reviewing the Medicare and LAN APM targets. New Mexico was one exception, noting that they considered the baseline Medicaid VBP performance for MCOs in their state when setting the targets overall and for different types of VBP models.

While four of the states set targets, each define these targets with their own parameters. For example, New York and New Mexico both require plans to provide detailed reporting based on the levels of VBP as defined by the states. While Ohio requires its MCOs to make 50 percent of provider payments value-oriented by 2020 and provides broad guidance on the types of strategies that MCOs can implement to satisfy the requirement. South Carolina requires that 30 percent of payments be in VBP models that resemble LAN categories 2C or higher for measurement years 2018 through 2021. However, South Carolina does allow MCOs to partially count required payments to PCMHs which would be categorized as 2A in the LAN APM Framework.

Table 4: Managed Care Payment Reform in Study States

Key Features and Requirements	Minnesota	New Mexico	New York	Ohio	South Carolina
State Directed Model(s)	ACO			PCMH; Episodes	PCMH
Specific VBP Payment Target(s) (% of Provider Payments)	None	20% by 2018 24% by 2019 30% by 2020 33% by 2021 36% by 2022	10% by 2018 50% by 2019 80% by 2020 (35% downside risk)	50% by 2020	30% per year, 2018-2021
Payment Models Counted Toward VBP Target	N/A	Plan flexibility within specific parameters established by state	State-defined “on menu” options; with plan flexibility to define “off menu” model subject to state approval	Plan flexibility within broad parameters established by state	Plan flexibility within LAN parameters established by state (LAN 2A counted at 50%; LAN 2B not counted)
MCO Financial Incentive or Penalty Linked to VBP or Delivery System Reforms ²⁰	None; MCO mandated to participate in ACO program	20% of 1.5% capitation withhold linked to VBP targets	Penalty of at least 2% of marginal difference between required vs actual amounts in VBP	None linked to VBP target. MCO mandated to participate in episodes and PCMH	25% of 1.5% capitation withhold linked to VBP target
Additional Funding Support for Delivery System Reform	SIM	SIM (Design only)	DSRIP, SIM	SIM	

SOURCE: Bailit Health’s 2020, review of state managed care contracts and related documents.

New Mexico and New York both defined their own categories of VBP that are similar, but not identical to the LAN. New Mexico defines three levels of VBP arrangements – incentives for meeting quality targets (Level 1); shared savings (Level 2); or shared savings and shared risk (Level 3), requiring MCOs to reach an overall VBP level of 36 percent in VBP arrangements by 2022. As depicted in Table 4, each year, the state specifies a portion of payments that must be in each level. For example, 8 percent of payments were required to be in a Level 2 arrangement in 2017, which increases to 15 percent in 2022. New York’s VBP targets for their MCOs are the most aggressive, with the state requiring MCOs to be at 80 percent VBP by March 2020 as required by the state’s DSRIP and 1115 waiver requirements. Of that 80 percent at least 35 percent must be in provider contracts with downside risk either through shared savings or

capitation arrangements. MCOs can select from a set of state designed models or receive state approval for a plan designed model.

- **State Prescribed VBP Models:** Three of the study states – South Carolina, Minnesota and Ohio – direct their MCOs to adopt a standardized payment model in their provider contracts. In these states, elements of the model, such as provider eligibility, payment methodology, and performance measures and thresholds, are standardized for all plans.

In South Carolina, MCOs must make additional per-member-per-month payments to PCMHs that obtain NCQA certification. The state makes quarterly PCMH payments to MCOs to cover the costs and provides MCOs with a PCMH incentive payment as well. This Medicaid approach builds off a PCMH program originally developed by BlueCross BlueShield of South Carolina, the dominant carrier in South Carolina. The state’s Medicaid MCO PCMH program uses a slightly different financial incentive and staffing model but adapted many of the BlueCross BlueShield program’s core PCMH elements.

Under Ohio’s SIM test grant, the state launched two multi-payer initiatives - the Comprehensive Primary Care (CPC) model for patient-centered medical care and an episodes of care (EoC) program. The state requires MCOs to implement both models. Today, Ohio has 18 Medicaid episodes linked to payment and 12 more episodes that are reporting only. The state requires Medicaid providers to participate in EoCs, but provider participation in CPC is voluntary. While the EoC program is multi-payer, there is not complete alignment across either the episodes that have been implemented or the specific parameters of each episode.²¹

Minnesota established the IHP initiative, which is an ACO model, through which IHPs participate in the model with a retrospective shared savings and shared risk payment methodology like the Medicare Shared Savings Program. Under the IHP model, Minnesota conducts a procurement to select and contract with IHPs. The state requires MCOs to make shared savings payments as calculated by Minnesota’s IHP actuarial consultant to IHPs that meet state-defined quality and performance targets.²² Other than making these IHP shared savings payments as directed by Minnesota, the MCOs are not involved in the IHP model and do not receive any information from the state on the quality performance of the IHPs with whom they contract.

Generally, states with more prescriptive payment models provide less flexibility to their plans and less incentive for MCOs to innovate or independently enter into VBP arrangements with providers that go beyond the minimum state requirements. New York provides plans with a menu of options from which MCOs can select state-defined VBP approaches, as outlined in the state’s VBP Roadmap, including ACOs, episodes, maternity bundles and other models. Plans have the flexibility to decide which options to implement and with whom. Until recently, New York did not allow MCOs to pursue state-approval of “off-menu” models. Ohio is directive in its PCMH and EoC requirements which are defined in state administrative code. The state defines and operationalizes the EoCs which are mandatory for providers and MCOs. The CPC program is optional for providers but MCOs are

required to support the CPC providers including issuing payments as directed by the state. Minnesota is also directive with its IHP. In addition to contracting separately with both IHPs and MCOs, Minnesota defines and operationalizes the shared savings, shared risk and quality components of the IHP contracts without MCO involvement. The MCOs are required to make the state-calculated shared savings payments to the IHP for their enrollees. MCOs have the flexibility, however, to enter into their own VBP contractual arrangements with IHPs or other providers within their network.

State approaches to payment reform are based on the uniqueness of each state Medicaid program.

State decisions on payment reform are also made within a context of how the state typically works with its Medicaid managed care plans and their relationship and history with managed care. South Carolina's first steps to payment reform in 2014 involved moving from a Medicaid primary care case management program to statewide mandatory managed care for their acute care services and populations. As the state Medicaid staff noted, South Carolina has tried to be non-prescriptive in their payment reform approach, encouraging plan variation, recognizing plans expertise, and aligning with payment reform initiatives in other markets. In contrast, Minnesota, both in its overall Medicaid managed care program and its delivery system transformation strategy has adopted a much more prescriptive approach, valuing consistency at the provider entity level over MCO flexibility and innovation. New Mexico's approach is a combination of specificity and flexibility. The state relies on MCOs to innovate and implement delivery system transformation initiatives and VBP models within state parameters that allow for some flexibility at the MCO and provider level. New Mexico's delivery system reform and VBP approach appear consistent with their overall MCO contracting approach.

In selecting their VBP approaches and their overall Medicaid managed care contracting approaches, state Medicaid agencies reported facing trade-offs. The state officials that we spoke with underscored the need for each state to find a path that works within their overall approach to MCO management, balancing between flexibility to encourage MCO innovation and prescriptive state requirements to ensure a more standardized outcome. States choosing a more directive approach with their MCOs may prioritize standardization and want to ensure consistent implementation of a specific model across providers, reducing the hassle and inefficiencies of providers responding to different payment and quality incentive models. However, while MCOs may enter into additional or different VBP arrangements with providers, in states that require prescriptive VBP models, MCOs noted that they and their providers face additional challenges working to innovate beyond state-defined models.

The staffing and resources required for a state to prescriptively define, and for its providers and/or MCOs to implement, a specific payment model was a key factor in state considerations as to which payment reform approaches to pursue. South Carolina did not receive SIM or DSRIP funding and New Mexico only received a small SIM design grant. Neither of these states have designed or required prescriptive, VBP models to the extent of those used in Minnesota, New York, or Ohio.

Box 3: Maternity-Focused Episode-Based Payment Models

Background: Medicaid paid for 43 percent of births in 2018.²³ Maternal mortality rates and preterm births have risen nationally in recent years.²⁴ Compared to the privately insured, women with Medicaid coverage are more likely to have preterm births, low-birthweight infants and poorer maternal and infant health outcomes.²⁵ Ohio and New York, have episode-based models focused on maternity care.

Ohio's Mandatory Perinatal Episodes of Care: Ohio requires its plans and providers to participate in this model which determines: 1) which births will be included in the episodes, 2) the services included (prenatal care, care related to labor and delivery, and postpartum care), 3) the expected costs of services, 4) the accountable providers, 5) the quality metrics and benchmarks,²⁶ and 6) the algorithms for financial incentives or penalties based on provider performance. By design, most providers fall within the average spend threshold and are therefore not eligible for shared savings or liable for downside risk payments. MCOs calculate whether cost and quality metrics are met.

Barriers to achieving cost savings and quality improvement results from perinatal episodes:

- The development of perinatal episodes is complex and data intensive. Initial results from Ohio indicate that perinatal costs increased 3 percent after episodes were used.²⁷
- Ohio and their MCOs, actuaries and interviewed provider cited challenges in terms of how to accurately reflect risks and predict outcomes and costs for perinatal EoCs.
- A provider noted that “it is hard to keep cost down and quality up” for perinatal care. There are contributing factors outside of providers’ control such as social determinants of health and patient choice of maternity hospitals. Interviewees noted that in Ohio total cost of care targets do not account for differences in hospital-negotiated prices. Consequently, choice of a hospital could have a sizable impact on cost.
- As one Ohio interviewee noted, some quality metrics, such as increasing the rate of post-partum visits, continue to be elusive and that it is hard to assess quality of care.

New York's Voluntary Maternity Episode: New York created a maternity bundle as an option for MCOs to meet VBP targets. The model includes care to attributed members from onset of the pregnancy, delivery, post-delivery and through the first month of the newborn’s care.²⁸ The model excludes newborns requiring neonatal intensive care and costs for episodes above a certain stop-loss threshold. The accountable providers are paid fee-for-service with retrospective adjustments; shared savings are available when outcome scores are sufficient; downside risk is reduced or eliminated when quality scores are high.²⁹ According to the state and other interviewees, no MCOs have implemented this model and there is limited provider interest.

Barriers to implementing voluntary maternity episodes:

- Hospitals are not required to participate in episodes; one interviewee noted that hospitals are very hesitant to take on risk associated with a maternity episode, knowing that an outlier can have huge impact on their bottom line.
- At least one health plan is considering a new, off-menu option to implement a maternity episode in the New York that differs from the state-defined perinatal episode.

State and provider resource constraints were less of an issue in states with significant additional funding (either through SIM or DSRIP) to support their payment reform efforts. For example, Ohio’s SIM grant enabled the state to expand its data analytic capacity to support episodes of care development including being able to analyze claims for physicians, hospitals, medication, rehabilitation, etc. to compare accountable providers’ cost-effectiveness for a specific episode.

States use financial incentives or penalties as the primary mechanisms for getting MCOs to engage in value-based payment models. According to state officials, financial incentives and penalties are important to getting MCOs to engage in VBP arrangements with providers. MCOs we interviewed agreed that the financial incentives and penalties are effective in motivating plans to engage in specific VBP activities to meet the state's expectations and targets. One MCO, however, noted that its commitment to VBP programs predates the contractual incentives.

