
Medicaid Population-Based Payment: The Current Landscape, Early Insights, and Considerations for Policymakers

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

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Executive Summary

Population-based payment (PBP) models are gaining increasing interest in health care as a way to pursue many goals including: (1) reducing the cost of health care; (2) improving quality; (3) improving patient experience; (4) improving provider experience; and (5) advancing health equity. PBPs are an advanced value-based payment (VBP) approach that delivers a prospective payment to health care providers and holds them financially accountable for quality and cost of care. These payments align provider and payer incentives to encourage providers to keep their patients well, rather than paying via the more typical fee-for-service (FFS) approach that rewards providers for performing a large volume of reimbursable services. The strong financial incentives present in PBPs represent a significant opportunity for Medicaid payers and providers to improve how health care is delivered to people enrolled in Medicaid.

With support from Arnold Ventures, the Center for Health Care Strategies (CHCS) developed this report to help guide effective design and implementation of state PBP models. The report includes:

- A landscape scan of existing Medicaid PBPs,
- Promising strategies for designing and implementing PBPs in Medicaid, and
- Considerations for state and federal policymakers looking to support PBP programs.

The report also includes [profiles of PBP approaches](#) used in **Colorado, Maryland, Massachusetts, New York, Pennsylvania,** and **Washington State**, and [an appendix](#) outlining current PBP models. The state profiles explore the varied approaches states have taken to implement PBP and highlight examples of primary care, hospital, and total cost of care (TCOC) models.

CHCS found that while there is still much to learn about PBPs, especially in Medicaid, there are important insights from existing and emerging PBP models, and concrete strategies that states can use to strengthen their efforts to design and implement PBPs in their Medicaid programs. Potential considerations for policymakers based on this knowledge are highlighted in each section of this report. While many state efforts are in the early stages of design, some are in early implementation, and a few programs are well-established. Current PBP models come in three distinct categories: primary care, hospital, and TCOC — though some states have multiple, aligned models. Despite these categories, each state's approach within each category is significantly different from the others. These differences reflect the state's environment, and design decisions made that would help states to accomplish their model goals and allow success within that environment. Despite the differences in model design, states did have some similar experiences when designing and implementing their programs, and these experiences can help inform future efforts in designing, implementing, and improving PBP models.

A list of the major factors that states identified as influencing their Medicaid PBP design can be found in the table below. These factors are explored in-depth in this report, and discussions of each factor references model examples, similarities, and differences.

Factors Influencing Medicaid PBP Design

STATE ENVIRONMENTAL FACTORS	PAYMENT MODEL DESIGN ELEMENTS
<ul style="list-style-type: none"> • Engaging stakeholders and getting buy-in • Implementing PBPs in Medicaid managed care • Navigating federal and state regulatory barriers • Determining provider readiness • Considering a multi-payer approach to increase alignment 	<ul style="list-style-type: none"> • Defining PBP model goals and scope • Transitioning to a PBP model • Determining voluntary or mandatory participation • Setting PBP rates • Evaluating the PBP model

Many Medicaid PBP models are relatively new and are still awaiting results. However, the results that are available are promising, and these models make intuitive sense to significantly reduce costs, improve quality, improve patient and provider experience, and advance health equity — all things that the current FFS delivery system has failed to do. PBPs also have stronger incentives in place than more well-established VBP approaches like pay-for-performance and shared savings models, which could allow them to outperform these models’ results. While more time is needed to see how PBP models fare, states are increasingly interested in pursuing PBP models, and it seems likely that more will develop over time.

Introduction

Population-based payment models (PBPs) are gaining increasing interest in health care as a way to pursue many goals including: (1) reducing the cost of health care; (2) improving quality; (3) improving patient experience; (4) improving provider experience; and (5) advancing health equity. PBPs are an advanced value-based payment (VBP) model that delivers a prospective payment to health care providers and holds them financially accountable for quality and cost of care. These payments align provider and payer incentives to encourage providers to keep their patients well, rather than paying them via the more typical fee-for-service (FFS) approach that rewards providers for performing a large volume of reimbursable services. The strong financial incentives present in PBPs represent a significant opportunity for Medicaid payers and providers to improve the way health care is delivered to people enrolled in Medicaid.

With support from Arnold Ventures, the Center for Health Care Strategies (CHCS) compiled this report to review the current landscape of Medicaid PBPs, identify promising strategies for designing and implementing PBPs in Medicaid, and outline considerations for state and federal policymakers seeking to support PBP programs. To produce this report, CHCS performed an environmental scan of Medicaid PBP models, identifying 11 current models (see [What is a Population-Based Payment Model?](#)).¹ CHCS also conducted interviews with state staff and provider organizations participating in Medicaid PBP models in these states, as well as subject matter experts. CHCS found that while there is still much to learn about PBPs, especially in Medicaid, there are important insights from existing and emerging PBP models, concrete strategies for states to strengthen the design and implementation of PBPs in their Medicaid programs, and valuable considerations for policymakers.

Key Definitions

- ✓ **Fee-for-service (FFS) payment:** The traditional model of payment to health care providers, where payments are based on claims for services performed and are not linked to quality of care.²
- ✓ **FFS delivery system:** Medicaid is administered by the state, rather than through managed care organizations. States pay providers directly for services delivered to Medicaid enrollees.³
- ✓ **Value-based payment (VBP):** Payment to health care providers (usually at the provider organization or health system level) that shifts from the traditional FFS payment model to incentivize value over volume and link payment to quality performance.
- ✓ **Population-based payment (PBP):** An upfront, prospective, VBP model that includes provider accountability both for quality and cost of care and is based on the number of patients a provider serves — as opposed to the number of services a provider performs.
- ✓ **Hybrid PBP:** A VBP model where providers are reimbursed through a mixture of FFS and PBP. In this model, FFS rates are decreased in response to the addition of the capitated payment.
- ✓ **Total cost of care (TCOC):** The cost associated with a patient for a defined period of time. In this report, TCOC refers to a PBP model where: (1) a defined array of services are covered for a patient; and (2) a provider is held financially accountable for total costs of the patient, including care from other providers.

What is a Population-Based Payment Model?

For this report, a PBP is defined as an upfront, prospective, VBP approach, which includes provider accountability both for quality and cost of care, and is based on the number of patients a provider serves, as opposed to the number of services a provider performs. Per the Health Care Payment Learning & Action Network (LAN), PBPs “represent the furthest departure from traditional fee-for-service payments, while they simultaneously ensure that providers possess the strongest possible incentives to deliver high-quality and efficient care.”⁴ Examples of PBPs include capitated payments, global budgets/payments, and bundled payments; and payments are typically made on a per member per month (PMPM) basis. Simply adding a small care management fee on top of typical FFS reimbursement is not a PBP model, as such arrangements do not significantly shift volume-based incentives.

This report focuses on three types of PBP models that are prevalent in Medicaid and have a broad scope of services: (1) primary care models; (2) hospital-based models; and (3) TCOC models. The PBP models explored within these categories include both PBP models where reimbursement is entirely paid as a PBP and hybrid models where total reimbursement is paid partially as a PBP and partially as a reduced FFS payment (see *Key Definitions* on the previous page for more details). This focus excludes some more narrow models that also use a PBP payment model, such as bundled payments for episodes of care, disease-specific models (e.g., behavioral health or end-stage renal disease), models designed for specific subpopulations (e.g., Program of All-Inclusive Care for the Elderly or PACE), and models specifically designed for Federally Qualified Health Centers (FQHCs).

Federally Qualified Health Center Population-Based Payment Models

While many state PBP models include FQHCs among their participants, Oregon and Washington State both use FQHC-specific PBP models,⁵ and California is currently designing an FQHC-specific approach.⁶ These FQHC-specific models are designed to account for the federal requirements for FQHCs to receive no payments lower than the prospective payment system (PPS) rates that pay by encounters rather than a FFS payment model, which limits their ability to take downside risk.⁷ Such models generally remove downside risk for FQHCs by paying them prospectively on a PMPM basis while tracking PPS encounters. If the FQHC would have earned more on a PPS basis, the state will provide a wraparound payment to reconcile that difference.

For more information on FQHC models, see: [*How Health Centers Can Improve Patient Care Through Value-Based Payment Models.*](#)

Key Design Elements

PBP models share many design elements with other types of VBP models, though how these elements are implemented may look different than in VBP models that are based on FFS payment infrastructure, such as pay-for-performance or shared savings models. The table below highlights some unique features of PBP models, many of which are detailed later in this report.

MODEL DESIGN ELEMENT	WHAT IT LOOKS LIKE IN A PBP
Payment mechanism	Payment is not tied to claims and covers all care provided within a specific scope of services outlined in the model. Payment is typically made on a PMPM basis.
Scope of services	The PBP covers a defined scope of services (typically primary care services, hospital services, or physical health services), and funding can be used flexibly, such as performing activities or providing services that are not usually reimbursed under FFS payment.
Quality accountability	PBP models tie quality to payment using a variety of methods. For example, performance-based payments may be added on top of the PBP or withheld from initial payment until quality targets are achieved, rates may be adjusted upward or downward based on past performance, or meeting a quality target may be a prerequisite for continued participation in a PBP model.
Cost accountability	PBP models inherently create cost accountability — providers earn a profit by keeping costs under the PBP and incur a loss if costs are greater than their PBP, though many models limit the amount of financial risk borne by providers.
Rate setting	Appropriate rate setting is one of the key challenges for gaining provider buy-in to PBP models. States typically set rates based on historical spending and adjust rates over time based on anticipated or ideal health care cost growth.
Risk adjustment	PBP rates are adjusted based on clinical complexity of patients. Some states also adjust rates based on social needs of patients, recognizing that social factors are a key driver of health outcomes.

