BRIEF | February 2016

CHCS Center for Health Care Strategies, Inc.

Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches

By Tricia Leddy, Tricia McGinnis, and Greg Howe, Center for Health Care Strategies

IN BRIEF

States are increasingly looking to move away from volume-driven fee-for-service payments and toward value-based payment (VBP) arrangements. This brief explores state options for using managed care contracts to accelerate VBP adoption at the provider level. This resource was produced by the Center for Health Care Strategies (CHCS) with support from the Center for Medicare and Medicaid Innovation as part of team led by NORC at the University of Chicago that is serving as the State Innovation Model Resource Support Contractor.

With more than half of all Medicaid beneficiaries receiving services via managed care organizations (MCOs), states are increasingly using MCO contracts as a vehicle to change how providers are paid for delivering health services. Traditionally, state Medicaid agencies, like other payers, have relied on their contracted MCOs to independently oversee value-based payment (VBP) arrangements with providers and move away from volume-driven fee-for-service payment. However, with greater attention focused on the benefits of multi-payer alignment, particularly through the State Innovation Model initiative (SIM), and the imperative to move more quickly toward VBP models, states are proactively leveraging MCO contracts to accelerate wide-scale adoption.

This brief draws from state experiences across the country to outline general approaches that Medicaid agencies are taking to promote VBP initiatives. It provides suggestions for developing Request for Proposal (RFP) questions to help assess which MCOs would be best positioned to implement VBP models.

General Approaches to Value-Based Payment in Managed Care Organization Contracts

States are using the following approaches with contracted MCOs to promote VBP goals:

1. ***Require MCOs to adopt a standardized VBP model.*** Under this approach, the state requires MCO(s) to adopt a specific payment model that was developed by the Medicaid agency or other stakeholders/purchasers. This would yield a high level of standardization across provider eligibility requirements, payment methods, care management requirements, and quality measures. The benefit of this approach is that the standardization across MCOs reduces the burden on providers to participate and enables the state to proactively

Made possible through the Center for Medicare & Medicaid Innovation

encourage and foster widespread uptake. It also enables the state to create a model that aligns well with commercial, Medicare, and other payers.

Minnesota and Tennessee have both used this approach for their SIM payment strategy. For example, Minnesota developed an accountable care organization (ACO) model, called the Integrated Health Partnerships (IHPs), with a shared savings/risk payment methodology similar to the Medicare Shared Savings Program. Minnesota requires its MCOs to participate in the shared savings/risk payment model with IHPs participating in the program. Likewise, Tennessee requires its Medicaid MCOs to implement its patient-centered medical home (PCMH) and retrospective episode-of-care models.

2. ***Require MCOs to make a specific percentage of provider payments through approved VBP arrangements**.* These arrangements could include a range of state-defined models, such as performance incentives or penalties, shared savings and/or risk based on quality and cost targets, episode or bundled payments, or global payment programs. The proportion of each MCO's revenue that must be tied to VBP arrangements could increase over time (e.g., year 1 could be five percent, year 2 could be 10 percent, etc.). MCOs would be able to submit proposed arrangements to the state for approval and would attest to meeting the percentage benchmark and provide supporting data as requested by the state.

   Arizona, Pennsylvania, and South Carolina are all using this type of MCO contracting. South Carolina requires health plans to meet value-oriented contracting targets. The target, set initially at five percent of payments in 2015, will increase to 20 percent by 2017. Plans must implement payment models that are designed to cut waste and/or reflect value. MCOs have a wide degree of flexibility but must submit their models for state approval. Arizona takes a similar approach. The proportion of MCO revenues started at five percent in 2013, increased to 10 percent in 2014, and moved up to 20 percent in 2015 and 2016. Like South Carolina, Arizona allows the health plans flexibility in determining those arrangements but provides broad guidance on the types of arrangements that are considered VBP, such as primary care incentives, performance-based contracts, bundled/episode payments, shared savings, shared risk, and capitation plus performance-based contracts. Rather than submit models for approval, Arizona asks MCOs to share examples of the primary arrangements. To enforce these requirements, Arizona and South Carolina both withhold a portion of the capitation payment, subject to the MCO meeting the annual VBP benchmarks as well as state-defined quality performance and improvement standards. In Arizona, the MCOs compete against each other for the incentive payments based on their quality performance. Pennsylvania plans to implement a similar approach within its physical health managed care program, imposing a two-percent withhold on MCOs that do not have 7.5 percent of the medical portion of capitation and maternity revenue expended via VBP in 2017; the proportion shifts to 15 percent in 2018 and 30 percent in 2019.

3. ***Require the MCOs to move toward implementation of more sophisticated VBP approaches over the life of the contract**.* VBP approaches vary in terms of the levels of financial risk and accountability that providers assume. While not all providers will be ready for risk-based contracting, it is important to move providers along a continuum of models with increasing accountability over time. For example, as part of its VBP Roadmap, New York State set a

five-year goal of having 80-90 percent of all provider payments in certain broadly defined VBP models by 2020, and a goal of 35 percent covered in risk-based arrangements by the same date.

4. ***Require MCOs to actively participate in a multi-payer VBP alignment initiative***. Multi-payer VBP initiatives could be facilitated by the state to create consistency, reduce burden, and align incentives across MCO VBP efforts for the provider community. Tennessee, for example, adopted a specific, uniform payment strategy in launching its multi-payer model. Conversely, the state could require alignment with multi-payer models along key parameters such as:

    - Uniform performance and payment metrics;
    - Provider eligibility criteria;
    - Consistent timing and/or phasing-in of increasingly advanced VBP models; and
    - Training and resources to support providers in transitioning to VBP models, including data analysis capacity building, provider training, and/or other relevant supports.