Three of the four states with VBP targets, place a performance incentive on their MCOs. Ohio does not tie MCO performance on the state's 50 percent VBP target to financial incentives or penalties. However, the plans note that they are able to meet the state's requirement by implementing the mandatory EoCs and CPC. South Carolina, New Mexico and New York each have contractual language allowing withholds or penalties based on meeting VBP targets. South Carolina withholds one percent of the MCOs' capitation rate related to performance on specific quality and VBP targets. MCOs forfeit 25 percent of the withhold if they fail to meet the state's 30 percent VBP target. In New Mexico, up to 1.5 percent of MCO capitation is at risk for performance on specified delivery system improvement performance targets. MCOs avoid a financial penalty if they meet all targets. In 2019, the point breakdown includes: 20 points each related to community health workers, telemedicine and PCMH requirements, and another 30 points related to MCO achievement of VBP targets. In New York, MCOs that do not meet the state's required VBP levels may be assessed a penalty equal to at least two percent of the marginal difference between the amount of payment that was required to be in a VBP arrangement and the actual expenditures within a VBP arrangement. To date, this penalty has not been applied.

C. Integration and Alignment with Other Delivery System and Payment Reform Strategies

Most state Medicaid payment and delivery system reform efforts build off common models already in use in commercial and Medicare markets and promoted through national groups or dominant payers. States have largely reviewed the menu of existing delivery system and payment reform models and adapted them to fit their unique circumstances. As noted above, some states indicated that work at the national level by CMS, Medicare, CPR, and LAN heavily influenced their payment reform strategy. National experts noted that the goals that CMS set for VBP in Medicare spurred states' thinking around VBP targets, while the LAN provided a framework for states to use.

The PCMH model is a common component of all five states' delivery system reform efforts. Ohio specifies eight PCMH-related activity requirements for CPC practices. South Carolina requires MCOs to use PCMHs, which also count towards VBP targets. In Minnesota, entities must have NCQA PCMH recognition or Minnesota Health Care Homes certification to participate as and be considered as an IHP. New York and New Mexico also have a PCMH recognition program built upon the NCQA PCMH certification model.

In terms of state defined delivery system reform efforts, Minnesota's IHPs have a shared-savings and shared-risk payment methodology that is modelled on the Medicare Shared Savings Program. This does not mean, however, that delivery system or payment reform models can easily be taken off a

shelf, tweaked, and implemented in a new line of business, a new state, or a new provider group. The SIM initiatives with ambitious delivery system reform objectives in Minnesota, Ohio and New York, for example, each involved a sizable and lengthy engagement process with providers, health systems, ACOs, MCOs and other stakeholders, not to mention staff and consultant resources to move through the development stage and into implementation.

Multi-payer alignment is not a common strategy among states. While interviewees noted that nationally, most Medicaid programs have not aligned their VBP strategies with Medicare and commercial payers due to differences in both populations and overall payment rates, most of the states we reviewed for this study tried to align at some point during their VBP program development. Some state officials we interviewed indicated that multi-payer payment and delivery system reform initiatives are good in theory but hard in practice.

Of the study states, only Ohio currently requires MCOs to participate in a multi-payer VBP initiative. Ohio's CPC program is multi-payer and a key goal is to minimize provider burden and increase participation through an aligned model. The EoC program is also multi-payer, however there is not complete alignment across episodes or how episodes are implemented.³⁰ Several interviewees noted that engagement and leadership from the Governor's office enabled the state to convene commercial plans and the Medicaid agency to collaborate on a multi-payer delivery system reform initiative. South Carolina does not require MCOs to engage in multi-payer VBP initiatives, but the state adopted many of the components of the LAN's APM Framework to better align Medicaid VBP requirements with other payers. In Minnesota, the IHP initiative was developed based on the Medicare Shared Savings Program framework.

While most of the states interviewed did not focus on multi-payer alignment, MCOs indicated that when possible, they try to align their provider contracting strategies across their product offerings. This creates a level of simplicity and standardization that makes it more likely for providers to engage in VBP arrangements.

Some interviewees pointed out that it may not be sustainable for Medicaid, Medicare and commercial payers to be moving in different directions with respect to VBP. The CMS officials we spoke with noted that they were planning to issue additional guidance to state Medicaid programs to help them promote alignment with other payers in their VBP efforts.

D. States' Monitoring and Evaluation of Payment Reforms

States vary in the extent to which they monitor MCOs' progress towards payment reform goals. The states we studied met regularly with MCOs to monitor overall performance, including to discuss progress towards VBP goals. MCOs in New Mexico report on progress towards delivery system improvement requirements on a quarterly and annual basis. Ohio holds monthly calls with individual MCOs related to payment innovation programs. In addition, Ohio Medicaid staff hold a monthly meeting with all MCOs to discuss changes in strategy, identify concerns around implementation, and solicit plan feedback. Minnesota does not specifically meet with its MCOs on VBP but does conduct site

visits and calls directly with IHPs that are geared towards learning about on-the-ground implementation; MCOs are not involved in those discussions.

The states we studied also used reporting tools for plans to provide updates on their progress in meeting VBP targets. Medicaid MCOs in South Carolina, New Mexico, New York and now Ohio are required to report at least annually on their performance to VBP targets, at varying levels of detail. In New York, for example, plans must complete annual reports describing their VBP contracts while MCOs in South Carolina submit annual documentation and calculations supporting their compliance to the 30 percent VBP target. Ohio requests its plans to provide information on their VBP models as part of their rate development survey, but only recently started requiring MCOs to submit reports on their progress to the 50 percent VBP target. MCOs in New Mexico must develop an annual strategy for reaching targets in each VBP component area as well as submit quarterly and annual VBP reports on templates provided by the state and summarize all VBP activities and achievements.

Several Medicaid programs not included in this study have developed MCO VBP reporting tools similar to the LAN APM data collection tool to categorize types of MCO payment models and measure their use. These states include but are not limited to Louisiana, Michigan, Oregon, Texas and Washington.³¹

MCOs are meeting VBP targets. In the four states that established VBP targets, states indicated that the VBP targets have been achieved by most, if not all, Medicaid plans. As one MCO noted, the VBP targets are challenging but achievable with careful planning and effort. MCOs in states with more complex, multi-faceted, and aggressive VBP targets noted that the targets are becoming more challenging to meet over time. In South Carolina, while the state indicated that their MCOs have typically met the state's 30 percent VBP target, one MCO we interviewed noted challenges related to state policy changes and retroactive Medicaid rate reductions that negatively affected the MCO's meeting of the VBP targets. In New Mexico, the state and MCOs interviewed noted both the effectiveness and the challenges of MCOs and providers meeting the separate, more advanced model VBP targets, and specific VBP requirements for contracts with non-primary care providers. Interviewees noted that providers are comfortable with arrangements that include shared savings, but those providers that are large enough to consider taking on risk are not comfortable with doing so in part because of their panel sizes. New York is on track to meet its 80 percent VBP target program-wide for 2020 even though all MCOs may not meet the target. The state reported that all MCOs were making progress on VBP targets and that some provider-sponsored or provider-aligned MCOs were exceeding the state's targets, based on their relationships with physician's groups.

Many states and MCOs we interviewed also described the roles providers play in whether MCOs meet VBP targets. Compared to other types of health plans, states and some MCOs noted that it was easier for provider-sponsored plans to meet VBP targets and engage providers in more advanced VBP models. However, even the provider-sponsored plans we interviewed noted provider reluctance to adopt models that could put their payment at risk. Providers' ability to move to these models require financial stability, as well as the capacity to understand their data and use it to manage patients

through a population health approach where they can focus on providing preventive screenings and closing gaps in care.

States and MCOs reported considerably more VBP activity underway with primary care providers than with specialists, hospitals or other provider groups. The focus on primary care providers in the states we studied is also not surprising given the earlier finding that PCMH is a common component of all five states' delivery system reforms. Many of the skills needed to obtain PCMH status are the same as the skills needed to succeed in value-based payment. Thus, primary care practices in these states that place great emphasis on PCMH are likely to be more prepared than other provider types to accept VBP arrangements.

The MCOs that we interviewed noted that they generally try to align their provider VBP contracts with the MCO's quality withhold requirements. One plan also noted that primary care providers are better able to influence the quality measures that states use for the MCO performance withholds. For example, if the state has an MCO quality withhold that includes primary care measures, the MCO will be more likely to focus on VBP arrangements with primary care providers, using the same measures that are in the MCO's quality withhold. MCOs articulated that this alignment strategy minimizes provider burden across MCO VBP strategies and increases MCOs' chances of earning the quality withhold dollars.

Little is known about how the implementation of VBP models has changed payment or care delivery at the provider level. It is not clear whether financial incentives are changing providers' care processes, or which care processes result in quality and outcomes improvement, if at all. The states we interviewed do not require their MCOs to report on data on the amount of provider incentive within a value-based contract. This would identify situations where a plan may have 40 percent or more in their overall VBP percentage, but the potential total incentive payments within the MCO's VBP contracts amount to a relatively small percent, maybe as low as 1 percent of total provider payments being earned by providers as incentives.

In Ohio, plans and providers noted that the financial incentives associated with the EoC program were generally too small to make it worthwhile for providers to change their approach to care. One exception consistently cited as being high dollar and getting providers' attention is Ohio's maternity episode, detailed in Box 3 above, which providers consider hard to influence. Multiple interviewees commented that the perinatal episode is complex, in part because it is necessary to separately consider and account for the highest risk pregnancies when assessing results. This type of an episode requires risk adjusting claims for clinical conditions. While states and providers can measure adherence to prenatal care appointments, it is harder to assess overall quality of care and establish clear links to specific perinatal costs and outcomes.

The limited evaluations of payment and delivery system reform efforts generally show modest savings. States which received SIM testing grants (Minnesota, New York and Ohio) and those who have received DSRIP or DSRIP-like funding (New Mexico and New York) have formal program evaluations available or in process. However, even these evaluations found it difficult to tease out

whether the payment or delivery system changes successfully improved care and reduced costs in a way that is transferable to other providers, plans, regions, and populations. In Minnesota, the state estimates that between 2013 and 2017, the IHP model saved \$185 million after accounting for shared savings payments and resulted in reduction in emergency department and avoidable hospital use. In Ohio, the CPC program has resulted in improved quality and \$78.1 million in net savings in 2017, and the episodes program has lowered the average cost per episode without any measurable reductions in quality. However, findings from the national SIM evaluation note that financial incentives from episodes may not be sufficient to support practice transformation and care coordination.³² New York is evaluating delivery system reform efforts in the state as part of its DSRIP Section 1115 waiver evaluation and has found statewide reductions in avoidable hospital use. However, because of all the other changes happening in the state it is difficult to isolate the effects of the managed care VBP changes.

Outside of the formal evaluation efforts required by CMS, the states we interviewed did not formally evaluate the effectiveness of their payment and delivery system reform initiatives. States largely focused on tracking MCOs' progress in meeting VBP targets for the purposes of administering the withhold; states know relatively little about the performance of providers who engaged in VBP arrangements compared to providers that continue to be paid on a fee-for-service basis.

Minnesota conducts provider-level analysis on an ongoing basis as part of its IHP program in order to determine whether IHPs have met their cost savings and quality goals. Specifically, the state measures whether the IHPs actual spending for their attributed population is less than the estimated spending on an annual basis, and whether the IHPs met the state's quality targets. New York is also beginning to conduct provider-level analyses, but, along with other states, has identified several methodological challenges. States most commonly use HEDIS measures which are designed to evaluate plan performance, and struggle with how to adapt them to accurately and reliably measure provider performance. States, MCOs and providers universally noted that assessing the impact of specific delivery system reform approaches is often difficult because care improvement initiatives are so ubiquitous that it is virtually impossible to isolate a particular initiative's impact.