Benefits and Challenges of PBP Models

PBP models provide many key benefits for providers, payers, and patients by decoupling payment from the provision of services.

Key benefits include:

- **Aligned financial incentives.** PBP models can be designed to align financial incentives to improve quality, equity, and efficiency in health care.⁸ Providers are incentivized to provide more cost-effective preventive care that helps them stay within their PMPM budget. Provider behavior change also benefits patients, who receive care that is oriented toward keeping them well rather than treating illnesses once they occur.
- **Flexibility.** PBPs allow providers greater flexibility to address specific patient needs that may not be reimbursed under FFS payments, such as allowing for more time to provide preventive care, care coordination, and wellness services.⁹
- **Predictability.** PBPs create financial predictability for both payers and providers. Providers can take advantage of a reliable revenue stream and upfront reimbursement to invest in the capacity-building and infrastructure required to provide high value care. Payers can offer a fixed budget for the providers in their network, allowing payers to set reliable cost growth targets.
- **Stability.** The revenue stability afforded by upfront PMPM payments is particularly valuable for providers that operate in challenging markets (e.g., rural hospitals, independent primary care practitioners) and under unusual supply shocks (e.g., the drop in utilization and FFS revenue during the COVID-19 pandemic).^{10,11}
- **Straightforward design.** The straightforward nature of PBP models — providers are paid a set amount based on their patient panel size — can decrease administrative burden for providers and payers in the long term.

While they have many benefits, PBP models are also challenging to design and implement.

Some challenges include:

- **Barriers to entry.** To succeed under the significant financial risk of a PBP, providers need to understand how to assess the needs of their population, and potentially redesign care delivery strategies to shift from a reactive to a more preventive model of care. PBP models often require a sophisticated infrastructure and commitment from providers, the state, managed care organizations (MCOs), and other stakeholders to a multi-year effort that drastically changes how health care payment is made. A state looking to implement PBPs would need robust mechanisms in place to ensure access, quality improvement, and equity — which may take time to implement. States that are not prepared to commit to a long-term VBP approach may not successfully MCO and provider participation in PBP models.

- **Financial risk mitigation.** Policymakers may need to shield providers from insurance-level risk through protections in the model design.¹²
- **Limited participation.** Some providers, such as FQHCs, may be ineligible to participate in some PBP models due to federal rules.¹³ Other providers, such as low-volume Medicaid providers, may not serve enough patients to meet the level of attribution required by a PBP model.
- **Potential for perverse incentives.** PBP models may create incentives for providers to withhold care and engage in adverse selection, thus avoiding patients with complex, costly needs.¹⁴ Including quality and equity incentives in PBP models, as well as using validated and trusted risk adjustment methods during the rate setting process, can mitigate some of these concerns. States may also consider monitoring health care utilization patterns for providers participating in PBPs, to ensure care is not being withheld. However, these methods may not yet be sophisticated enough to totally remove perverse incentives.
- **Short-term administrative burden.** In addition, the potential long-term benefit of reduced administrative burden has proven challenging to fully realize, as many PBP models require some mechanism for ensuring delivery of care and/or may need to reconcile their payments back to FFS levels. For this reason, the ability to meaningfully reduce administrative burden is heavily dependent on the specifics of the PBP model design.

The Current Medicaid PBP Landscape

Medicaid PBP models come in a variety of forms. A comparison of the 11 current models identified in CHCS' environmental scan can be found in the [Appendix](#). Detailed summaries of six innovative Medicaid PBP models — **Colorado, Massachusetts, Maryland, New York, Pennsylvania, and Washington State** — can be found in the [State Profiles](#) section at the end of this report.

There are limited existing PBP models, but state interest in these models is increasing. While there are six mature Medicaid PBP models, **Colorado** launched an additional model in the last year and two more are under development in **Maine** and **Washington State**. In addition, states participating in the CMS Innovation Center's Primary Care First¹⁵ and Community Health Access and Rural Transformation (CHART) models¹⁶ are developing Medicaid models to align with Medicare and, in some cases, commercial payment reforms. Many of the new models being developed are primary care models. This aligns with recent federal government activities indicating a greater prioritization and interest in strengthening primary care delivery.^{17,18,19} Some states chose to create multiple, aligned PBP models with differing scopes of service (e.g., **Massachusetts'** TCOC and primary care models).

As with other Medicaid VBP models, each state's PBP model reflects the unique needs and historical context of the state that developed it, including any prior experience participating in earlier federal models (e.g., CPC+, Next Gen ACO). These models are quite variable, with differing approaches to payment, desired outcomes of the model, roles for MCOs and providers, and other factors. This is reflective of the state-based nature of Medicaid programs, which interviewees noted enables model design to build on strengths and improve weaknesses of the providers and payers participating in the model. However, there are some commonalities in model design and implementation, which will be explored in greater detail throughout this report.

Analysis of Current Medicaid PBP Approaches

The environmental scan and interviews revealed that while all of the state PBP models were different, consistent themes emerged on how to design and implement a PBP model, and states faced some universal challenges no matter what their model looked like. The following analysis is split into two parts: **state environment factors** and **payment model design elements**. The former explores how states’ specific environments influenced PBP model design, while the latter explores how states translated these factors into technical decisions to support their PBP model goals. Major environmental factors and design elements that states identified are listed in the table below. While these factors are not the only ones influencing PBP model design, they were the ones that were featured prominently across interviews. Subsections in each section outline policymaker considerations for each of these factors to help inform future efforts by federal and state agencies when designing Medicaid PBP models.

Factors Influencing Medicaid PBP Design

STATE ENVIRONMENTAL FACTORS	PAYMENT MODEL DESIGN ELEMENTS
<ul style="list-style-type: none"> • Engaging stakeholders and getting buy-in • Implementing PBPs in Medicaid managed care • Navigating federal and state regulatory barriers • Determining provider readiness • Considering a multi-payer approach to increase alignment 	<ul style="list-style-type: none"> • Defining PBP model goals and scope • Transitioning to a PBP model • Determining voluntary or mandatory participation • Setting PBP rates • Evaluating the PBP model

State Environmental Factors

Each current state Medicaid PBP approach is unique, reflecting the characteristics of the state's environment. For benefits to be fully realized, VBP models, especially advanced and complex models like PBPs, need to be tailored for the patients served, and set up to ensure success for the participating providers, MCOs, community-based organizations, and other stakeholders involved. Important environmental factors include: stakeholder buy-in and engagement; whether the state has a managed care or fee-for-service delivery system; regulatory barriers; provider readiness; and whether a multi-payer PBP model is possible.

Engaging Stakeholders and Getting Buy-in

Implementing a PBP program requires sufficient stakeholder buy-in. At the state level, overall political support including the governor, legislature, and Medicaid agency leadership, is often important to effectively communicate state goals and encourage participation in the model. Additionally, interviewees suggested that MCO and provider thoughts on PBP models vary, and often depend on whether stakeholders view such models as an opportunity or a threat to their business prospects. For example, interviewees noted that gaining provider buy-in may be easier when models focus on increasing provider compensation or financial sustainability (e.g., primary care models or targeted approaches like the **Pennsylvania** and CHART rural health models) than when models focus largely on cost savings (e.g., some TCOC or hospital-only models), which are often viewed as a bigger risk by established provider organizations. As another example, part of the value proposition of PBP is that providers may be better positioned than MCOs to take on some historically MCO-operated functions, such as care management. However, MCOs are often resistant to delegate such capabilities to providers, in part because it may reduce their role within the health care system.

Local market dynamics, provider readiness, and national political or economic factors can also impact stakeholder buy-in and the degree to which PBP is seen as a threat or opportunity. Providers and payer organizations with significant VBP experience tend to be more supportive of a move to PBP models. Interviewees also described how national economic and political factors play an important role in gaining buy in. For example, provider experiences with reduced/unpredictable FFS payment during the COVID-19 pandemic have made many providers more open to, and even champions for, adopting PBP models with predictable revenue streams.^{20,21,22} Similarly, many interviewees described how the federal government influences state policy goals. For instance, **Maine** noted how aligning with the CMS Innovation Center's Primary Care First model helped garner support from providers and health systems, which in turn helped the state to move forward with conversations with other payers on PBPs. The economy and its impact on state budgets is also an important factor in influencing payers, including Medicaid agencies, to focus on cost savings as a goal.