5. ***Require MCOs to launch VBP pilot projects subject to state approval***. This approach would require the MCOs to implement a set of VBP projects, encompassing specific goals, payment models, and provider partners. The state would require MCOs to submit VBP proposals for input, review, and approval. The state would work with the MCOs to establish an implementation timeline and other key parameters such as evaluation and quality metrics.

    New Mexico Medicaid took this approach as part of its Centennial Care waiver. Each of its four MCOs submitted proposals for at least two VBP projects of their choosing. The state approved a subset of complementary projects that engage different provider types across New Mexico. The state also selected uniform quality and cost metrics and created a template that the MCOs must use to report quantitative and qualitative results for each approved project. The state plans to evaluate the projects to determine both effectiveness and scalability, with the goal of scaling the most successful projects across the Medicaid delivery system.

    Minnesota is also pursuing this approach through its Integrated Care System Partnerships (ICSPs). The ICSPs are designed to improve health care access, coordination, and outcomes for beneficiaries who are dually eligible for Medicare and Medicaid by establishing partnerships across MCOs, primary, acute, long-term care, and mental health providers. Medicaid MCOs submit ICSP proposals, including specified quality measures, to the state for approval.

Developing Questions for the Request for Proposal

In addition to requiring or encouraging MCOs to enter into VBP agreements with providers, states can develop RFP questions to help assess MCO interest in and experience with VBP. For example, below is a list of VBP models that could be referenced in the RFP. The state could ask MCOs about: (1) experience with each of these VBP arrangements; and (2) willingness to advance VBP principles in provider contracts, including specific ideas and proposed timelines for doing so.

1. ***Bundled Payments***: Providers receive an inclusive payment for a specific scope of services to treat an "episode of care" with a defined start and end point. This approach incentivizes coordination across physicians and hospitals to provide care at or below the payment level for specific episodes. Payment is contingent on quality performance.

2. ***Shared Savings/Risk***: Providers have an annual, risk-adjusted, predicted total-cost-of-care target for an attributed set of patients. Providers that succeed in keeping actual costs below projected costs can keep part of the savings. This approach incentivizes quality and cost improvements across all services included in the total cost and can be effective with PCMH and ACO models.

3. ***Rewards***: Providers receive a bonus payment for measureable performance in quality, patient satisfaction, resource use, and/or cost.

4. ***Penalties***: Providers receive lower or no payment for events and procedures that are harmful and were avoidable.

5. ***Global or Capitated Payment***: Providers receive a per-member-per-month payment to cover a wide range of services and bear the financial risk for their patients for the specified services. This approach incentivizes investments in care coordination, quality improvement, and efficiency across the full continuum of care, and is best used with ACOs, hospitals, and multi-specialty provider groups.

The state can also use the RFP to query when the MCO's provider contracts will be up for renewal to identify opportunities to change terms to include VBP. This is particularly important for large multi-specialty group practices, large primary care group practices, and hospitals. Finally, the state may wish to strengthen RFP requirements and contract terms in areas related to VBP. These areas could include, but are not limited to: provider network requirements, especially in rural areas; access standards for routine, urgent, and emergent care, including standards for physical health and behavioral health; requirements for behavioral health integration with primary care; and promotion of primary care provider credentialing as PCMHs.

Additional Resources

State Examples

Following are links to contract agreements and RFP documents from states referenced in this document:

State	Links to Pertinent Contract Language or Other Documents
Arizona	2015 Contract Language
Minnesota	Contract Information and Resources
New York	DSRIP VBP Roadmap
Pennsylvania	2015 Medicaid MCO RFP and 2017 Draft Agreement
Tennessee	2015 Contract Agreement

Advancing Payment Reforms in Managed Care Provider Networks: Tools for State Purchasers

CHCS developed the following resources to help state purchasers design and implement effective VBP strategies within managed care. The resources (available through the below links and posted on www.chcs.org) were developed through support from the Robert Wood Johnson Foundation:

- **PART I: Strategic Considerations for State Purchasers** – This brief outlines strategies states can use to advance delivery and payment reform. It presents key steps states would need to take to move the delivery system under managed care away from FFS — or transaction-based reimbursement — and toward payment for value or outcomes.
- **PART II: An Implementation Guide for State Purchasers** – This implementation guide is designed to assist states in more effectively engaging Medicaid health plans, state employee insurance plans, and state insurance marketplaces to move the delivery system toward VBP. The guide outlines policy and regulatory levers states can use to implement VBP.
- **PART III: Planning Template for Value-Based Purchasing** – This template aims to help states develop a tangible strategy for advancing system reforms through their health plans. The template can serve as a starting point for discussions with both health plans and other purchasers in the state.

About this Resource

This resource was produced by the Center for Health Care Strategies (CHCS) with support from Center for Medicare and Medicaid Innovation. CHCS is part of a team led by NORC at the University of Chicago that is serving as the State Innovation Model Resource Support Contractor. CHCS is supporting the states and the Innovation Center in designing and testing multi-payer health system transformation approaches, along with NORC and other technical assistance partners, including SHADAC, the National Governors Association, and Manatt Health Solutions.