States do not involve external quality review organizations or actuaries in assessing the outcomes of payment and delivery system reform initiatives. All state Medicaid MCOs must contract with an EQRO to conduct an annual external quality review. Federal requirements detail the types of mandatory and optional review activities EQROs must complete for states.³³ None of these federally-defined EQRO activities specifically relate to evaluating payment and delivery system reform initiatives and it is not included as an optional service in any of the states we studied. However, some states seem intrigued by that potential. As part of its next EQRO procurement, South Carolina is considering expanding its EQRO's role to encompass validating the MCO VBP payment reports and value-based contracts. South Carolina is interested in how EQROs could help the state take a more "comprehensive approach to performance management and improvement across the quality, financial, and operational domains."³⁴

Similarly, while actuaries consider whether payment and delivery system reforms might affect the actuarial soundness of MCO capitation rates, they noted that they are not necessarily involved in reviewing such reform efforts' cost-effectiveness at the state or the provider levels. Actuaries also noted that they are not frequently involved in assessing performance on quality metrics other than as part of MCO capitation withhold arrangements.

E. Challenges to Implementing Payment Reform Initiatives in Medicaid Managed Care

State resource and capacity issues are common challenges to implementing payment reform.

Developing, implementing, and monitoring these initiatives in Medicaid managed care can be complex and requires collaboration among state staff responsible for three areas of work: (1) program development innovation; (2) managed care oversight; and (3) quality. In some of the states we studied, state officials noted that staff developed a coordinated strategy, but in others, the staff continued to operate independently, often a consequence of limited capacity. In one state, six to seven full-time equivalent staff comprise the managed care oversight team, which has responsibility over contract procurement, ensuring state compliance with federal managed care rules, and monitoring plan compliance with contract requirements, among others. Interviewees noted that staff already have a significant amount of responsibilities in just their core area of responsibilities, leaving little time to collaborate with other departments. In addition to having relatively few staff to implement these programs, there is also turnover at the staff and leadership level that impact capacity.³⁵

Transformation requires significant investments in data infrastructure and analytic capacities at the state, plan and provider levels. Interviewees noted that data analytics is critical to identifying opportunities for performance improvement, setting appropriate goals and targets, monitoring progress towards those goals, and assessing outcomes. States indicate that this has been a challenge that involves time and resources to address. In Ohio, the leadership from the Governor's office and the SIM test model grant both were cited as necessary to support the significant investments in data needed to develop and support a statewide PCMH initiative and many episodes of care. Minnesota had already established a data system for collecting and measuring performance prior to implementing IHPs but needed additional staff to manage additional reporting and analytic needs. New Mexico has had to develop a new data analytics system so the state can better understand and monitor its MCO delivery system and payment reform strategies.

States, plans and providers alike noted the importance of having correct and timely data as a part of their VBP strategies and implementation. Across states, plans noted a need for more transparency in calculations, such as total cost of care methodology, and the importance of fixing gaps or mistakes in data. Likewise, they noted the need for providers to have the capacity to accept and use data to support delivery system reform efforts. MCOs often offer support to providers in terms of increased sharing of data, focused on more real time information and identification of gaps in care. In addition to support in the mechanics of data sharing, providers also often can benefit from technical assistance in understanding on how to use the available data to manage care for their patient panels.

Payment and delivery system reforms affect MCO capitation rate development. Our interviews of actuaries representing four of the five states made clear that implementation of payment and delivery system reform models take time and require engagement with both MCOs and providers to be successful. The mechanics of VBP arrangements can be very complex and how they are implemented will impact MCO capitation rates and determination of total cost of care targets.

In addition, as states aim for cost savings through payment and delivery system reform efforts, the actuaries noted that states should not underestimate what they considered to be the outsized amount of effort to include impact of delivery system reform and VBP on MCO, ACO, and episodes rate development, particularly where states have previously captured savings related to reductions in emergency department utilization and avoidable hospitalizations and readmissions. Actuaries that we interviewed suggested that state Medicaid agencies try to keep things simpler when creating state-defined models that work alongside or within Medicaid MCO capitation arrangements. The more complex the VBP models the harder it is for the state, the MCOs and the provider entities to effectively predict, implement, and assess their impact.

It is also important to consider the long-term impact of time of delivery system and payment reform efforts on capitation rate. As one plan noted, initially these models should slow growth. However, over time, if payment reform models are successful, actuarially sound rates would be contained and there would be fewer dollars available to the provider for shared savings. Over time this could become a challenge to the sustainability of the delivery system reforms.

National plans describe challenges tailoring national VBP initiatives to meet state-specific requirements. The national plans we interviewed indicated that in many respects, states' goals around value-based payments are very aligned with their organizational goals. However, it can be challenging when the state sets very specific requirements around value-based payments. MCOs implementing VBP with providers in their commercial and Medicare markets have many established contracts and models that they try to draw from as much as possible. Their systems and processes are set up to support those existing models and changing them to comply with specific state requirements can sometimes pose difficulties. Likewise, they may have an overall Medicaid VBP approach that they are trying to implement across Medicaid programs to gain administrative efficiencies.

Most providers are not yet ready or willing to enter into downside risk arrangements. States such as New Mexico and New York that require more detailed reporting on VBP targets see very few APMs involving downside risk. New Mexico and its MCOs indicated that the tier 3 targets were harder to meet because of provider reluctance and lack of readiness to take on risk. In addition, New Mexico has many rural areas where providers simply do not have large enough patient panels to take on risk. While New York will meet its goal of having 35 percent of its VBP payment models including risk, physician groups are more likely to engage in downside risk compared to hospital-led systems. One plan noted that engaging hospitals in VBP arrangements is the number one barrier, given that it is inconsistent with their business models focused on recouping high capital costs instead of accountability on quality and cost. These findings are consistent with the LAN, which showed under 6 percent of payment arrangements in Category 4.³⁶ Likewise, while just over 17 percent of

arrangements were in Category 3, the vast majority of those (15 percent) are shared savings only arrangements without any potential for downside risk and only 2.4 percent include shared risk.³⁷

MCOs uniformly indicated that many providers still do not have the core capabilities and tools – including a sufficient provider network to use a population health approach to delivering care, mature care management processes, and data and technology infrastructure to measure performance – to manage clinical and financial risk. MCOs indicated that provider discussions not only focus on payment, but also on the tools and supports MCOs need to offer to move providers further along the VBP continuum. In some areas, providers are only starting to get acquainted with the concept of value-based payments, thus MCOs cannot even broach the topic of downside risk.

MCOs widely acknowledged the need to meet providers where they are, but also noted concern over being held accountable to VBP targets when similar requirements do not exist for providers. In most of the states we reviewed, MCOs are at financial risk for not being able to meet VBP targets, but providers typically do not face any consequences for not engaging in value-based contracts with MCOs. Some MCOs noted that this can put them at a relative disadvantage with larger providers during contracting negotiations. New York is the only state in our study that contractually addresses this by allowing MCOs to pass on part of the penalty for failing to meet VBP targets to providers that can be reasonably expected to implement value-based contracts but refuse to engage in such contracts with MCOs. Provider engagement in this context is defined as participating in value-based contracting discussions with the MCOs; if the provider participates in the MCO contracting conversation they are not subject to a penalty, even if the provider did not ultimately sign a value-based contract with the MCO. New Mexico reported working with provider groups and associations, in conjunction with MCOs, to reach agreement on common VBP model aspects, such as using existing quality metrics that are already reported rather than creating new provider performance measures.

F. Looking Ahead – Future State Delivery System and Payment Reform Approaches

While the states that we reviewed as part of this study have relatively mature delivery system and VBP programs, none of the states appeared to be in a steady state mode in terms of their payment model approach. States continue to adjust to and improve their models. While New York is allowing more flexibility, other states such as South Carolina that started with a very flexible approach to payment reform with MCOs, are looking to add more specificity in the MCO contracting approaches to support increased adoption of VBP models at the provider level or address particular areas of interest. These changes to state approaches are representative of the tradeoffs between flexibility and specificity to MCO contracting previously referenced. They also reflect the evolving understanding of how best to measure MCO use of VBP models and which models and characteristics may be more likely to result in better provider performance, improved population health, and reduced costs of care.

Specifically, study states have recently implemented or are working towards very specific modifications to their models. For example, for 2020, South Carolina has increased the level of standardization and detail required in annual MCO reporting on VBP targets. The state is also considering how it may change its 30 percent VBP target for MCOs in future years. In New Mexico, while the VBP targets for the next few years are laid out in MCO contracts that started in 2019, the state

will continue to amend its MCO contract annually and may make adjustments to its required Delivery System Improvement Performance Targets based on lessons learned and new priorities for the state. New Mexico noted challenges of creating the right incentives with specific benchmarks for certain MCO delivery system transformation expectations, particularly after a procurement where two of its four MCOs are new and there was considerable rearrangement of Medicaid membership even among the legacy MCOs. In New York, the state introduced more flexibility in how Medicaid MCOs could meet VBP targets by allowing MCOs to develop their own APMs, subject to state approval, for the purposes of meeting VBP targets.³⁸ In December 2019, based in part on feedback from clinicians and health systems, Ohio announced it was retiring 13 EoCs over the course of the next two years, to focus on 30 episodes. Of the remaining episodes, 15 are linked to provider shared savings and downside risk arrangements in 2019 and a different set of 7 episodes will be linked to payment in 2020. Finally, in 2018, Minnesota implemented the second iteration of its IHP initiative – moving some of its IHPs to a risk-based model and adding a population-based payment to support its IHPs in their transformation work. The payment is calculated at an IHP’s population level, adjusted for social and clinical risks and can be utilized to support on-going care coordination and delivery reform activities.

Stakeholders reported that getting MCO and provider buy-in is a challenge. As South Carolina state officials noted, the state is consistently working to marry quality improvement and payment reform work as part of comprehensive approach, not separate streams of work. We also heard from MCOs and providers how important and challenging it is to effectively engage clinicians, quality improvement staff and provider contracting staff in both the financial and the value-based outcomes aspects of these managed care delivery system reform efforts. As one interviewee noted, understanding a variety of different delivery system, payment reform models, and quality metrics is not what physicians signed up for. States can help by providing a focus and frameworks for VBP to be more successful at the provider and patient level.

The CMS officials that we spoke with noted that CMS was not planning to continue SIM or DSRIP funding. However, CMS is planning to issue additional guidance about how states can use existing authorities to promote VBP in their Medicaid programs and align their efforts with other payers.

Key Themes

Based on the findings discussed previously, we identified the following key themes:

- 1. National VBP models have informed Medicaid VBP strategies, but states and MCOs have adapted their strategies to local circumstances and have modified their approaches based on experience.***

Despite similar efforts to promote the use of VBP nationally in Medicare and commercial insurance, most of the Medicaid VBP approaches that we studied were unique to Medicaid. In many cases, states adapted national models to fit their local circumstances. The MCOs generally tried to align their provider contracting strategies across payers even if they weren’t required to do so, noting that providers would be more likely to engage if VBP arrangements were more standardized across markets. In addition, national plans that operate in multiple

state Medicaid markets noted that it was more efficient for them to adopt VBP models that they had used in other states rather than create new models for each market.

Interviewees noted that because Medicaid is a particularly large payer for some types of services, such as maternity and behavioral health, the program has a particularly important role in designing effective payment models for these services. MCOs are still learning from their early implementation of VBP models and are likely to continue to adjust their models in the future based on their experience. As states consider future changes, ongoing engagement with stakeholders will be critical.

2. *Existing Medicaid authorities provide states with multiple tools to promote the use of VBP in managed care, but developing and implementing VBP initiatives still requires substantial state investment and stakeholder engagement.*

The states we examined were able to implement a variety of different types of delivery system transformation and VBP in managed care through existing authorities and did not cite federal policy as a barrier. Some states used the new directed payment option added by the 2016 revisions to the Medicaid managed care rule, while others used longstanding managed care authorities.

States' VBP approaches have evolved over time and required substantial upfront effort to design and develop. The necessary tools are available to all states, but those states that benefited from additional federal funding through SIM or DSRIP awards were able to implement more advanced payment models. Of the five states we reviewed, three received significant funding through these programs to support transformation in their state.