In addition to contextual factors, interviewees emphasized the need for thoughtful and structured stakeholder engagement from the very beginning of the PBP model design process to best garner buy-in and design models that are appropriate for the state context. Engaging providers, MCOs, community-

based organizations, patients and patient advocates, and others is essential for defining the goals of PBP models, defining key elements of PBP model design, and mitigating unintended consequences. For example, to build support for **Washington State’s** Multi-payer Primary Care Transformation Model, the state organized a multi-pronged effort, including stakeholder meetings, public comment periods, and surveys to engage a wide variety of stakeholders throughout the state’s two-year model design process. Notably, the state held two types of meetings: meetings focused on needs of particular stakeholder groups (e.g., payer- and provider-only meetings) to explore stakeholder concerns and multi-stakeholder meetings to support cross-stakeholder alignment.^{23,24,25,26}

Effectively engaging Medicaid members, patient advocacy organizations, and community-based organizations during PBP design and implementation is particularly critical. These stakeholders offer important perspectives on how PBP models may impact patient experience, access, and address patient priorities. For example, some interviewees reported that consumer advocate organizations were concerned that PBP models may introduce incentives that encourage withholding care, leading to reduced care access or exacerbating health disparities. Addressing these types of concerns is essential to ensuring the PBP models are designed to be patient-centered and advance health equity goals. While engaging Medicaid enrollees in VBP model design is important, it is also challenging. Because VBP is a technical and jargon-heavy topic, it is not always clear how to engage Medicaid members most effectively in design discussions. This is compounded by the fact that federal and state regulations often limit a Medicaid agency’s ability to compensate members for time spent in engagement activities, making it hard to recruit Medicaid members to participate in design activities.

Policymaker Considerations: Engaging Stakeholders and Getting Buy-in

- **Understand the value proposition.** When assessing the feasibility of and approach for PBP implementation, states should consider the value proposition of PBP models for different stakeholders, including payers, providers, and communities. PBP models that require dramatic shifts in the business strategies or roles of health care organizations may necessitate stronger participation incentives or requirements.
- **Support cross-stakeholder buy-in.** States should develop strategies to support PBP model design and buy-in such as: (a) defining and clearly communicating long-term state goals for VBP implementation; (b) developing an approach for engaging a variety of stakeholders throughout the PBP model design and implementation process; (c) identifying champions of PBP models (within and outside of state government); and (d) working with such stakeholders to build broader support.
- **Engage Medicaid members.** States should consider how to engage Medicaid enrollees and communities to design models that address patient priorities and advance health equity. CMS may also consider providing technical assistance to states, which would be helpful in supporting this work.

Implementing PBPs in Medicaid Managed Care

One key factor that influences Medicaid PBP design is whether the state operates under a Medicaid managed care or FFS delivery system. Out of the 10 PBP models reviewed for this paper, five are operated through Medicaid MCOs,²⁷ three are implemented through FFS delivery systems, and two are federal models that operate across multiple states and include managed care and FFS delivery systems. Designing a PBP in managed care can be complex because states must consider the role of both MCOs and provider organizations, though it is typically easier from a regulatory standpoint than implementing PBP in FFS delivery systems (for more information on FFS delivery system implementation, see [Navigating Federal and State Regulatory Barriers](#)).

Key decision points for states implementing PBPs in Medicaid managed care include how prescriptive states should be in providing guidance on: (1) design elements of PBP models; and (2) division of administrative and care management functions between MCOs and provider organizations. States must consider how to balance MCOs' desire for flexibility in PBP model design (e.g., to align with pre-existing provider contracts, population health programs, claims processing, and data capabilities) with the need for consistent payment approaches across MCOs to reduce provider burden and align incentives. Additionally, states must consider what capabilities (e.g., care coordination, utilization management, quality improvement programs, and data collection/sharing) will be the responsibility of MCOs versus provider organizations, and whether to explicitly define these roles as part of the PBP program. This is likely more relevant to TCOC or hospital models than primary care models, as larger health systems are more likely to have the capabilities and capacity to take on traditional MCO functions. Overall, the managed care PBP models explored in this report tend to be more prescriptive about payment design elements than how to divide responsibilities across payers and providers, largely leaving that decision to MCOs and providers. At the same time, some interviewees expressed that additional state guidance on MCO and provider roles may ease implementation of PBP models.

Policymaker Considerations: Implementing PBPs in Medicaid Managed Care

- Provide guidance, but maintain flexibility for MCOs.** States with Medicaid managed care programs should provide clear guidance, informed by stakeholder feedback, on which elements of PBP models should be aligned across MCOs and which entities are responsible for administrative and care management functions. In providing such guidance, states should aim to balance clarity and flexibility. While some guidance is likely needed to support contract negotiations, states should also recognize that some flexibility is also necessary to ease transition to PBP and accommodate variable capabilities across providers.



Navigating Federal and State Regulatory Barriers

States seeking to implement a PBP model need to obtain the authority to do so from the Centers for Medicare & Medicaid Services (CMS). States with existing PBP models have done so through: (1) an 1115 demonstration; (2) a state plan amendment (SPA); (3) the Center for Medicare and Medicaid Innovation, under Section 1115A of the Social Security Act; and (4) CMS review of managed care rates, contracts, and directed payments.²⁸ Other potential vehicles include 1915(b) waivers and a contract under Social Security Act 1915(a).^{29,30} A state may need to use multiple authorities, or may be able to use existing authorities granted to the state (such as a waiver authorizing the state’s managed care program), to implement a PBP model, depending on the model’s attributes.

Obtaining authority to implement PBP models in Medicaid managed care is generally easier than in a FFS delivery system. Existing managed care authorities can often be used without additional CMS approval, providing states with significant flexibility to incentivize MCOs to adopt VBP models and direct MCOs to pay providers in a specific way.³¹ States with a FFS delivery system face more challenges developing and implementing PBPs. There is currently no clear regulatory pathway to move Medicaid payments entirely off of FFS delivery system architecture, and interviewees that are currently pursuing this approach reported that they expect to use SPAs or waivers to put their PBP models into place.

The regulatory authority used generally depends on what the state is requesting to do, though the amount of effort involved usually parallels the scope of the PBP approach. For example, wholesale changes to the state’s approach (such as a TCOC arrangement for **Vermont’s** ACO Program) would require a more comprehensive 1115 waiver, while a more modest transformation (such as a voluntary hybrid PBP approach for primary care providers (PCPs), like in **Washington State**) could use the state’s existing managed care authority.

States interested in participating in an established federal model, such as CPC+ or Primary Care First, generally have an easier time getting off the ground, but many states have found such models unaccommodating to Medicaid delivery systems.³² States pursuing CMS approval have reported lengthy negotiation and approval periods, requirements for rapid implementation and results reporting, and impediments to innovation, such as policies on budget neutrality — although some recent flexibility has been shown by CMS on budget neutrality with the renewal of **Vermont’s** 1115 waiver.³³

Policymaker Considerations: Federal and State Regulatory Barriers

- **Encourage the development of new PBP models.** CMS has an opportunity to encourage the proliferation of PBPs. It could potentially do so by releasing additional guidance regarding PBP implementation in FFS delivery systems, designing a new model or models for PBPs under the CMS Innovation Center, or creating waiver flexibilities or a specific demonstration waiver for PBPs (similar to the DSRIP 1115 demonstration waivers).



Determining Provider Readiness

When deciding on a PBP approach, states must also consider level of provider readiness for advanced VBP implementation. This may include whether providers meet certain care delivery standards (e.g., advanced primary care capabilities, population health management capabilities) and/or have administrative capabilities and adequate financial reserves to manage risk-based contracts. Both across and within states, provider organizations vary in readiness to implement PBP models due to factors such as provider size and resources, states' history with VBP implementation, and provider participation in Medicare VBP models, such as the Medicare Shared Savings Program. States generally use stakeholder engagement during the design process to gain a high-level understanding of provider readiness across the state (see [*Engaging Stakeholders and Gaining Buy-in*](#) for examples of this process). Additionally, some states conduct more in-depth assessment of individual provider organizational readiness as a prerequisite for PBP participation. For example, **Washington State** is planning a structured process for assessing primary care practice capabilities that will impact payment structure, while **Colorado** allows providers to self-select the level of risk to take on without any formal assessment by the state.

In states with Medicaid managed care programs, MCOs often play a role in evaluating provider readiness, especially for plan functions delegated to providers as part of the PBP contract negotiation process, which is the case in **New York's** VBP Innovator Program. The VBP Innovator Program requires providers to handle some administrative responsibilities (e.g., utilization review, care management, and claims administration), but allows providers and MCOs to negotiate which entity would take on a range of additional administrative responsibilities (e.g., appeals and grievances, member/customer service, and network management).³⁴ Assessing provider readiness may be more critical for TCOC models than primary care or hospital-only models, as TCOC models hold providers accountable for some spending that is outside of their direct control and are therefore more likely to involve participating provider organizations in taking on new administrative functions.

States may also consider offering flexibility and support to providers to help them participate in a PBP model. Allowing flexibility in model elements, such as scope of services covered by PBP, level of financial risk, or timeline for implementation to accommodate different levels of readiness may encourage participation.^{35,36,37} Multiple interviewees described how providing upfront funding or technical assistance to support care delivery transformation or build data infrastructure can be important to help providers develop new capabilities to shift from FFS payments to PBPs. Such support may be particularly crucial for historically under-resourced providers and providers disproportionately serving populations experiencing health disparities.^{38,39} Provider readiness assessments can be used to inform the level of support states need to offer. A number of existing PBP models were developed with DSRIP funding (e.g., **Massachusetts**⁴⁰ and **New York**⁴¹) that allowed providers to invest in infrastructure to support their new models. States that built models without supplemental funding noted that this was a key challenge (**Pennsylvania, Colorado**), though design elements, such as **Pennsylvania's** technical assistance for hospitals, helped model participants build capacity to transform care.⁴² Other research has noted similar

difficulties in implementing models developed by the CMS Innovation Center, which typically do not include significant funding for infrastructure and health system transformation.⁴³

Policymaker Considerations: Determining Provider Readiness

- **Understand provider experience with VBP.** As part of the stakeholder engagement process, states should seek to understand provider experience with VBP, which will inform PBP model design and determine the level of flexibility and support providers need to encourage PBP model participation.
- **Target provider supports.** States should specifically consider how to support historically under-resourced providers and providers disproportionately serving populations experiencing health disparities when providing funding for capacity-building, technical assistance, or other provider supports.



Considering a Multi-Payer Approach to Increase Alignment

Multi-payer PBP models and/or multi-payer alignment are attractive to states. Interviewees in states with multi-payer models valued this collaboration highly — noting that providers need to reach a “tipping point” in terms of percentage of reimbursement within a payment model to substantively change how they do business and care for patients. As the LAN notes, “multi-payer alignment plays an important role in creating the business case for providers to adopt [VBP models] and change how care is delivered,” leading to greater provider engagement, including those who serve a small panel of Medicaid patients.^{44,45}

That said, state interviewees noted that getting buy-in for multi-payer models is challenging, and federal models may not be well-suited to the specific needs of Medicaid patients and providers, often because Medicaid is not part of these initial design conversations. However, the CMS Innovation Center has acknowledged this shortfall in their recent strategic refresh, and prioritized improving engagement with Medicaid and increasing Medicaid participation in their models.⁴⁶ There is also the risk that multi-payer models including individuals enrolled in both Medicare and Medicaid will lead to cost-shifting among payers — such as cost savings on hospital readmissions and inpatient stays accruing to Medicare rather than Medicaid.⁴⁷ For this reason, **Maryland** Medicaid monitors its TCOC model, an all-payer PBP, for cost-shifting.^{48,49}

In states that designed multi-payer PBP models, interviewees identified three key factors leading to success. First, these states noted that participation in federal models helped facilitate multi-payer alignment. Second, states identified the need for champions who advocate strongly for alignment — such as a large commercial payer that is interested in working with Medicaid to develop an aligned model. Finally, states noted the role of the governor and/or state legislature in helping to bring payers outside of Medicaid to the table.

Policymaker Considerations: Considering a Multi-Payer Approach to Increase Alignment

- **Explore multi-payer models to improve alignment.** While designing a multi-payer model is complex, and gaining buy-in is difficult, policymakers should consider designing multi-payer models where feasible, or aligning aspects of their Medicaid models with other payers to reduce barriers of entry for providers.
- **Prioritize Medicaid goals within multi-payer models.** When designing multi-payer models, CMS and the CMS Innovation Center should consider the needs of Medicaid — ensuring Medicaid is made part of the model design team in its early stages, and that model goals are appropriate for the Medicaid population.



Payment Model Design Elements

States will need to make several key decisions about what their PBP model will look like. Many of these answers will depend largely on the model goals, which should be informed by the stakeholder environment. Key decisions that are critical to the PBP model design process identified through interviews include: (1) defining the model goals and scope; (2) the plan to transition to a PBP model; (3) whether the model will be voluntary or mandatory; and (4) how rates will be set. Other decisions, such as which quality metrics are selected, how to incentivize quality improvement, governance of data exchange, care delivery requirements, patient attribution methodology, and more will also need to be addressed.^{50,51} However, interviewees noted that many of these details are likely to be similar to other VBP models, such as shared savings and pay-for-performance approaches, hence this report does not delve into these issues for PBP. On the other hand, the four design elements, identified above and described below, may need to be approached differently when designing a PBP approach. This section also addresses how to evaluate PBP programs to ensure that model goals are met since PBP models have few results to date and may not be evaluated independently of other models.

Defining Model Goals and Scope

Articulating and clearly prioritizing specific goals and orienting decision choices toward achieving those goals is key to successful implementation of PBP models. States should consider goals that will encourage political buy-in and muster resolve for multi-year change. One must-have goal for any VBP model is quality improvement. Many PBP models use or adapt existing VBP quality programs to fit their PBP models, which benefits states and participating providers by minimizing administrative burden and aligning quality incentives across all Medicaid programs and, hopefully, statewide. Cost savings, growth mitigation, and budget predictability are also common goals, and will influence the rate-setting process (for more information, see [Setting PBP Rates](#)).

States are also increasing their focus on health equity in PBP models by including health equity as a population health goal. PBP models in **Colorado**,⁵² **Massachusetts**,⁵³ **Maryland**,^{54,55} **New York**,⁵⁶ and other states are being built or updated to explicitly address health equity — and a growing number of resources can help guide future efforts.^{57,58}

Once the model goals are defined, the scope of the model must be considered. States are currently exploring three main types of PBPs: primary care, hospital, and TCOC models, though the scope of services included under these broad categories varies from state to state. Each of these three types of models has distinct goals and design features and can stand on their own; however, states that are interested in multiple domains can design complementary PBP models. For example, the **Maryland** TCOC Model started as a hospital PBP model, developed a complementary Medicare primary care model, and will soon include a Medicaid primary care model. Together, these models are designed to create accountability for TCOC statewide.⁵⁹ In **Massachusetts**, the state is working to develop a primary care PBP that operates within the MassHealth ACO Model.⁶⁰ However, stakeholders across the landscape generally agreed that while primary care PBPs, hospital PBPs, and TCOC PBPs may exist in the same state, primary

care PBPs should not be viewed as a gateway into broader PBP models — the goals and design elements of each scope of service are too different.

Model Scope of Services Comparison

Primary Care PBPs – States seeking to increase investment in prevention and primary care⁶¹ may be interested in a primary care PBP model. These models tend to focus on financial predictability for payers and providers, rather than controlling costs, as primary care is not a key driver of overall health system costs, and greater primary care investment could lead to reduced overall health system costs. Primary care PBP models are easier to design, and there are examples that policymakers can draw from, including the CMS Innovation Center’s CPC+⁶² and PCF⁶³ models. Primary care PBP models in Medicaid tend to use a hybrid payment mechanism that may help incentivize higher volume of under-utilized preventive care services while creating greater revenue stability than FFS payment.

Hospital PBPs – Hospital PBPs can vary significantly in program design, depending on the model goal. Some models may aggressively address costs of care,⁶⁴ while others may be primarily designed to provide stable revenue to keep rural or other struggling hospitals open.^{65 66}

TCOC PBPs – Due to its large scope, TCOC PBP models have the potential to achieve the greatest cost control, and advancement of quality improvement, population health, and health equity, but it is also the most complex option and requires long-term dedication. Medicaid TCOC models tend to be less generalizable from state to state. States seeking to use PBPs to address health care costs may be most interested in fully capitated TCOC models.

For detailed descriptions of the PBP models that informed this report, see the [Appendix](#).

Policymaker Considerations: Defining Model Goals and Scope

- **Set clear model goals.** States should develop a vision for what their model can do in the short-, medium-, and long-term. They should plan to increase provider accountability over time to continually advance progress on the model’s goals.
- **Leverage stakeholder partnerships.** Strong partnerships can help states develop compelling PBP model goals. Stakeholders will be more interested in participating in a model with goals that clearly work to solve a problem they are concerned about.
- **Select a PBP model to align with cross-stakeholder and VBP goals.** States should select a PBP model and scope that aligns with the goals developed by the state and its stakeholders. States with multiple VBP models should consider how new PBP models will align with existing incentives, payment streams, and quality measurements.



Transitioning to a PBP Model

States often have multi-year timelines to fully implement PBP models, recognizing that it takes time to build administrative infrastructure, transform care delivery, achieve cost savings, or meet other model goals. Implementation timelines for PBPs also tend to be long because these models are complex and a major shift for providers — many interviewees noted that their models were more complicated to design and implement than initially expected. In the early years of a model, policymakers may choose to support provider efforts by including time-limited upfront funding, starting with a measurement year that does not include cost or quality accountability, or both.

Hybrid models are common, especially in primary care, and may offer a gradual on-ramp to full PBP models. **Washington State's** goal is to start with a hybrid model for primary care and move these providers into fully capitated payment over time. **Colorado** is also exploring the possibility of a transition from a hybrid model to fully capitated payments. The state's APM 2 approach allows providers to choose how much of their total reimbursement is capitated vs. FFS payment (i.e., choosing their level of financial accountability),⁶⁷ and early enrollment saw providers split between taking nearly all payments as capitation and taking nearly all payments as FFS, based on their individual readiness.

Policymaker Considerations: Transitioning to a PBP Model

- **Set reasonable expectations for change.** States and CMS should have realistic expectations for the speed of transformation, including a reasonable timeline to expect improvement or results.
- **Consider offering additional financial supports.** States and CMS could potentially offer funding for capacity-building and infrastructure changes for providers in PBP models.
- **Develop models with an on-ramp to increased accountability.** States should consider how to design models with a variety of starting points for quality and cost accountability based on provider experience participating in VBP models. Models might include an on ramp for all participants (e.g., starting with a measurement-only year) or allowing advanced providers to opt into an accelerated timeline.