3. *States face tradeoffs in deciding whether to be prescriptive or flexible in their managed care VBP initiatives.*

There is no clear consensus on whether states should be prescriptive or flexible. On one hand, prescriptive approaches ensure consistency across the multiple Medicaid MCOs that providers contract with, but on the other hand, it can limit an MCOs' incentive and ability to adapt payment models based on the unique needs of each provider. Conversely, where states provide a general VBP target with broad parameters, MCOs can focus their efforts on providers that are ready to participate in alternative payment models, and can use their experience with VBP in other markets to help design their payment models. However, because the different MCOs in a state are likely to pursue different models when given the flexibility to do so, providers may be burdened by having to negotiate and implement multiple VBP contracts, and it is difficult to evaluate which models are working best.

4. *Contract requirements are effective in changing MCO behavior, but do not address challenges with provider participation in VBP models.*

VBP targets have been effective at changing MCO behavior, but provider readiness and willingness remain a challenge. Compared to other types of health plans, provider-sponsored

plans were less likely to report challenges engaging providers, but still observe provider reluctance to adopt models that could put their payment at risk.

Providers need to first develop their infrastructure for measuring performance on quality measures and managing population costs to participate in payment models that tie payments to these metrics. Even if providers are able to participate, they may not be willing to take on increased risk, especially for Medicaid services which are typically have lower payment rates than other payers. Because providers generally have a choice about whether or not to participate in VBP models, they have additional leverage when negotiating with health plans that must meet state-imposed VBP requirements.

5. *Although states are monitoring MCO compliance with VBP requirements, plans to formally evaluate the effects of VBP efforts are limited, particularly in states with less prescriptive models.*

Despite implementing VBP requirements for several years now, the states we studied have limited data to assess whether the increase in value-based provider contracting has led to delivery system reforms, improved quality of care or reduced costs. States with prescriptive VBP models were able to share some early findings from their efforts which showed state savings. However, the initiatives' impact on quality and outcomes were more mixed. In states with less prescriptive models, it is more difficult to assess the effects of the VBP efforts in part due to limited state monitoring efforts. Several other activities underway in the state also make it difficult to isolate the effects of the managed care VBP changes.

Endnotes

¹ Catalyst for Payment Reform, *Medicaid Managed Care Contracts as Instruments of Payment Reform, A Compendium of Contracting Strategies* (Catalyst for Payment Reform, San Francisco, December 2019). https://catalyze.org/wp-content/uploads/woocommerce_uploads/2019/12/Medicaid-MCOs-as-Agents-of-Payment-Reform-1.pdf

² Health Care Payment Learning & Action Network, *Roadmap for Driving High Performance in Alternative Payment Models, Data Collection Tools*, October 2019, <https://hcp-lan.org/workproducts/data-collection.pdf>

³Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019. <http://hcp-lan.org/workproducts/apm-methodology-2019.pdf>

⁴ Medicaid and CHIP Payment and Access Commission (MACPAC). *MACStats: Medicaid and CHIP Databook*. December 2019. MACPAC: Washington, DC. <https://www.macpac.gov/macstats/>.

⁵ Catalyst for Payment Reform, *Medicaid Managed Care Contracts as Instruments of Payment Reform, A Compendium of Contracting Strategies* (Catalyst for Payment Reform, San Francisco, December 2019). https://catalyze.org/wp-content/uploads/woocommerce_uploads/2019/12/Medicaid-MCOs-as-Agents-of-Payment-Reform-1.pdf

⁶ U.S. Department of Health and Human Services (HHS), Press Release: *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value* (HHS: Washington, D.C., January 26, 2015). <https://wayback.archive-it.org/3926/20170127185400/https://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>

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- ⁷ Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019.
- ⁸ Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019.
- ⁹ Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019.
- ¹⁰ Health Care Payment Learning & Action Network, *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs (LAN, October 24, 2019)*.
- ¹¹ Health Care Payment Learning & Action Network, *Roadmap for Driving High Performance in Alternative Payment Models, Data Collection Tools*, October 2019, <https://hcp-lan.org/workproducts/data-collection.pdf>
- ¹² Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019.
- ¹³ Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019.
- ¹⁴ Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework, Refreshed for 2017*. 2017 <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>
- ¹⁵ States can implement comprehensive managed care under the Social Security Act Section 1932 state plan authority, Section 1915 waiver authority, or Section 1115 waiver authority.
- ¹⁶ M. Forbes and R Nelb, *Managed Care Issues and Use and Oversight of Directed Payments*. Presentation to the Medicaid and CHIP Payment Access Commission. September 26, 2019. <https://www.macpac.gov/wp-content/uploads/2019/09/Managed-Care-Issues-and-Use-and-Oversight-of-Directed-Payments.pdf>.
- ¹⁷ Catalyst for Payment Reform, *Medicaid Managed Care Contracts as Instruments of Payment Reform, A Compendium of Contracting Strategies* (Catalyst for Payment Reform, San Francisco, December 2019). https://catalyze.org/wp-content/uploads/woocommerce_uploads/2019/12/Medicaid-MCOs-as-Agents-of-Payment-Reform-1.pdf
- ¹⁸ Catalyst for Payment Reform, *Medicaid Managed Care Contracts as Instruments of Payment Reform, A Compendium of Contracting Strategies*.
- ¹⁹ Kaiser Family Foundation, *Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans*, (Kaiser Family Foundation, Washington, D.C., 2018).
- ²⁰ For purpose of this review, withholds related to VBP are those where an MCO may receive funding based on meeting VBP requirements. If a state pays a withhold based only on an MCO meeting quality measures benchmarks, those are included as a withhold related to quality.
- ²¹ Centers for Medicare and Medicaid Service, *State Innovation Models (SIM) Round 2; Model Test Annual Report Three*, RTI International (2019) <https://downloads.cms.gov/files/cmml/sim-rd2-test-ar3.pdf>
- ²² Minnesota Medicaid actually works with two different actuaries, one related to calculating the total cost of care targets and shared savings payments for IHPs and the other actuary for certifying the rates paid to Medicaid MCOs.
- ²³ Medicaid and CHIP Payment and Access Commission (MACPAC). *Financing Maternity Care: Medicaid's Role*, January 2020. MACPAC: Washington, DC. <https://www.macpac.gov/publication/financing-maternity-care-medicoids-role/>
- ²⁴ Medicaid and CHIP Payment and Access Commission (MACPAC). *Access in Brief: Pregnant Women and Medicaid*, November 2018. MACPAC: Washington, DC. <https://www.macpac.gov/publication/access-in-brief-pregnant-women-and-medicoid/>
- ²⁵ Ibid.
- ²⁶ Providers are eligible to share in savings if they meet perinatal care benchmarks related to HIV screening rate, 2) C-section rate and 3) post-partum follow-up visit rate. Medicaid quality metrics and spend thresholds for performance period 4, CY2019 – Perinatal accessed at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Threshold/Perinatal-Thresholds.pdf>

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- ²⁷ Ohio Governor's Office of Health Transformation, *Moving Ohio's Health Care Payment System Upstream*, Greg Moody, Executive Director Office of Health Transformation, presentation, April 18, 2018. <https://www.healthpolicyohio.org/wp-content/uploads/2018/04/Moody.pdf>
- ²⁸ New York State, Department of Health, *A Path toward Value Based Payment*, (September 2019), accessed at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2019/docs/sept_redline2cms.pdf
- ²⁹ Ibid.
- ³⁰ Center for Medicare and Medicaid Services, *State Innovation Models (SIM) Round 2; Model Test Annual Report Three*, RTI International (2019).
- ³¹ Robert Wood Johnson Foundation, *State Medicaid Approaches for Defining and Tracking Managed Care Organizations Implementation of Alternative Payment Models* (State Health Value and Strategies, Princeton, NJ, February 2018). <http://www.bailit-health.com/publications/2018-0206-SHVS-APM-Tracking-Brief.pdf>
- ³² Center for Medicare and Medicaid Services, *State Innovation Models (SIM) Round 2; Model Test Annual Report Three*, RTI International (2019)
- ³³ The mandatory and optional EQRO activities are described in §42 CFR 438.358, Activities related to external quality review. <https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#sp42.4.438.e>
- ³⁴ State of South Carolina, Department of Health and Human Services, External Quality Review Request for Information RFI 2018-01. <https://www.scdhhs.gov/internet/pdf/EQRO-RFI.pdf>
- ³⁵ Center for Health Care Strategies, *The History, Evolution, and Future of Medicaid Accountable Care Organizations* (February 2018) https://www.chcs.org/media/ACO-Policy-Paper_022718.pdf
- ³⁶ Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models, 2019 Methodology and Results Report*. October 2019.
- ³⁷ Ibid.
- ³⁸ New York also requested to renew its DSRIP Section 1115 demonstration, expanding the focus of delivery system reform efforts to include more non-hospital providers, but this demonstration request was denied by CMS in February 2020. Centers for Medicare and Medicaid Services, Letter from Calder Lynch to Donna Frescatore, February 21, 2020, <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/medicaid-redesign-team/ny-medicare-rdsgn-team-cms-ltr-state-20200221.pdf>.

Appendix A: State Profiles

State Profile: Minnesota

Minnesota was an early adopter of value-based payment models. In 2010, the Minnesota State Legislature authorized the Integrated Health Partnership (IHP) Demonstration. The state used a State Innovation Model (SIM) award to implement the initiative. The Minnesota Department of Human Services (DHS) administers the state’s Medicaid program and selects and oversees the IHPs, which are provider systems that come together similar to an accountable care organization. MCOs must contract with the state-selected IHPs and make payments based on state calculations of shared-savings or risk, similar to the Medicare Shared Savings Program.

State Profile: Minnesota	
Medicaid Managed Care Background	
Managed care penetration	In July 2017, 76.4 percent of Minnesota’s 1.1 million Medicaid beneficiaries were enrolled in comprehensive managed care. ¹
Managed care market	Minnesota uses a competitive procurement process to select Medicaid managed care plans. The state contracts with seven local, not for profit MCOs on a regional basis. One plan is almost statewide. These MCOs are responsible for providing almost all medical services, including behavioral health.
Value Based Contract Mechanism	
VBP Targets	No.
State Directed Payment Model	<p>Minnesota requires its MCOs to make state-calculated shared savings payments to integrated health partnerships (IHPs) that meet state-defined quality and performance targets. Under the IHP initiative, the State contracts directly with health care provider organizations and partnerships. The providers within each IHP work together to achieve a demonstrable level of savings when compared to targets developed by the State. Providers that demonstrate savings across their population and maintain or improve quality of care beyond a specified benchmark receive a portion of the savings. The State may require providers that cost more over time to pay back a portion.</p> <p>MCOs do not play a role in the administration of the IHP program. MCOs are required to pass through quarterly payments to the IHPs based on the State’s calculation of whether each IHP has met its quality and cost targets. Specifically, the State provides the MCO with a list of its enrollees that are attributed to each IHP, information on the total cost of care, and interim and final payments. MCOs must make payments to the IHP within 30 days of notice from the state.</p> <p>Minnesota began its IHP program in 2013, and has added participants each year since then. As of March 2018, there are 24 IHPs that have been selected by the state, covering over 460,000 beneficiaries in both the managed care and FFS systems (approximately 40% of total members).</p>

¹ Includes comprehensive managed care and Programs of All-Inclusive Care for the Elderly.