Determining Voluntary or Mandatory Participation

One of the key debates regarding VBP models is whether participation should be mandatory or voluntary. Voluntary models are likely to get less participation, but are easier to implement and allow providers to determine their own readiness to participate. Mandatory models get widespread participation, and therefore may be more impactful, but are likely to face stronger stakeholder opposition. Mandatory models may also require providers to participate before they are ready to succeed, or the state may choose to be less ambitious in model design to enable all providers to participate successfully. Further, consensus is building that it may be harder to achieve cost savings through voluntary models than mandatory models.⁶⁸

PBPs are certainly part of this discussion, and as very advanced VBP models, the stakes may be even higher as these models require more sophisticated infrastructure to be successful. Participating providers could become financially unstable if they are unsuccessful, and rigid models could potentially drive providers away from accepting Medicaid enrollees. To date, most Medicaid PBP models have been voluntary for providers, but some states, like **Washington State**, have indicated a willingness to transition from a voluntary to a mandatory model over time. Many state interviewees cited the participation of safety net providers, such as public hospitals and FQHCs, as a reason to make programs voluntary, since the financial risk of a PBP model may be more precarious for these historically underfunded providers.

In addition to making the model mandatory or voluntary for providers, managed care states need to decide whether to mandate participation for Medicaid MCOs. While allowing for voluntary participation among MCOs can be helpful for gaining buy-in, making the MCOs voluntary participants in a model that they may not support could essentially give them “veto power” over the model, no matter what number of providers are willing to participate. Some Medicaid managed care states have taken a different approach on mandatory participation for MCOs, as **Maryland, New York, and Pennsylvania** all have some requirements for MCO participation in their PBP approaches.⁶⁹

Policymaker Considerations: Determining Voluntary or Mandatory Participation



- **Consider key factors to guide model type.** When deciding on a voluntary or mandatory PBP model, states should consider their PBP model goals, the state’s provider and payer readiness, and what is politically possible given stakeholder positions. If VBP models already exist in the state, participation in those models may also be a determining factor in the decision.
- **Don’t rule out mandatory approaches.** While many CMS and Medicaid models have been largely voluntary to participate in, mandatory models are possible at a state or federal level, and could be considered if CMS or Medicaid would want a large model capable of making a more significant impact.

Setting PBP Rates

States with existing Medicaid PBP models have varied approaches to rate setting based on state-specific considerations. Key aspects of the rate-setting process include the scope of services, benchmarking, growth rate, risk adjustment, and whether the rates maintain ties to FFS payment. Policymakers designing a PBP model will need to determine an approach that will produce a fair, sustainable rate for participating provider organizations that will generate savings potential for the payer. Any rate-setting approach should include ample justification, as transparency is essential to alleviating provider concerns.

The PBP rate should cover the complete scope of services defined by the model. Primary care PBPs, such as those in **Colorado, Washington State**, and others include payment for primary care services, though states may also opt to include behavioral health services, care coordination/care management services,

and other services delivered in a primary care setting or by PCPs. TCOC models always broadly include physical health services (including primary care, hospital inpatient and outpatient services, and specialty care), and some models include behavioral health care and pharmacy costs. Long-term supports and services are less common. State decisions on what services are included are important, as models with certain costs carved in or out of the scope could create perverse incentives such as cost shifting to alternative settings or weakened incentives for certain providers or sectors to participate in the model.

Determining how the rates are calculated is also critical. The rates might be based on historical utilization (e.g., the last three years of costs under FFS), optimal utilization (e.g., a global budget for the provider), an individual providers' costs, average costs across the state, or a national benchmark. The growth rate will also need to be established, which will likely depend on historical trends in the state or nationally, as well as the PBP program goals. While health care costs are generally not expected to decrease over time, a rate lower than inflation can help curb relative costs. Under the **Maryland** TCOC Model, all-payer per capita hospital growth is limited to 3.58 percent per year.⁷⁰ One common hesitancy for providers and payers to participate in a PBP model is the fear that if they consistently reduce costs, their rates would be adjusted downward when rates are rebalanced. States can alleviate these concerns by including provisions that clearly state that this would not be the case, such as by taking rate decreases off the table, or establishing a clear corridor of ranges that can exist.

Risk adjustment is another critical element of the rate-setting process. If it is done well, it can mitigate the risk of adverse selection, which has great potential to exacerbate health disparities. While medical risk adjustment processes are common and well-established, they still need to be done well for the rates to reflect expected effort needed to serve each attributed patient with the amount of care necessary. Being as transparent as possible with this methodology may increase stakeholder buy-in. In addition to medical risk adjustment, many states are considering social risk adjustment for their PBP models, and two have done so. **Massachusetts** has implemented adjustments for housing insecurity, serious mental illness diagnosis, substance use disorder diagnosis, disability, rural residency, and neighborhood stress score^{71,72} into its rate calculations, and the state has been pleased with the accuracy of the results. **Minnesota** also uses a socially risk adjusted PBP that acts as an upfront payment for the state's accountable care organization (ACO)-like Integrated Health Partnerships model. **Minnesota** includes many different factors in its calculation, including substance use disorder, serious mental illness, homelessness, past incarceration, deep poverty, and involvement with child protective services.⁷³ State interviewees observed that serious mental illness and substance use disorder had the greatest effect on cost of care and were not adequately accounted for in medical risk calculations, while deep poverty had the lowest impact. While these pioneering models have successfully implemented social risk adjustment, their approaches are still new, and states and stakeholders worry about the accuracy of adjustments, availability of individual-level data via Z-codes or other sources, and potential perverse incentives that may exacerbate health disparities.⁷⁴

Another factor that is critical to consider is the extent to which a PBP rate-setting process truly breaks free from the FFS payment architecture. PBPs offer immense flexibility to providers relative to FFS payments, but if rates are initially calculated or continuously reconciled with historical or current FFS equivalents, they will not be truly independent from the FFS construct. The majority of existing PBP models still reconcile rates back to FFS payment in some way, due to CMS waiver/SPA requirements or actuarial soundness requirements. While FFS payment reconciliation reduces the risk that providers will withhold care for patients due to the PBP structure, a well-designed set of quality metrics and incentives could serve the same purpose without limiting the PBP's potential for flexibility or to reduce administrative burden. Such reconciliation approaches may further codify existing health disparities that drove utilization in prior years due to lack of health care access, health-related social needs, and other factors.⁷⁵
^{76 77} Breaking free from FFS payments could also create additional cost accountability, as providers in PBP arrangements typically have supplemental payments awarded to them based on FFS reconciliation, which could negatively impact the incentive to reduce costs.

Policymaker Considerations: Setting PBP Rates

- **Justify rate-setting decisions.** The PBP rates and risk adjustment methodologies that are being developed will need to have ample justification for how they are designed, and why they are designed that way.
- **Consider all facets of risk adjustment, including social factors.** Risk adjustment is a critical element of the rate-setting process. While medical risk adjustment is a long-standing best practice, states should also consider social risk adjustment. While there may be some growing pains, states could start slow and build in social factors gradually over time. The potential benefit of doing so may outweigh the risks of not getting it right immediately.
- **Explore opportunities to move away from FFS reconciliation.** Part of the advantage of PBPs is the degree of separation from the FFS payment architecture and its volume-based incentives. While CMS may require FFS reconciliation in some models, both CMS and states may want to consider moving away from FFS reconciliation in the long term.



Evaluating the PBP Model

The current evidence on the impact of state PBP models is limited. Of the 11 PBP models reviewed in this analysis, only models in three states — **Maryland**, **Massachusetts**, and **Vermont** — and CPC+'s Medicare component currently have cost or quality results for their programs, and **Pennsylvania's** model has anecdotal findings from early evaluations. Even in these cases, results are limited to the first few years of program implementation and some results are limited to Medicare populations. Early results from these state models suggest that TCOC models have promise to generate costs savings. State primary care PBP models are too early in development for results, but CPC+ Track 2 results suggest these models may increase overall spend, depending on how much primary care payment is increased. Across models, impact on quality is mixed, with evaluations most commonly showing that quality measures either

remain stable or improve. There is also some evidence that PBP models helped stabilize provider finances during the COVID-19 pandemic (see [State Profiles](#) and the [Appendix](#) for more details on evaluation results for PBP models).

Further evaluation for PBP programs is needed to fully understand outcomes such as quality, cost, patient experience, and health disparities. Notably, the CMS Innovation Center’s recent strategy refresh highlights the need for increased focus of VBP evaluations on health equity impacts.⁷⁸ Increased evidence is also needed to help policymakers understand the implications of PBP design choices, including how factors such as scope of PBP model (e.g., TCOC vs. limited scope), level of risk (e.g., fully PBP vs. hybrid models), and multi-payer participation impact outcomes. One reason for limited evidence is the relatively limited uptake of PBPs at the state level, particularly for primary care models. Specifically, many of the primary care PBP models reviewed in this analysis are still being designed or were recently implemented. While the hospital and TCOC models reviewed have been in existence for longer, the time required to process health care claims and analyze cost and quality data means evaluation results are generally not available until years after a model is launched.

The COVID-19 pandemic also skewed the results for states that were operating PBP models prior to 2020, creating an environment where year-over-year performance on cost and quality were largely impossible to track. Interim evaluations of only the first few performance years give an incomplete picture of model performance, particularly considering that it may take multiple years for providers to change care delivery practices and produce a return on investment in VBP models.^{79,80,81}

Finally, states often have limited resources for conducting evaluations. Notably, **Maryland, Pennsylvania,** and **Vermont’s** evaluations were funded by CMS, as these were Innovation Center models, and the **Massachusetts** evaluation is a requirement of DSRIP. States without such federal support or requirements for evaluation may not prioritize or have funding for robust program evaluations. Compounding this issue is that PBP models are often implemented alongside other state VBP initiatives or care delivery system reforms. In some cases, states evaluating broad Medicaid reforms may not evaluate the impacts of PBP approaches specifically. For example, **New York** had a program evaluation for its DSRIP waiver, but the evaluation did not break out the performance of the VBP Innovator Model from the overall results.


Policymaker Considerations: Evaluating the PBP Model

- **Prioritize PBP model evaluation.** Additional evaluation is essential to building the evidence base on best practices for PBP model design and PBP model impact on quality of care, patient experience, health disparities, and cost.
- **Provide federal funding for PBP evaluation.** Federal policymakers should consider providing additional funding to support enhanced Medicaid PBP program evaluations.



Conclusion

While PBPs hold great potential to accomplish many goals for state Medicaid agencies, there are limited examples currently available. Existing examples vary in size, scope, and approach, and many of those examples are relatively new and are still awaiting results. The results that are available for Medicaid populations, however, are promising, and these PBP models make intuitive sense to significantly reduce costs, improve quality, improve patient and provider experience, and advance health equity — all things that the current FFS delivery system has failed to do within Medicaid. Even more well-established VBP approaches like pay-for-performance and shared savings models have only made small improvements in delivery of care and cost reductions for Medicaid populations, though the stronger incentives in a PBP model may generate greater results. While more time is needed to see how PBP models fare, states are increasingly interested in pursuing PBP models, and it seems likely that more will develop over time.



State Profiles: Population-Based Payment Approaches

Colorado: Alternative Payment Model 2

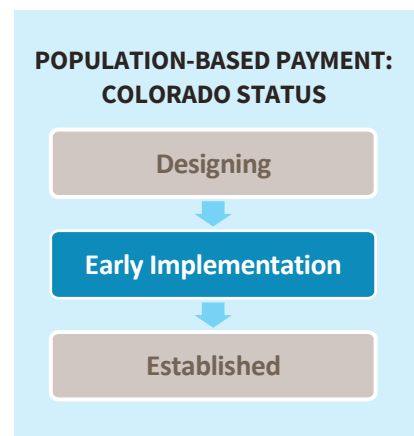


KEY TAKEAWAYS: Colorado’s APM 2 focuses on increasing flexibility and financial stability for PCPs while containing Medicaid costs for people with chronic conditions. The state plans to maximize impact of the approach by moving toward automatic enrollment in primary care capitation in Medicaid and developing an aligned multi-payer approach by 2025.

Colorado’s APM 2 is a partially capitated primary care model that was influenced by the state’s participation in the federal CPC+ model.⁸² It pays part of the primary care reimbursement as a capitated payment and the rest through FFS.⁸³ Launched in January 2022, the model has 14 participating provider organizations as of August 2022, with approximately 225,600 attributed members — about 15 percent of the state’s total Medicaid enrollment.⁸⁴

Technical Details

Payment Design. There are two parts of this model — a PBP and gainsharing payments. First, PCPs are paid through a mixture of capitated and FFS payments. Capitated payment rates are based on historical claims over the last two years. Since PCPs vary in their level of sophistication with VBP, PCPs self-assess their capacity to participate in this model and select what percentage of their payment is capitated (including the option to take no capitated payments), with the ability to adjust that percentage upward or downward over time. About half of early adopters opted into fully capitated payments, while the other half opted into very low percentages of capitated payments. Providers receiving fully capitated payments must record their claims to decrease risk of underutilization⁸⁵ and to support reconciliation back to FFS payments. Second, the model focuses on controlling costs for patients with chronic conditions by allowing PCPs to earn gainsharing payments (often referred to as shared savings) by decreasing TCOC for their panel of patients with one or more of 12 chronic conditions. FQHCs can participate in the capitated payment portion of the model, and Colorado is currently seeking approval from CMS to allow FQHCs to join the gainsharing part of APM 2.



Data Sharing. The state has appropriated funds to build a freely available data dashboards that will help PCPs track and address utilization in real-time. This is designed to help PCPs manage TCOC for patients with qualifying conditions.

Quality Measurement. APM 2 uses the same quality approach as its predecessor, APM 1. PCPs are accountable for 10 quality metrics from a set of 30 — three mandatory measures and seven PCP-selected metrics. PCP-selected metrics can include process or outcome measures.⁸⁶ PCPs must meet a quality threshold to be eligible for gainsharing payments and can earn an enhanced capitation rate based on quality performance.⁸⁷

What’s Next?

In the short-term, Colorado expects increased provider enrollment in APM 2. In the medium- and long-term, Colorado is pursuing automatic enrollment with an opt-out option in APM 2 by 2025 and is exploring the possibility of moving the program from a partially capitated program to fully capitated. The state also passed a law to work toward a commercial primary care APM, which will likely be developed in alignment with APM 2.⁸⁸

Maryland: Total Cost of Care Model

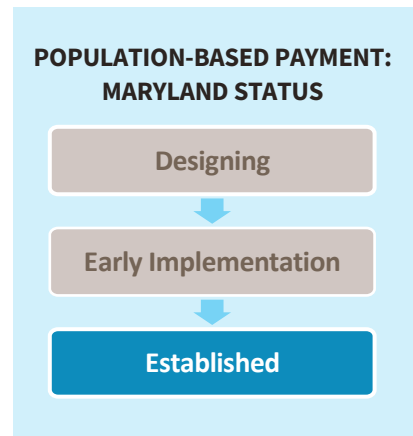


KEY TAKEAWAYS: Maryland’s all-payer rate setting and all-payer model approaches were groundbreaking moves toward hospital PBPs and have improved quality and lowered health care expenditures. Building on the hospital model, the TCOC model seeks to further align incentives between primary care, hospitals, and their partners toward high value preventive care.

The Maryland TCOC model is a multi-payer partnership between the CMS Innovation Center and Maryland, building on the state’s long-standing efforts to manage hospital expenditures, including the adoption of an all-payer rate setting system in 1977 and the 2014-2018 All-Payer Model for hospitals.^{89,90} The TCOC model was implemented in 2019 to build on the All-Payer model, and includes three parts: (1) an all-payer hospital PBP; (2) care redesign programs; and (3) a partially capitated primary care program.⁹¹ Under this model, Maryland is accountable to CMS for statewide TCOC for Medicare Parts A and B. All acute care hospitals in the state are part of the TCOC model, and 508 practices providing care for approximately 50 percent of all eligible Medicare FFS beneficiaries participate in the primary care program.⁹² The state is currently designing a Medicaid alignment approach to the primary care program.

Technical Details

Payment Design. Hospitals are paid a PBP for all patients, with consistent rates across Medicare, Medicaid, and commercial payers. The PBP amount is based on historical utilization, and adjusted annually based on several factors.⁹³ Hospitals are also held accountable for TCOC of Medicare patients — which includes non-hospital spending.⁹⁴ In 2017, care redesign programs were added, allowing hospitals to spend some of their savings on incentive payments to non-hospital partners to help achieve their care delivery goals.⁹⁵ Medicare’s Maryland Primary Care Program (MDPCP) was launched in 2019⁹⁶ and Maryland’s Medicaid agency is currently developing an aligned primary care program. The state’s dominant commercial payer also has a primary care model aligned with MDPCP.⁹⁷



Quality Improvement. Under the TCOC model, Maryland’s Health Services Cost Review Commission develops performance-based payment programs, including a hospital quality program aligned with the goals of Medicare’s hospital VBP programs.^{98,99} Medicare, commercial payers, and Medicaid each select quality metrics and incentives in their respective primary care models, designed to complement the state’s population health goals.¹⁰⁰

Results to Date. Maryland’s TCOC model has outperformed CMS’ cost savings and hospital acquired conditions performance targets for its first three of its performance years. In 2019 and 2020, the model also met performance targets for hospital readmissions, but did not meet this target in 2021.¹⁰¹

What’s Next?

Maryland is currently designing and improving the primary care component of its TCOC model. The Medicare primary care model has been updated to add a new track starting in 2023, which increases financial accountability for participating providers,¹⁰² and Medicaid is working to develop its aligned primary care program. The state and the CMS Innovation Center hope to see increased commercial payer participation in aligned primary care models.

Massachusetts: Accountable Care Partnership Plans



KEY TAKEAWAYS: Massachusetts’ Accountable Care Partnership Plans model shows how states can implement a statewide TCOC PBP model through Medicaid managed care. The model also demonstrates how states can incorporate social risk adjustment into PBP arrangements.

Beginning in 2018, Massachusetts Medicaid (MassHealth) launched an ACO model as part of a broader set of care delivery reforms and health system investments implemented through an 1115 waiver.¹⁰³ Eligible members choose to enroll in a specific ACO as part of MassHealth enrollment.¹⁰⁴ One of three ACO types is an Accountable Care Partnership Plan (ACPP), in which providers and an MCO partner to form an ACO that is paid through a PBP arrangement. As of 2020, over 640,000 MassHealth members were enrolled in 13 ACPP ACOs — about 38 percent of MassHealth enrollment.¹⁰⁵

Technical Details

Payment Design. ACPPs are paid a capitated PMPM rate, which includes physical health, behavioral health, and pharmacy services, as well as an administrative component. If spend is below the capitated rate, ACPPs may keep savings if quality benchmarks are met; if spend is above the rate, losses may be mitigated by quality performance.¹⁰⁶ In 2023, ACOs can earn an incentive payment of up to 1.5 percent (not tied to cost) for quality and health equity performance.