State Profile: Minnesota	
	<p>In 2018, DHS launched an “IHP 2.0” model, which introduced multiple tracks to accommodate diverse provider systems, and which added a quarterly population-based payment made through the MCOs to support care coordination and infrastructure needs. The IHP 2.0 model eliminated gain sharing for smaller, less integrated IHPs, and also provided greater incentives for IHPs to partner with community-based organizations. A portion of payment is contingent on an IHP’s scores on quality measures. The core set of measures is used for calculation of the overall quality score, which affects 50 percent of an IHP’s potential shared savings. DHS may require providers who cost more over time to pay back a portion of losses.</p> <p>MCOs are required to contract with Certified Health Homes and to pay them a care coordination fee where an enrollee is not attributed to an IHP or other comprehensive arrangement model.</p>
Enforcement Mechanisms	
Financial Incentive - VBP Adoption	The MCO contract includes language that penalizes the MCO if it fails to make timely payments to the IHPs as directed by the state, and includes potential for financial remedies, including withholding capitation and suspension of new enrollment.
Financial Incentive - Quality Improvement	<p>The MCO contract includes a withhold of 8 percent of MCO capitation, however, only 0.5% percent of the capitation is at risk due to loss limits within the contract. Plans can earn back the withhold funds for meeting quality and performance targets. 62.5 percent of the withheld funds can be earned if plans meet quality targets.</p> <p>The MCO quality incentive is not focused on the same measures as required of IHPs. For the MCOs, the state is currently focusing its quality improvement efforts on its dental program (95 percent of the incentive). There is minimal incentive funding focused on reducing ED utilization, achieving 5 percent annual reduction in hospital admissions, and 5 percent annual reduction in its 30-day hospital readmission percentage.</p>
Non-Financial Incentives	The MCO contract does not include any non-financial incentives related to timely payment to the IHPs.
Liquidated Damages	The MCO contract does not contain specified liquidated damages related to payment to the IHPs.
State Monitoring and Evaluation	
VBP Reporting & Transparency Requirements	<p>Minnesota has had a statewide quality reporting system for over a decade where providers report on a standard set of quality measure, regardless of payer, through the Statewide Quality Reporting and Measurement System.</p> <p>MCOs must submit annual summaries of how their quality improvement program has improved service and quality for enrollees. Reports must describe what each MCO considers significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. Reports are posted on the</p>

State Profile: Minnesota	
	DHS website. These quality improvements are not directly linked to the IHP initiative. Quality measurement for the IHPs are reported directly by the IHPs to the state, and shared with the MCOs only as part of the calculation for any shared shavings/shared risks that MCOs are required to pass on to the IHPs. MCOs are not specifically charged with overseeing the quality performance of the IHPs or providing specific support towards improvement.
Oversight Meetings with MCOs	The state does not have oversight meetings with the MCOs related to the IHPs. However, the state does conduct site visits with IHPs that are educational in nature rather than compliance based.
Evaluations	There are two evaluations of the Minnesota IHP model. The Minnesota House Research conducted an analysis of the IHP demonstration in December 2018. Previously, in September 2017, the State Health Access Data Assistance Center (SHADAC) published the Evaluation of the Minnesota Accountable Health Model: Final Report, which is an evaluation of the SIM.
Quantifiable Results Related to VBP and Delivery System Reform Efforts	
VBP Adoption	The state does not measure VBP adoption by its MCOs. MCOs may enter into VBP arrangements with their providers outside of the IHP initiative, but are not required to do so.
Delivery System Reform Results	DHS estimates that total savings from the IHP program for the five-year period from 2013 to 2017 was about \$277 million, with about \$92 million of this amount returned to IHPs as shared savings.
Quality Results	According to the state, quality performance among IHPs has been steady or improving based on most recent data (CY17.) Generally, the state has found that strong IHPs have gotten slightly better. Those that have been weaker performers have improved. DHS estimates that it has seen a 7 percent decrease in ED visits, and 14 percent decrease in hospital stays between 2013 and 2017 as a result of the IHP program. The state has found that patient experience has been most challenging to measure.
Other Medicaid Delivery System Reform Efforts	
DSRIP	No.
PCMH	Yes - Minnesota uses the term certified health care homes, and as noted above requires MCOs to pay a care coordination fee for providing primary care to a beneficiary that is not attributed to an IHP.
Multi-Payer Delivery System Reform Efforts	
SIM	Yes. In 2013, the State was awarded \$45 million to advance the Minnesota Accountable Health Model, of which IHP is a component.
Multi-Payer Initiative	Yes, the Minnesota Health Care Homes Initiative.

Minnesota State Profile Resources

Mathew Spaan, "Addressing Social Determinants of Health through Medicaid ACOs," Center for Health Care Strategies (CHCS), February 2018 webinar slide set. CHCS: Princeton, NJ.

<https://www.chcs.org/media/CHCS-Slides-for-February-2018-National-ACO-SDOH-Webinar.pdf>

Medicaid and CHIP Payment and Access Commission (MACPAC). *MACStats: Medicaid and CHIP Databook*. December 2019. MACPAC: Washington, DC. <https://www.macpac.gov/macstats/>.

Minnesota Department of Human Services, "Contract for Prepaid Medical Assistance and MinnesotaCare," January 1, 2019. <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp>

Minnesota Department of Human Services, "Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration," June 11, 2018.

https://mn.gov/dhs/assets/2019-ihp-rfp_tcm1053-294430.pdf

Minnesota Department of Human Services, *Comprehensive Quality Strategy*, 2018.

<https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/MN%20Comprehensive%20Quality%20Strategy%202018.pdf>

Minnesota House Research, "Integrated Health Partnerships Demonstration," December 2018.

<https://www.house.leg.state.mn.us/hrd/pubs/ihpdemo.pdf>

State Health Access Data Assistance Center (SHADAC), "Evaluation of the Minnesota Accountable Health Model: Final Report - Executive Summary," September 2017. SHADAC: Minneapolis, MN.

<https://www.shadac.org/our-focus-areas/mn-sim-evaluation>

State Profile: New Mexico

New Mexico’s delivery system and payment reform strategy includes a specific framework for MCOs but plans have some flexibility to innovate within the framework. The State’s approach includes financial penalties or re-investment requirements for Medicaid MCOs that fail to meet specific delivery system improvement targets. The MCO capitation at risk is set at 1.5 percent for attaining specific delivery system improvement targets, including VBP targets.

The State’s VBP approach includes requiring MCOs to move away from traditional fee-for-service payments for a variety of provider types (including hospital, behavioral health and LTSS providers) to meet or exceed a tiered and increasing set of VBP targets and requirements.

State Profile: New Mexico	
Medicaid Managed Care Background	
Managed care penetration	<p>In July 2017, 77.4 percent of New Mexico’s 899,000 Medicaid beneficiaries were enrolled in comprehensive managed care.</p> <p>In 2014, New Mexico consolidated multiple Medicaid waiver populations into a comprehensive 1115 waiver (Centennial Care) that provides the full array of covered physical, behavioral, long-term care, and home and community-based services.</p>
Managed care market	<p>The state currently contracts with three statewide, full-risk MCOs. In 2019, the state completed a new competitive managed care procurement, adding one new MCO and discontinuing contracts with two prior MCOs. These MCOs are responsible for providing almost all medical services, including behavioral health and LTSS.</p>
Value Based Contract Mechanism	
VBP Targets	<p>For 2017, New Mexico added VBP targets to their Medicaid MCO delivery system improvement requirements. The VBP targets will double from 16 percent in 2017 to 36 percent by 2022.</p> <p>Annually, MCOs must meet minimum targets for the percentage of provider payments as a component of a VBP payment arrangement in each of three levels:</p> <ul style="list-style-type: none"> • Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets. MCO must include a mix of physical health, behavioral health, long term care and nursing facility providers. • Level 2: Fee schedule based with upside-only shared savings -- available when outcome/quality scores meet agreed-upon targets (may include downside risk). MCO must include two or more bundled payments for episodes of care. • Level 3: Fee schedule based or capitation with risk sharing (at least 5 percent for upside and downside risk); and/or global or capitated

State Profile: New Mexico

payments with full risk. Arrangements with full risk for covered services shall include full delegation of care coordination.

The state established targets within the overall VBP target to encourage MCOs to increase the percentage of provider payments in VBP Level 2 and Level 3 arrangements. The tables below outline the minimum percentage of provider claims that must be associated with a VBP payment arrangement for each contract year in order for an MCO not to be subject to a financial penalty.

CY 2017	CY 2018	CY 2019
Level 1: 5%	Level 1: 7%	Level 1: 8%
Level 2: 8%	Level 2: 10%	Level 2: 11%
Level 3: 3%	Level 3: 3%	Level 3: 5%
Total: 16%	Total: 20%	Total: 24%

CY 2020	CY 2021	CY 2022
Level 1: 10%	Level 1: 11%	Level 1: 12%
Level 2: 13%	Level 2: 14%	Level 2: 15%
Level 3: 7%	Level 3: 8%	Level 3: 9%
Total: 30%	Total: 33%	Total: 36%

For all types of VBP arrangements, MCO must establish a process for providers to have access to data that provides information about members' utilization of services including total cost of care on a quarterly basis. Beginning in 2019, at least 5 percent of overall MCO percentages in Levels 2 and/or Level 3 VBP contracting must be with high volume hospitals and require avoidable readmission reduction targets of at least 5 percent of the hospital's CY 2017 or MY 2016 baseline.

State Directed Payment Model

No.

Other

Since 2013, the state's MCO contracts have included delivery system improvement objectives. While the delivery system improvement components have changed over time, the MCO capitation at risk has been set at 1.5 percent. The 2019 delivery system improvement targets relate to MCO use of VBP, community health workers, telemedicine, Hepatitis C treatments, and PCMH. Every year, the state has required MCOs to hit certain PCMH targets, but other requirements have changed over time.

Most years, each delivery system improvement category is worth 20 out of the possible 100 points. The state defines targets differently for legacy MCOs compared to the newly entered MCO, Centene. For example, beginning in 2019, legacy MCOs that contracted under Centennial Care 1.0, must demonstrate a minimum of a 5 percent increase in members assigned to a PCP who is a PCMH. If an MCO achieves a rate of 50 percent of membership being served by PCMHs, then the

State Profile: New Mexico

MCO must maintain this percentage. The new MCO is required to have a minimum of 10 percent of total members assigned to a PCP who is a PCMH by the end of the calendar year.

Similarly, legacy MCOs must demonstrate a specific increase in the use of Community Health Workers and in the use of telemedicine for specialty care provided in rural and frontier areas. In addition, to earn full points for the Hepatitis C provisions, an MCO must treat at least 90 percent of the MCO's target number of patients receiving Hepatitis C drug treatments during the contract year. The state provides the MCO with the applicable Hepatitis C target.

Initially, the 2013 MCO contract required plans to participate in a collaborative approach with other MCOs and certain provider associations to develop payment reform projects related to the ambulatory treatment of adult diabetes and pediatric asthma as well as bundled payments for members with pneumonia and congestive heart failure. In 2015, the state replaced the collaborative requirements with a requirement that MCOs develop at least one payment reform project subject to state approval. As part of its 2019 contract, the state will develop a prospective bundled ambulatory rate to be paid by the MCOs to lead practices involved in pilot programs for children with asthma and adults with diabetes. MCOs will be allowed to withhold a portion of the total ambulatory rate to assess practice performance on specific outcomes including reductions in ER visits and hospital re-admissions.

Enforcement Mechanisms

Financial Incentive - VBP Adoption

The MCO delivery system performance improvement program places 1.5 percent of capitation at risk and scores plans under a 100-point system. To avoid financial penalty, the MCO must meet all the requirements and earn 100 points. The VBP requirements account for 20 points in all years except in 2018 when meeting the VBP targets was worth 30 out of 100 points. MCOs must meet minimum targets for the three levels of VBP arrangements. Failure to meet these targets results in deduction of points available. An MCO will have 10 points deducted for each level of VBP target not achieved and 2 point deducted for each additional VBP requirement it fails to meet.