Administrative Requirements. Since ACPPs are composed of an MCO and providers, they are responsible for both MCO and provider functions, including managing provider networks, paying claims, and care coordination.^{107,108,109}

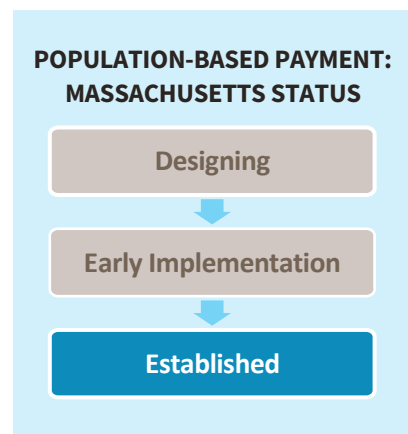
Quality Measurement. MassHealth defined a set of 22 quality measures, which began as pay-for-reporting but have shifted to pay-for-performance over the course of the program.¹¹⁰

Social Risk Adjustment. In addition to medical risk adjustment, capitated payments are risk-adjusted for social risk factors. Social risk adjustment factors include measures of disability, behavioral health diagnosis, housing instability/homelessness, living in a rural area, and Neighborhood Stress Score.¹¹¹

Results to Date. Evaluation results are available from the first three years of the ACO program. In 2018 and 2019 survey results, most ACO members reported positive care experiences. During the same years, there was evidence of shifts in care use toward lower-cost outpatient settings. Clinical outcomes, hospitalization rates, and self-reported health ratings generally improved or remained stable.¹¹² Most ACPPs exceeded their capitation rates in 2018 and 2019, which was largely driven by a rise in member acuity.^{113,114} 2020 results are challenging to interpret, due to COVID-19 disruptions.¹¹⁵

What’s Next?

Massachusetts recently received approval from CMS for its 1115 waiver extension for 2022-2027, through which the state will increase investment in primary care via sub-capitated primary care payments, enhance ACO expectations related to investing in and supporting pediatric care, and hold ACOs accountable for measuring and reducing health disparities.¹¹⁶



New York: Value-Based Payment Innovator Program



KEY TAKEAWAYS: New York’s VBP Innovator Program requires less administrative support from the Medicaid agency than broader PBP models in other states, making it an efficient and generalizable model for states interested in piloting PBP.

New York developed a VBP Roadmap under its Delivery System Reform Incentive Payment (DSRIP) waiver, laying out options to increase adoption of VBP models in Medicaid managed care.¹¹⁷ The state sets participation criteria for specific VBP models, allowing provider organizations to demonstrate their readiness to take on specific levels of financial risk and accountability for patient outcomes. One of these options is the VBP Innovator Program, a PBP designed to allow experienced provider organizations to take on full financial risk and responsibility for some functions typically handled by MCOs.¹¹⁸ If a provider organization applies for and is approved as an Innovator, it may pursue Innovator contracts with MCOs. The program launched in 2018, and four provider organizations in New York were named Innovators.

Technical Details

Payment Design. In this program, MCOs are required to pass 90-95 percent of premiums to the Innovator. The amount passed through and which administrative tasks the Innovator takes on are decided during contract negotiations.¹¹⁹

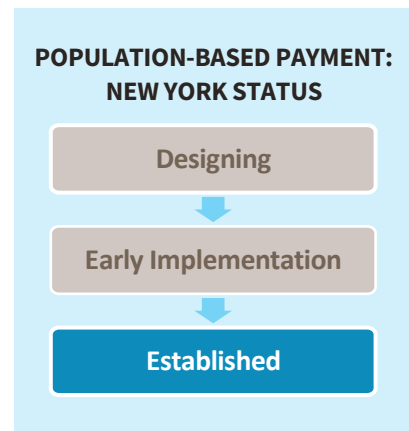
Administrative Requirements. New York sets baseline administrative requirements for Innovator organizations, which must at a minimum take responsibility for: (1) utilization review; (2) utilization management; and (3) disease management. Innovators must also share responsibility for at least five additional administrative tasks that the Innovator and MCO must agree upon. To achieve the maximum 95 percent of premium, Innovators must also be responsible for claims administration and credentialing.¹²⁰

Attribution. Innovators must have 25,000 members attributed for a general population TCOC contract (i.e., responsibility for total care of all attributed members), or 5,000 members for a subpopulation TCOC contract (i.e., responsibility for total care for members with a specific condition which may require special services or incur higher costs).¹²¹ Members are attributed based on MCO-assigned primary care physician.

Quality Measurement. Innovators and MCOs select their own quality metrics, but participants in the VBP Innovator program must include at least one quality measure recommended by New York’s DSRIP Clinical Advisory Groups for each subpopulation covered by the model. Innovators must perform at or above average on quality metrics to continue participation in the program.

What’s Next?

Through development of its 1115 waiver renewal,¹²² New York hopes to build on the VBP Innovator program to pursue a greater focus on population health, health equity, and health-related social needs. The state sees growing interest in global budget programs like the VBP Innovator program that could operate on a regional level, increasing provider accountability and hopefully engaging new patient populations in VBP.



Pennsylvania: Rural Health Model



KEY TAKEAWAYS: The Pennsylvania Rural Health Model is an innovative and successful global budget approach that could serve as an example for other states seeking to offer their rural hospitals a predictable and sustainable revenue stream.

The Pennsylvania Rural Health Model (PARHM) is a collaboration between the Pennsylvania Department of Health and the CMS Innovation Center that began in 2019 and runs through 2024.¹²³ Pennsylvania’s state legislature established the Rural Health Redesign Center (RHRC), an independent entity to manage the program.^{124,125} This all-payer program pays 18 participating rural hospitals a global budget designed to deliver a predictable revenue stream to rural hospitals that is sufficient to encourage care transformation, quality improvement, and preventive care. As of 2021, the program served approximately 1.3 million Pennsylvanians.¹²⁶

Technical Details

Payment Design. The model pays participating rural hospitals a global budget that covers all inpatient and outpatient hospital-based services. Physician fees at the hospital are not included. The global budget is based on hospitals’ historical net revenue for these services, and participating Medicare, commercial, and Medicaid payers pay their respective portions of the overall budget to the hospital.¹²⁷

Participation. Participation is voluntary, but widespread. Rural hospitals, especially those that are independent, face financial struggles nationwide, and many in Pennsylvania saw PARHM as an opportunity to stabilize their revenues and use the predictable funding stream to innovate within their systems (e.g., by developing a hospital-based care management program). Interest in the model increased during the COVID-19 pandemic, as five new hospitals began to participate in the program in 2021. Six payers currently participate in the program, including Medicare FFS and five MCOs, which offer commercial, Medicare and/or Medicaid coverage.¹²⁸

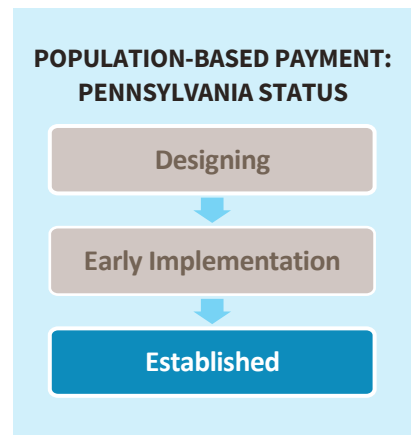
Quality Measurement. The model currently monitors eight statewide quality measures.¹²⁹ The RHRC’s efforts to develop its own All-Payer Quality Program was interrupted by the COVID-19 pandemic.

Collaboration Among Participants. Hospitals participating in the model must develop a transformation plan to indicate how they will improve quality and population health outcomes.¹³⁰ The RHRC provides technical assistance and facilitates learning opportunities for hospitals to discuss insights, implementation strategies, and challenges.

Results to Date. Evaluations of the program found that global budgets helped stabilize the finances of participating hospitals, especially during the early portion of the COVID-19 pandemic.¹³¹ Impacts on quality have not yet been assessed.¹³²

What’s Next?

Formal recruitment to the program has concluded, and will continue with the 18 hospitals and payers that have on-boarded to the voluntary program.



Washington: Multi-Payer Primary Care Transformation Model



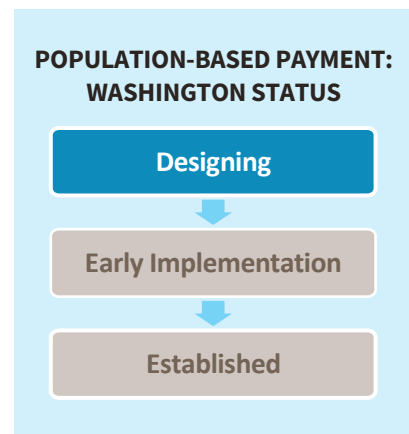
KEY TAKEAWAYS: Washington’s Primary Care Transformation model is an example of how states can develop a multi-payer primary care PBP model that includes Medicaid managed care. Washington State also provides an example of a stakeholder engagement process that other states can emulate.

In 2019, Washington Health Care Authority (HCA) began the process of designing a multi-payer Primary Care Transformation Model (PCTM). PCTM will complement HCA’s history of encouraging VBP through managed care and its broader goals of implementing more advanced VBP models across public purchasing programs.¹³³ Through an extensive multi-stakeholder engagement process, HCA is developing a model that will support quality improvement and payment alignment across Medicaid managed care, public employee, and commercial plans.¹³⁴ In August 2020, HCA and eight additional payers signed a non-binding memorandum of understanding committing to implement and comply with all components of the model.