Financial Incentive - Quality Improvement

The MCO quality performance improvement program places 2.0 percent of capitation at risk. To avoid financial penalty, the MCO must meet all State defined performance targets for selected HEDIS measures. This 2.0 percent of capitation at risk is separate and distinct from the 1.5 percent capitation at risk based on MCO performance on delivery system improvement targets.

Non-Financial Incentives

None identified.

Liquidated Damages and Other Penalties

The state may impose MCO performance penalties of up to 1.5 percent of capitation payments if an MCO does not meet the delivery system improvement performance targets. The MCO is allowed to retain the percentage of funds equal to the

State Profile: New Mexico	
	percentage of points earned in a given year. An MCO that would otherwise have delivery system performance incentive funds recouped by the state may submit a proposal for state review and approval to retain the funds in question. The proposal must demonstrate how the MCO will invest the funds in “system improvement activities for provider network development and enhanced activities that benefit members.” The state may assess a comparable penalty approach up to 2.0 percent of the capitation if an MCO does not meet all the quality performance metrics for a given year.
State Monitoring and Evaluation	
VBP Reporting & Transparency Requirements	<p>MCOs must develop an annual strategy that describes its work plan for reaching targets in each VBP component area during contract period. In addition, MCOs must submit quarterly and annual VBP reports on templates provided by the state and include a summary of all VBP activities and achievements.</p> <p>MCOs also have reporting requirements related to HEDIS metrics and quality withhold measures.</p>
Required Meetings with MCOs	There are some regular ongoing meetings, particularly related to new and more collaborative VBP initiatives, such as engaging nursing facilities.
Evaluations	Annual determinations as to whether each MCO has met the delivery system improvement requirements (including the VBP targets) and quality improvement requirements sufficient to avoid a penalty or re-investment requirement. There is a 2017 Centennial Care 1115 waiver evaluation report.
Quantifiable Results Related to VBP and Delivery System Reform Efforts	
VBP Adoption	The state has assessed MCO performance to the VBP targets and has generally determined their performance to meet or exceed the VBP contractual requirements. The state noted that some MCOs have challenges with the Tier III VBP requirements. It is too early for the MCOs or the state to assess whether the VBP models are resulting in improved quality and/or total cost of care reductions.
Delivery System Reform Results	<p>The state annually assesses MCO performance to all delivery system improvement targets and has generally determined their performance to meet or exceed the contractual requirements. The state has typically not needed to assess financial penalties on MCOs. One year, an MCO missed a target related to telehealth and instead of paying the penalty, the MCO invested funds equivalent to the penalty in telehealth infrastructure support for behavioral health providers.</p> <p>A 2017 Centennial Care 1115 waiver evaluation found that the state experienced improvements in the use of mental health services, desirable decreases in hospital readmission rates, and positive increases in the use of substance abuse services – among other positive changes. However, the waiver evaluation did not assess the extent to which these changes were attributable to delivery system improvement requirements in managed care or other aspects of the waiver.</p>

State Profile: New Mexico	
Quality Results	<p>New Mexico indicated that few penalties have had to be assessed related to MCOs missing quality targets. The State has discussed but not been able to determine how best to examine quality results separately for providers engaged in VBP.</p> <p>The October 2017 demonstration waiver evaluation found continued improvements in quality of care, including:</p> <ul style="list-style-type: none"> • improvements in the EPSDT screening ratios; • increases in BMI monitoring rates for adults, children and adolescents; • increases in asthma medication management; • Decreases in hospital admission rates across all five ambulatory care sensitive (ACS) measures, and • a decline in the percentage of ER visits that were potentially avoidable. <p>New Mexico's Quality Strategy presents aggregate annual HEDIS results reported by the four contracted MCOs under Centennial Care 1.0.</p>
Other Medicaid Delivery System Reform Efforts	
DSRIP	Yes, New Mexico used Section 1115 waiver funding to implement the Hospital Quality Incentive Improvement Program, a DSRIP-like program with \$29 million combined federal and state funding over 2015-2018. The HQII program has been extended until FY 2021, at which time the state is required to develop a plan to phase out HQII and transition to an alternative payment mechanism.
PCMH	Yes, as noted above within their Medicaid MCO contractual requirements and below within SIM efforts.
Multi-Payer Delivery System Reform Efforts	
SIM	Yes. In 2016, New Mexico received almost \$2 million in funding from CMS during the second round of the State Innovation Model (SIM) Design awards. Design work involved stakeholder convenings and a strategy for multi-payer definition and recognition of PCMHs.
Multi-Payer Initiative	No.

New Mexico State Profile Resources

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State Profile: New York

New York actively embraced payment and delivery system reforms leveraging opportunities through SIM and DSRIP to provide infrastructure support across the system to the state, MCOs and providers. New York developed and annually updates its *Path to Value Based Payment*, which provides a roadmap for the state’s goals towards payment and delivery system reform. The state set a goal of achieving 80 percent of payments in VBP by March 2020 and during our interviews in the Fall of 2019, the state believed it would achieve this goal. The state allows MCOs flexibility in meeting this requirement through a set of pre-approved payment and delivery system reform strategies, or ability to request approval for additional strategies.

State Profile: New York	
Medicaid Managed Care Background	
Managed care penetration	In July 2017, 74.1 of New York’s 6.1 million Medicaid beneficiaries were enrolled in comprehensive managed care. ²
Managed care market	<p>New York contracts with Medicaid MCOs for its acute care populations using a non-competitive application process. These MCOs are responsible for providing almost all medical services, including behavioral health.</p> <p>Given its size and Medicaid membership, New York has a variety of plans including those that operate nationally or regionally, and New York-specific provider plans. New York contracts with 17 managed care organizations (MCOs) for its mainstream plans, which cover the beneficiaries under 65 without long term care needs.</p>
Value Based Contract Mechanisms	
VBP Targets	<p>MCOs must meet targets for the percentage of payments made under VBP arrangements. The state has developed its own categorization that is similar to the Health Care Payment Learning & Action Network (HCP-LAN).³</p> <p>The target amount increases by year:</p> <ul style="list-style-type: none"> • 10 percent by April 2018 (in Level 1 VBP or above); • 50 percent by April 2019 (in Level 1 or above; with 15 percent or above in Level 2 or higher and 5% of partially capitated expenditure in Level 2 or higher); and

² For this study, we reviewed the 2019 – 2024 contract for the state’s mainstream managed care program New York also operates other managed care programs that were not part of this study, such as a managed long-term services and supports program and a managed care plan for individuals dually eligible for Medicare and Medicaid. The VBP targets identified in this profile also apply to these programs.

³ NY uses its own categorization for VBP: Level 0: (FFS with bonus and/or withhold based on quality scores; LAN Category 2); Level 1: (FFS with upside-only shared savings for a total cost of care or episode/bundle; LAN Category 3a); Level 2: (FFS with upside and downside risk sharing; LAN Category 3b); Level 3: (prospective payment with quality component – including global capitation, primary care capitation, and bundled payment; LAN Category 4).

State Profile: New York	
	<ul style="list-style-type: none"> 80 percent by April 2020 (in Level 1 or above, with 35 percent or above in Level 2 or higher and 15% of partially capitated expenditure in Level 2 or higher). <p>There is no credit for payment methods within Level 0 (except for screening and preventions activities). These requirements are aligned with NY's DSRIP requirements to move MCOs to APMs.</p> <p>MCOs may enter into "on menu" or "off menu" VBP arrangements to meet the annual target. "On menu" VBP options are described in the state's annual VBP roadmap, "A Path toward Value Based Payment" and include:</p> <ul style="list-style-type: none"> Total care for general population (e.g., sub-capitation agreement); Selected care bundles such as maternity bundle or Integrated Primary Care; and, or, Total care for special needs subpopulations (e.g., behavioral health, HIV/AIDS). <p>If the MCO has a Level 2 or 3 VBP arrangement, it is required to include a social determinant of health (SDOH) intervention. If the MCO would like to utilize an "off menu" option, it must receive approval from the State, though there is little to no "off menu" activity to date.</p> <p>As of October 1, 2019, off menu VBP contracts submitted to DOH for review must include specific quality measures related to the VBP identified by the state. All VBP contracts must meet the quality requirement by January 2021.</p>
State Directed Payment Model	MCOs are required to make enhanced payments to Patient Centered Medical Homes (PCMHs) which meet New York's medical home standards.
Enforcement Mechanisms	
Financial Incentive - VBP adoption	While there have been no penalties assessed against MCOs to date, they may be penalized if they do not meet the required VBP levels. The penalty is at least 2 percent of the marginal difference between value that was required to be in VBP and actual expenditure through VBP. If MCOs cannot meet goals because providers refuse to participate, the MCO can pass on penalty to providers if it could be reasonably expected to make transition.
Financial Incentive- Quality improvement	MCOs receive positive performance adjustments based on meeting performance requirements related to total cost of care, integrated primary care and maternity care. The premium may be adjusted up to 3 percent based on quality performance. MCOs also receive positive performance adjustments if they enter into higher level VBP arrangements.
Non-Financial Incentives	No

State Profile: New York	
Liquidated Damages	No
State Monitoring and Evaluation	
VBP Reporting & Transparency Requirements	The state has developed VBP reporting requirements and quality specifications. All MCOs with VBP arrangements are required to report.
Evaluations	The state has contracted with an independent evaluator under its 1115 Waiver but there is no complete report to date.
Quantifiable Results Related to VBP and Delivery System Reform Efforts	
VBP Adoption	<p>Between 2014 and 2018 the percentage of payments in VBP level 1 or higher increased from 25.5 percent to approximately 60 percent. In December 2018, 35 percent of payments were in in Level 1; 24.72 percent in Level 2; and 2.76 percent in Level 3. NY DoH conducted a baseline survey of MCOs related to CY 2014 for measuring statewide progress towards both the overall 80-90 percent VBP Goal and the 35 percent VBP Target for Levels 2 and 3. VBP Baseline of Levels 1 -3 for CY 2014: 25.5 percent.</p> <p>According to the 2019 Roadmap, in 2018, state survey results showed that approximately 62 percent of the respondents' total Medicaid Managed Care payments were in VBP Levels 1-3 and approximately 40 percent in level 2 or higher. The state met the April 1, 2019 VBP Roadmap milestone, which required NYS to transition at least 50% of MCO expenditure into Level 1 VBP arrangements or above, and at least 15 percent of expenditure in Level 2 or higher (for full capitation plans only), by April 1, 2019.</p>
Delivery System Reform Results	There has been significant activity on the part of the Performing Provider Systems (PPSs) in implementing specific projects aimed at supporting delivery system reform in order to earn DSRIP funds. While PPSs have earned most available funding based on progress towards project specific milestones, they have not been as successful in receiving funding that is tied to outcomes and meeting annual improvement targets.
Quality Results	The state has seen reductions in preventable hospital readmissions (18% reduction from baseline). There have been slight reductions in preventable ED visits.
Other Medicaid Delivery System Reform Efforts	
DSRIP	Yes. New York's DSRIP waiver was approved in 2014, and provides \$6.9 billion in federal funds over six years to performing provider systems implementing delivery system reform improvement projects. The Section 1115 waiver authorizing the DSRIP program requires the state to develop a VBP roadmap and reduces DSRIP funding if the state does not meet its goals for increasing the use of VBP in managed care. In the Fall 2019, New York requested an extension to continue its DSRIP waiver, which CMS denied in February 2020.
PCMH	Yes - MCO contract provision

State Profile: New York	
Multi-Payer Delivery System Reform Efforts	
SIM	Yes. New York received two rounds of SIM grants. The first was a Model Pre-Testing Assistance Award to help the state develop its health care transformation strategy. The second was a Round Two Model Test award in the amount of \$99.9 million to support implementation.
Multi-Payer Initiative	There is not a statewide multi-payer initiative, however, MCOs must provide an enhanced rate to providers that participate in the Adirondack Health Care Home Multi-payer Demonstration Program, which operates in the upper northeast region of the state.

New York State Profile Resources

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State Profile: Ohio

Ohio’s delivery system reform approach includes a multi-payer approach focused on Episodes of Care (Episodes) and a statewide, patient centered medical home (PCMH) approach referred to as Comprehensive Primary Care (CPC). Ohio also requires MCOs to develop and implement strategies to make 50 percent of aggregate net payments to providers value-oriented by 2020.

State Profile: Ohio	
Medicaid Managed Care Background	
Managed care penetration	In July 2017, 82.7 percent of Ohio’s 3.1 million Medicaid beneficiaries were enrolled in comprehensive managed care.
Managed care market	<p>Ohio uses a competitive, statewide procurement process to select Medicaid managed care plans and limits the number of awardees. There are five MCOs statewide; three are for-profit and two are non-profit. Care Source, a not-for-profit plan, dominates the Medicaid market with over 50 percent of the managed care enrollment.</p> <p>MCOs are responsible for providing almost all medical services, including behavioral health which was carved into managed care in 2018.</p>
Value Based Contract Mechanism	
VBP Targets	<p>In 2013, the state required Medicaid MCOs to make 50 percent of aggregate net payments to providers value-oriented by 2020 defined as:</p> <ul style="list-style-type: none"> • Paying providers differentially according to performance; • Designing approaches to payment that reduce waste while not diminishing quality, including reducing unwarranted payment variation; • Designing payments to encourage adherence to clinical guidelines (at a minimum, including policies to discourage elective deliveries before 39 weeks); and • Developing payment strategies to reduce unwarranted price variation, such as reference or value pricing.
State Directed Payment Model	<p>Ohio requires MCOs to implement episode-based payments and the CPC program in accordance with state rules and regulations. The state also requires that all Medicaid providers participate in the episodes program. The CPC program is voluntary for providers.</p> <p>Ohio developed 43 different types of Medicaid episodes, of which 18 are linked to payment. Episodes were selected and prioritized for implementation based on criteria that included size, relevance to Medicaid and other populations.</p> <p>For 2019 and 2020, the state eliminated 13 episodes based in part on input from clinicians and health systems regarding episodes that were seen as less relevant to population health and existing standards of excellence in care.</p>

State Profile: Ohio

Ohio uses a retrospective payment model where the MCO pays providers for services as they occur. For a given episode, Ohio defines a principal accountable provider (PAP), the entity accountable for the quality and cost of care delivered to a patient for the entire episode. At the end of the performance period, the MCO calculates the PAPs incentive payment (or required recoupment) based on the quality and cost of the episode. Only providers performing well above or well below the cost targets are subject to recoupments or eligible for incentive payments.

Ohio launched its CPC program in Medicaid in 2017 to provide financial incentives for primary care practices to provide more coordinated care to patients statewide. The state now specifies eight PCMH-related activity requirements, 20 quality metrics and five efficiency metrics for CPC practices.

As part of the Ohio CPC program, MCOs are required to pay participating CPCs the agreed upon PMPM payment for attributed members and any shared savings for meeting model requirements in accordance with state. MCOs must have the administrative capacity to offer feedback to individual providers on adherence to practice guidelines and variances from clinical pathways that may impact outcomes or costs. To receive CPC payments, CPC practices must meet all activity requirements, 50 percent of applicable quality metrics, and 50 percent of applicable efficiency metrics.

In 2020, the state will launch CPC for Kids to improve pediatric wellness.

In addition, MCOs must pay Qualified Behavioral Health Entities incentive payments for meeting quality, efficiency, or total cost of care metrics in accordance with state requirements.

In 2018, the state implemented the Care Innovation and Community Improvement Program (CICIP). Under CICIP, four large Medicaid safety-net and academic medical centers are eligible for bonuses paid through MCOs in alignment with state requirements. CICIP goals include improving opioid use disorder and maternity measures with a focus on timeliness of prenatal care; live births weighing less than 2,500 grams; and postpartum care.

Enforcement Mechanisms

Financial Incentive - VBP Adoption

There is no specific financial incentive or disincentive for MCOs to meet the 50 percent VBP target.

Financial Incentive - Quality Improvement

In 2018, the state established a quality withhold of 2.0 percent of MCO capitation linked to MCO performance. This withhold approach replaced a prior MCO pay for performance incentive program. MCO quality withhold measures are primarily based on Healthcare Effectiveness Data and Information Set (HEDIS) metric benchmarks aligned with core measures from a collaborative effort with CMS and the America’s Health Insurance Plans.

State Profile: Ohio	
	<p>For SFY 2019 and SFY 2020, MCO performance will be assessed on four quality indices: 1) cardiovascular disease; 2) diabetes; 3) behavioral health; and 4) healthy children. The state will award each MCO a percentage of the potential payout allotted to each quality index based on the percentage of quality benchmarks obtained by the MCP.</p> <p>Ohio allows for unreturned quality withhold dollars to be put into a bonus pool. To qualify for a share of the bonus pool, MCOs must achieve:</p> <ul style="list-style-type: none"> • An average index score of 75 points or greater across all indices; and • At least 90 percent of CPC practices with MCO members must pass at least 50 percent of applicable quality metrics and at least 50 percent of applicable efficiency metrics. <p>Some measures designated for use in the quality withhold include a minimum performance standard. An MCO's failure to meet a standard will result in the assessment of a noncompliance penalty as described in liquidated damages below. If the MCO is noncompliant with more than 50 percent of the quality standards for two consecutive contract years, the state reserves option to terminate contract.</p>
Non-Financial Incentives	Non-financial strategies used by Ohio include performance-based auto-assignment.
Liquidated Damages and Other Penalties	The state may assess MCOs with financial sanctions due to accumulated points for compliance violations over a rolling 12-month schedule. No points are assigned for a violation if the MCO is able to document that the precipitating circumstances were not foreseeable.
State Monitoring and Evaluation	
VBP Reporting & Transparency Requirements	<p>MCOs are required to participate in state initiatives to design and implement member accessible comparisons of provider information including quality, cost, and patient experience among providers. MCOs must contribute to the program design, provide data as specified by the state and publish results in accordance with state standards.</p> <p>MCOs must now submit a quarterly progress report that addresses progress towards meeting their VBP obligations, including the MCO's strategy to make 50 percent of aggregate net payments to providers value-oriented by 2020. The MCO VBP's report must include:</p> <ul style="list-style-type: none"> • A description of the value-based purchasing strategies; • Type of provider(s); • Objective of each VBP strategy and progress in meeting each objective; • Type of value-based arrangement (e.g. upside risk or downside risk); • Sum of total gross payments, Sum of total net payments; and • Unique count of members. <p>MCOs also have reporting requirements related to HEDIS metrics and quality withhold measures.</p>

State Profile: Ohio	
	<p>Quarterly CPC practice reports include member level data indicating quality performance and cost of care. CPC Referral Reports share episode provider performance information with CPC participants to inform referral patterns and promote cross-program integration. CPC Practices receive an annual CPC practice report, which includes data on quality, efficiency and total cost of care measures for the full program year, including practice eligibility for shared savings payments.</p>
Required Meetings with MCOs	<p>Ohio engages in significant stakeholder engagement, including with Medicaid and other health plans. Interviewees described robust and ongoing meeting/governance structure supporting the state's episodes and CPC initiatives.</p>
Evaluations	<p>Evaluation of the state's delivery system reform efforts include:</p> <ul style="list-style-type: none"> • State Innovation Model (SIM) Round 2, Model Test Annual Report Three developed for CMS by RTI International. The Year 3 Annual Report analyzes data collected between May 1, 2017, and March 30, 2018, and • Ohio's SIM Grant Final Report in June 2019
Quantifiable Results Related to VBP and Delivery System Reform Efforts	
VBP Adoption	<p>Outside of its assessment of episodes and CPC, and its review of MCO performance on quality metrics included in the withhold, the state has not separately assessed the impact of MCO VBP adoption.</p>
Delivery System Reform Results	<p>By 2017, Ohio's combined SIM programs covered about 65 percent of Ohio Medicaid members, 35 percent of Medicaid spend, and 35 percent of clinical providers.</p> <p>RTI's SIM Round 2, Model Test Annual Report Three includes the following Ohio payment reform and delivery transformation results for 2017-2018 timeframe:</p> <ul style="list-style-type: none"> • Increased Episodes reporting to 43 episodes in Medicaid; • Issued financial incentives for 3 Episodes; • Increased CPC provider enrollment from 111 to 161 practices. <p>The state's Final SIM Report shows positive results from both the implementation of the CPC program, (\$78.1M in net savings in 2017) as well as episodes (no impact on quality but decreased spending trend for savings that range between \$ 31.8M-\$ 92.2M).</p> <p>Early results for the CPC program suggest a positive impact on both quality and cost. In the 2017 program year, 95 percent of CPC practices met all program requirements for activity, quality and efficiency - performing eight activity requirements as well as passing at least 50% of applicable clinical quality metrics and at least 50 percent of program efficiency metrics. All CPC practices met program quality requirements in 2017, contributing to an increase of 2.2 percent in overall annualized quality performance for CPC practices from 2015 to 2017. Of the 34 practices meeting size requirements for shared savings eligibility, five received a combined total of \$11.2M in shared savings payments. CPC had a negative 1.9</p>

State Profile: Ohio	
	<p>percent cost trend compared with the non-CPC control group for risk-adjusted total cost of care per member per month. Ohio has strong payer and provider participation in the CMS-led Comprehensive Primary Care Plus (CPC+).</p> <p>In the Episodes program, average performance rates across all episode quality metrics held largely steady for the first two years of the program. Over the same two-year period, average costs per episode decreased for the nine episodes linked to payment. In 2017, PAPs received \$4.0M in positive incentive payments across the nine episodes, incurred \$4.2M in negative incentive payments and 74percent of unique episode PAPs met quality requirements. While acute COPD and asthma episodes of care costs dropped markedly, perinatal costs increased 3 percent, potentially reflective of the complexity of certain types of episodes. The Ohio Episodes have been designated as an Advanced Alternative Payment Model through Medicare’s Quality Payment Program.</p>
Quality Results	<p>In addition to the quality results mentioned in the delivery system reform section above, Ohio reports that in 2017 and 2018, results for all MCO P4P measures met the state goal of at least exceeding the 25th national Medicaid percentile, increasing from 57 percent of all P4P measures above the 25th percentile in 2015. MCO performance on reported HEDIS measures not included in the P4P arrangement also increased during this time from 35 to 85 percent of measures at or above the 25th percentile. The state’s P4P target was set at the 10th NCQA national Medicaid percentile in 2013.</p>
Other Medicaid Delivery System Reform Efforts	
DSRIP	No.
PCMH	CPC, described above, is a multi-payer PCMH program in Ohio.
Multi-Payer Delivery System Reform Efforts	
SIM	Yes. In 2014, Ohio received a \$75 million SIM Test award from CMS to develop a multi-payer approach focused on developing Episodes and CPC. By 2017, the combined SIM programs covered about 65 percent of Ohio Medicaid members, 35 percent of Medicaid spend, and 35 percent of clinical providers.
Multi-Payer Initiative	Yes. The goal of Ohio’s SIM project was to create a roadmap for expanding the capacity and availability of qualified medical homes to most Ohioans, and to define and administer episode-based payments for acute medical events across Medicaid/CHIP, Medicare, and commercially insured patients.

Ohio State Profile Resources

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State Profile: South Carolina

South Carolina’s delivery system reform and VBP strategy includes: 1) requiring MCOs to meet or exceed a certain, annual VBP target for provider contracting, 2) financial incentives for MCOs to meet both the VBP target and quality performance targets as part of a capitation withhold program, and 3) requiring MCOs to make state-defined incentive payments for patient-centered medical homes (PCMHs) that meet certain certification standards deemed credible by the State.