Technical Details

Payment Design. PCTM payment depends on practice certification level; practices will have the opportunity to earn higher payment at higher certification levels.

- **Level 1 practices** will receive additional per-member per-month Transformation Payments along with their typical FFS payments. Practices may receive these Transformation Payments for up to three years to help build capacity to transform care, based on committing to make progress on specific practice transformation measures.
- **Level 2 practices** will receive Transformation Payments and, potentially, a hybrid FFS/PBP to gradually transition to Level 3 payment. Practices are also eligible for performance-based quarterly Quality Incentive Payments.
- **Level 3 practices** will be paid through Prospective Comprehensive Care Payments (PCCP) along with Quality Incentive Payments. PCCP payments are PMPM payments to cover a comprehensive set of primary care services, including some behavioral health services delivered in primary care settings.



Care Delivery Requirements. The PCTM will require participating providers to demonstrate specific competencies across 10 domains. The model will include a centralized process for certifying providers that meet defined competencies — including the three levels of certification to accommodate provider readiness and support providers in the care delivery transformation process. Payers will be expected to support practices by aligning on a payment model, data sharing, member attribution principles, and other practice supports.¹³⁵

Quality Measurement. The HCA Primary Care Measure Set Workgroup defined a core set of 12 measures for inclusion in payer and provider contracts.¹³⁶

What’s Next?

Implementation of PCTM will begin in January 2023.



Appendix

Select State Medicaid Population-Based Payment Models

The following table summarizes select Medicaid PBP models that focus on TCOC, hospitals, or primary care. The models included are either full PBPs or hybrid models. This does not include programs that have a supplemental capitated payment without any decrease in FFS (e.g., the addition of a care management fee, as in the original [Comprehensive Primary Care Initiative](#) [CPC]).

STATE / MODEL STATUS	DESCRIPTION	RESULTS
<p>Colorado APM 2 Primary care model in FFS delivery system - Implemented January 2022, State Plan Amendment pending CMS approval</p>	<p>Payment streams: Hybrid or full PBP, based on provider selection. Additionally, gainsharing payments can be earned by decreasing TCOC of patients with a qualifying chronic condition. Quality incentive: Can earn an enhanced capitation rate based on quality. Must meet a quality performance threshold to be eligible to earn gainsharing payments. Payer participation: State law requires aligned commercial model development by 2025.¹³⁷</p>	<p>No results yet — model is in early implementation.</p>
<p>Maine PCPlus Primary care model in FFS delivery system - Implemented July 2022, using a State Plan Amendment¹³⁸</p>	<p>Payment streams: Phase 1 of the model adds a monthly PBP on top of FFS payments. Phase 2 of the model will shift to a hybrid PBP. Quality incentive: Quality performance impacts the performance-based adjustment used to calculate the PBP.¹³⁹ Payer participation: Developed to align with Primary Care First, a CMS Innovation Center model that will include Medicare and may include commercial payers.</p>	<p>No results yet — model is in early implementation.</p>
<p>Maryland Maryland Total Cost of Care Model TCOC model in MCO delivery system - Implemented 2019 in partnership with the CMS Innovation Center;¹⁴⁰ Medicaid Primary Care Model under development will use that authority</p>	<p>Payment streams: Medicaid payments to hospitals are paid through a PBP by MCOs. Primary care model is envisioned to be a hybrid payment. Quality incentive: Hospitals participate in a statewide quality program, which includes all payer accountability on the majority of measures.¹⁴¹ Medicare, commercial payers, and Medicaid each select quality metrics and incentives in their respective primary care models, to complement the state's population health goals.¹⁴² Payer participation: The model includes Medicare, Medicaid, and commercial payers.</p>	<p>MD exceeded targets related to Medicare cost savings, all-payer hospital costs, hospital acquired conditions, and hospital readmissions in 2019 and 2020. In 2021, MD exceeded all targets except readmissions, which exceeded national growth for the first time in 7 years.¹⁴³</p>
<p>Massachusetts Accountable Care Partnership Plan TCOC model in MCO delivery system - Implemented 2018, using an 1115 waiver¹⁴⁴</p>	<p>Payment stream: PBP that covers all care provided by the ACO. Additionally, an embedded primary care PBP has recently been approved and will launch in 2023.¹⁴⁵ Medicaid MCOs and provider organizations contract together to form an ACO. Quality incentive: ACOs report on 22 quality measures as part of a pay-for-performance program.¹⁴⁶ Payer participation: Medicaid-only model.</p>	<p>In 2018 and 2019, there was evidence of shifts in utilization toward outpatient settings. Clinical outcomes, self-reported health and hospitalization rates generally improved or remained stable. In the first year, average expenditures across all ACO types exceeded benchmarks, though 9 of 17 ACOs spent below their benchmark.¹⁴⁷</p>
<p>New York VBP Innovator Program TCOC model in MCO delivery system - Implemented 2018, under existing 1115 waiver¹⁴⁸</p>	<p>Payment stream: MCOs pass 90-95% of premiums through to contracted provider organizations. Provider organizations must perform some administrative tasks typically performed by MCOs. Quality incentive: Must meet a quality threshold to participate in the program. Payer participation: Medicaid-only model.</p>	<p>No evaluations of the VBP Innovator program have been done to date.</p>

STATE / MODEL STATUS	DESCRIPTION	RESULTS
<p>Pennsylvania Rural Health Model Hospital model in MCO delivery system - Implemented 2019 in partnership with the CMS Innovation Center¹⁴⁹</p>	<p>Payment stream: Hospitals are paid a PBP for all hospital-based services by MCOs. Quality incentive: The model currently monitors eight statewide quality measures.¹⁵⁰ Payer participation: All significant payers in the state participate in the model, including Medicare.</p>	<p>The PBP helped stabilize the finances of participating hospitals, especially during the uncertainty of COVID-19. Impacts on quality have not yet been assessed.¹⁵¹</p>
<p>Vermont All-Payer ACO Model TCOC model in FFS delivery system - Implemented 2017 in partnership with the CMS Innovation Center, using an 1115 waiver¹⁵²</p>	<p>Payment stream: The sole ACO participating in the model, OneCare Vermont, is paid through VBP arrangements. Vermont Medicaid provides unreconciled fixed PBPs to certain providers participating in the ACO. Quality incentive: A set of quality measures, some aligned across payers and some payer-specific, which includes pay-for-reporting and pay-for-performance incentives.¹⁵³ Payer participation: Medicaid, Medicare, and commercial payers participate in the model.</p>	<p>A non-statistically significant reduction in net Medicare spending for the ACO and reductions in acute care utilization and readmissions were observed over two program years.^{154,155} State surveys found mixed results on cost and quality,^{156,157} but PBPs aided providers during COVID-19.¹⁵⁸</p>
<p>Washington State Multi-Payer Primary Care Transformation Model Primary care model in MCO delivery system - Under development, planning to use managed care authority</p>	<p>Payment stream: Three certification levels offering hybrid or full PBP, based on provider readiness. Payments will be made by MCOs. Quality incentive: Model participants will be able to earn performance-based incentive payments by performing well on 12 quality metrics.¹⁵⁹ Payer participation: The model is being designed in partnership with Medicaid, state employee, and commercial payers who all intend to participate.</p>	<p>No results yet — model is in the design phase.</p>
<p>CMS Innovation Center Comprehensive Primary Care Plus (CPC+) Primary care model - Implemented 2017, completed 2021. Medicaid programs in AR, CO, MT, OH, OK, OR, and TN participated</p>	<p>Payment stream: Track 2 PCPs received a hybrid of PBP and FFS payments. They also received Care Management Fees paid out as a PMPM. MCO role depends on the state. Quality incentive: Prospectively paid and retrospectively reconciled performance-based payments. Payer participation: Designed as a multi-payer model. In the participating states, Medicare and Medicaid chose to participate. In many states, commercial payers also participated.</p>	<p>Over four years, Track 2 practices saw reductions in utilization though impact on quality measures was mixed. When including the enhanced CPC+ payments to providers, the model increased total Medicare FFS costs by 2.6%.¹⁶⁰</p>
<p>CMS Innovation Center Primary Care First (PCF) Primary care model - Implemented 2021. Many Medicaid models are still under development; Medicaid programs in LA, ME, MT, and OH participate or plan to</p>	<p>Payment stream: Hybrid of PBP and flat fee-per-visit payments. MCO role depends on the state. Quality incentive: Performance-based adjustment on model payments Payer participation: Designed as a multi-payer model. In the states mentioned, Medicare and Medicaid chose to participate. In many of these states, commercial payers also participated.</p>	<p>No results yet — model is in early implementation.</p>
<p>CMS Innovation Center Community Health Access and Rural Transformation (CHART) Model Hospital model - Selected regions, and will begin implementation 1/2023, with Medicaid alignment targets starting 1/2024; Medicaid programs in SD, TX, and WA will participate</p>	<p>Payment stream: PBP for hospital services based on prior utilization for each Participant Hospital Quality incentive: Performance-based adjustment on the Payer participation: State Medicaid agencies participating in the model are required to be an aligned payer.¹⁶¹</p>	<p>No results yet — model is in early implementation.</p>

ENDNOTES

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