The State’s Medicaid VBP and delivery system initiatives are designed: 1) to consider both payment reform and quality improvement and 2) to coordinate with other purchasers’ VBP strategies, including financial and certification requirements of the statewide PCMH Alliance.⁴

State Profile: South Carolina	
Medicaid Managed Care Background	
Managed care penetration	As of July 2017, 63.5 percent of South Carolina’s 1.2 million Medicaid beneficiaries were enrolled in comprehensive managed care.
Managed care market	<p>South Carolina contracts with Medicaid MCOs for its acute care populations and services using a non-competitive application process.⁵ As a result, new MCOs may enter, and existing plans may depart, the state’s Medicaid managed care program at any time. MCOs are responsible for providing almost all acute medical services, and behavioral health.</p> <p>There are five statewide MCOs: a BlueCross BlueShield plan, and four national for-profit entities. AmeriHealth Caritas has over 40 percent of the Medicaid managed care market. One additional for-profit MCO is set to enter the Medicaid market soon.</p>
Value Based Contract Mechanism	
VBP Targets	<p>In 2015, the state established a 5 percent target of MCO payments attributed to VBP models. The state increased the VBP requirement to 12 percent in 2016 and to 20 percent in 2017. For measurement years 2018 through 2021, MCOs are required to have 30 percent of total payments each year in VBP models as described in the SCDHHS Policy & Procedure Guide for MCOs. The state may evaluate and change the VBP percentage goal for future years.</p> <p>The state refers to the Health Care Payment Learning & Action Network (LAN) Alternate Payment Model (APM) Framework and the MCO contract lists the following VBP models, which are further defined in the Managed Care Policy and Procedure Guide:</p>

⁴ South Carolina’s SC Patient Centered Primary Care Alliance is a collaborative effort of BlueCross BlueShield of South Carolina, BlueChoice HealthPlan, the South Carolina Department of Health and Human Services, the South Carolina Department of Health and Environmental Control, the South Carolina Medical Association, the South Carolina Primary Health Care Association and the South Carolina Office of Rural Health. <https://scorh.net/pcmh-alliance/>

⁵ An MCO must be licensed as a domestic insurer by the South Carolina Department of Insurance and secure, at a minimum, Interim Health Plan Accreditation status from NCQA prior to contracting with the state to render Medicaid managed care services.

State Profile: South Carolina	
	<ul style="list-style-type: none"> • Payment for Performance, • Episodes of Care, • Shared Savings Arrangements, • Shared Risk Arrangements, and • Capitation Payments with Performance and Quality Requirements. <p>The MCO contract indicates that payments for infrastructure and operations (LAN APM Category 2A) and reporting (Category 2B) are not considered VBP payments. However, South Carolina does allow MCOs to count half the value of state directed PCMH incentive payments as part of their VBP payments.</p>
State Directed Payment Model	<p>Prior to having MCOs, Medicaid enrollees were in a Primary Care Case Management program. Since the inception of capitated Medicaid managed care in 2014, MCOs have been required to make additional payments to PCMHs that obtain NCQA certification. The state makes quarterly PCMH payments to MCOs to cover both MCO PCMH incentive payments and provider incentive payments. PCMH practices recognized under NCQA recognition standards are paid \$1 to \$2 per member per month. Similarly, for each member that an MCO has in a recognized PCMH, the MCO earns between \$0.15 and \$0.25 PMPM.⁶</p> <p>In 2018, the state Medicaid agency and the Office of Rural Health began working with the state medical association to further develop efforts to support the PCMH process, including guiding practices in the alignment of the PCMH program with other quality initiatives, such as the MCO withhold program.</p>
Enforcement Mechanisms	
Financial Incentive - VBP Adoption	<p>An MCO's failure to meet the VBP adoption target for each measurement year may result in the MCO forfeiting 25 percent of the capitation withhold dollars. If an MCO misses the VBP target and indicates it is due to changes in state policy changes, the MCO can submit documentation and re-calculate the target to exclude the impact of the state policy change. The State makes the final determination of whether an MCO has achieved the target and whether to retain the applicable withheld capitation funds. By contract, the state also has the right to audit any MCO provider contract or payments claimed to qualify as VBP.</p>
Financial Incentive - Quality Improvement	<p>In 2012, South Carolina began to withhold 1 percent from MCO capitation payments as an incentive for improving performance on quality measures. Today, the state withholds 1.5 percent of the MCO capitation rate.</p> <ul style="list-style-type: none"> • Plans can earn back up to 75 percent of the withhold funds based on their performance on three sets of HEDIS measures, each referred to as a Quality Withhold Index. For each HEDIS measure within an Index, an MCO earns points based on their performance compared to regional NCQA Quality Compass percentiles. An MCO that performs at or above the 50th percentile

⁶ Beginning with the 2017 NCQA standards for PCMH recognition, NCQA is no longer awarding recognition at varying levels (I, II, or III). Practices who become recognized under current NCQA standards are incentivized at \$2 PMPM, the same level as those practices who were Level III under previous versions of NCQA's PCMH Recognition.

State Profile: South Carolina	
	<p>and below the 75th percent earns a score of 4 for that HEDIS measure. Not all measures are equally weighted within a Quality Withhold Index.</p> <ul style="list-style-type: none"> • To earn back the entirety of the Quality Withhold, an MCO must earn a combined score of 4 or more on each of the three measure sets. • To participate in the bonus pool for a given Index an MCO must earn a combined score of at least 5, which represents MCO performance between the 75th and 90th percentiles. The bonus pool is funded by any Quality Withhold dollars that are not earned back by MCOs. The state establishes quality withhold indices that include groups of HEDIS measures related to diabetes care, women’s health, pediatric preventative care, and more recently, behavioral health care.
Non-Financial Incentives	<p>Medicaid plans in South Carolina that achieve higher NCQA ratings get a higher portion of auto-assignments. The MCO Contract and Policy and Procedures Manual describe the state’s auto-assignment algorithm. For each MCO, the state assigns a Quality Weighted Assignment Factor based on the MCO’s South Carolina overall rating for NCQA’s annual Medicaid Health Insurance Plan Ratings.</p>
Liquidated Damages and Other Penalties	<p>An MCO’s failure to meet minimum quality performance levels on HEDIS measures may result in liquidated damages as reflected in Section 18 of the MCO Contract. Liquidated damages up to \$500,000 per clinical topic area may be assessed if an MCO’s quality score indicates performance at less than NCQA’s 10th percentile for Medicaid plans.</p> <p>If an MCO does not meet the medical loss threshold of 86 percent and achieves an NCQA Medicaid health plan quality rating of three or less, the MCO must provide a remittance to the state.</p>
State Monitoring and Evaluation	
VBP Reporting & Transparency Requirements	<p>The State initially only required its MCOs to report overall VBP payments combined to determine whether each MCO met the VBP target. Beginning in 2019, the state required MCOs to separately report on their VBP percentages by LAN APM Framework categories.</p> <p>If an MCO misses the VBP target and indicates it is due to changes in state policy, the MCO can submit documentation and a recalculation of the target to exclude the impact of the state policy change. The methodology for evaluating the VBP percentage and the reporting requirements are detailed in the Policy and Procedure Guide for Managed Care Organizations and the MCO Report Companion Guide. Payments for pharmacy, durable medical equipment, and Federally Qualified Health Centers may be excluded from the MCOs’ VBP calculations.</p> <p>The State makes the final determination of whether an MCO has achieved the target and reserves the right to audit any contract claimed to qualify as VBP as well as any payments claimed to have been made pursuant to a VBP contract.</p>

State Profile: South Carolina	
	<p>In 2019, South Carolina required its MCOs to complete a more detailed VBP survey, which asked plans to report VBP spending by the following LAN APM categories: Category 1, Category 2a-2b combined, Category 2c, and Category 3 and 4 combined. This survey also asked questions about how MCO VBP models were linked to quality improvement and information on the clinical focus of different MCO VBP models.</p> <p>MCOs also have reporting requirements related to HEDIS metrics and quality withhold measures.</p>
Oversight Meetings with MCOs	State and MCO interviewees described ongoing meetings, in aggregate and individually with MCOs, supporting and emphasizing the state’s delivery system reform and quality initiatives. The state consistently works to marry quality improvement and payment reform work as part of comprehensive approach, not two separate streams of work.
Evaluations	No recent delivery system or payment reform evaluations, other than VBP observations as part of the state’s Medicaid managed care quality strategy, and the state’s annual determination as to whether each MCO has met the VBP and quality requirements sufficient to earn their withheld capitation funds. An early report on the multi-payer PCMH initiative was conducted by the University of South Carolina.
Quantifiable Results Related to VBP and Delivery System Reform Efforts	
VBP Adoption	<p>South Carolina reports that all MCOs have met its VBP contracting goal each year, so the incentive to reach the 30 percent VBP goal to avoid funds being withheld seems to be working. Most, if not all MCOs are anticipated to meet the VBP goals for 2019.</p> <p>South Carolina’s Medicaid Quality Strategy identifies MCO VBP data collection as a challenge noting that formulas used for the calculation may not be uniform across MCOs and that MCOs have not been required to report on the type of payment models used or measurable impacts of their adopted VBP models.</p>
Delivery System Reform Results	Based on early analyses of PCMH results between 2013-2014 in South Carolina, higher level PCMH certification was associated with increased access (prevention) for children and adults and lower costs associated with emergency department visits and inpatient hospital stays. At the time, the largest number of practices in the state were in the application phase associated with lower access and higher overall costs. However, the study was not able to isolate the impact of the PCMH model alone to address the potential selection bias. For example, it was hard to determine whether providers who initially elected to and became certified as higher level PCMHs were better resourced, better performing providers than the providers still in the application phase.
Quality Results	As noted in the state’s quality strategy, the MCO withhold program has been successful at incentivizing increased HEDIS performance among contracted MCOs. For reporting year 2017, ten of the 12 HEDIS withhold measures statewide exceeded the goal set based on the 50th percentile for the CMS Atlanta region.
Other Medicaid Delivery System Reform Efforts	

State Profile: South Carolina	
DSRIP	No.
PCMH	Yes, as noted above and below.
Multi-Payer Delivery System Reform Efforts	
SIM	No.
Multi-Payer Initiative	<p>To better align VBP requirements with other payers, the state is a member of the Catalyst for Payment Reform and has adopted components of the APM Framework developed by the LAN.</p> <p>The State funds and participates in a statewide PCMH Alliance which draws together diverse payers, provider groups and associations from across the state to improve the health and patient experience by implementing the PCMH model statewide.</p>

South Carolina State Profile Resources

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Appendix B: Listing of Organizations Interviewed

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State Medicaid Agencies

- Minnesota Department of Human Services
- New Mexico Human Services Department
- New York State Department of Health
- Ohio Department of Medicaid
- South Carolina Department of Health and Human Services.

Managed Care Organizations

- AmeriHealth Caritas, Select Health of South Carolina, (SC)
- Blue Cross Blue Shield New Mexico, Health Care Services Corporation (NM)
- Blue Cross Blue Shield Minnesota (MN)
- CareSource (OH)
- EmblemHealth (NY)
- HealthPartners (MN)
- Molina Healthcare of South Carolina (SC)
- Presbyterian Health Plan (NM)
- Paramount Health Care (OH)
- UnitedHealth Community Plan (NY)

Provider Organizations

- MetroHealth (OH)

External Quality Review Organization

- Carolinas Center for Medical Excellence

Actuaries

- Mercer
- Milliman

National Experts

- Catalyst for Payment Reform
- Center for Health Care Strategies
- Community Catalyst

Federal Agencies

- Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services