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Accelerating the Adoption of Value-Based Payment in Medicaid by Linking Delivery System Reform to Managed Care Payment

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Summary

To improve the quality of health care and patient outcomes and slow growth in spending, state Medicaid programs are pursuing a variety of strategies to reform the health care delivery system. Payment reform is a defining feature of these strategies. Like private payers, Medicaid agencies are trying to move away from the fee-for-service model, which reimburses health care providers based on the volume of services they deliver. Instead, agencies are moving toward value-based payment (VBP) arrangements that reward providers for better outcomes.

This brief examines how 10 states are seeking to accelerate the use of VBP—and sustain the delivery system reforms achieved through Medicaid section 1115 demonstrations—by setting requirements or targets for managed care plans (MCPs) to contract with network providers using VBP arrangements. We compare how states design the interaction and sequencing of provider delivery reforms with VBP goals for MCPs. We also assess the extent to which state policies align the incentives to increase the use of VBP for both providers that receive delivery reform funding and MCPs.

It is too early to know which mix of policies is most effective in advancing VBP, and other factors—such as continued use of supplemental Medicaid payments to providers—may dampen VBP incentives. However, in 2018 and 2019, the 10 states in this study began to hold health plans, providers—and, in some cases, the state itself—accountable for reaching VBP goals. To compare states' progress fairly, it is important to consider how their goals differ with respect to the level and pace of VBP adoption, how much financial risk providers must assume to reach VBP goals, and the extent to which strategies to promote VBP by safety net providers and MCPs are mutually reinforcing.

I. Introduction

State Medicaid agencies are implementing a wide array of delivery system and payment reforms designed to contain rising Medicaid costs and improve the quality of care and outcomes for Medicaid beneficiaries. In 2019, 44 states reported having at least one—and sometimes several—initiatives designed to reform care delivery and payment. These initiatives include patient-centered medical homes, Medicaid health homes, accountable care organizations (ACOs), episode-of care-payment, or delivery system reform incentive payment (DSRIP) demonstrations (Gifford et al. 2019). These reforms are intended to redesign the care delivery system for Medicaid beneficiaries, improve their access to coordinated physical and behavioral health services, and connect them to social services and supports. To support these goals, states are reforming the way providers are paid, shifting away from fee-for-service (FFS)—which pays providers for the volume of care delivered—and moving toward paying for better value, measured by higher quality and better health outcomes.

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some states have used section 1115 waiver authority to implement delivery system reform incentive payment (DSRIP) demonstrations. Since the first DSRIP program was approved in 2010, the breadth and specific goals of these demonstrations have evolved, but each aims to advance delivery system transformation among safety net hospitals and other Medicaid providers through infrastructure development, service innovation and redesign, and population health improvements. More recent DSRIP demonstrations have also emphasized increasing provider participation in alternative payment models, which intend to reward improved outcomes over volume.

In the past few years, the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies used two strategies to accelerate the shift toward rewarding value. One strategy focused on health care providers, and another on Medicaid managed care plans (MCPs).

- **Delivery system reform demonstrations.** Authorized by section 1115 waivers, these Medicaid demonstrations were designed to transform the delivery system by giving financial incentives to health care providers who serve Medicaid patients and the uninsured. Their goal was to deliver more coordinated care and to improve quality and population health outcomes. These demonstrations included DSRIP programs as well as similar delivery system reforms. Many of these demonstrations were designed to help prepare safety net providers, which serve disproportionate shares of Medicaid and uninsured patients, to participate in value-based payment (VBP) and alternative payment model (APM) arrangements, whether directly with the state or with Medicaid managed care plans (Heeringa et al. 2018). To sustain delivery system reforms after the demonstrations end, several states made a commitment to achieve specific VBP goals under the special terms and conditions (STCs) in section 1115 demonstrations. In some cases, they faced financial penalties for failing to meet the VBP goals.

- **Medicaid managed care plans (MCPs).** States are also advancing the adoption of VBP by requiring MCPs to implement APMs with providers or to use VBP for a specific share of payments to providers. Under federal rules, states can require MCPs to (a) implement certain types of VBP models to pay network providers, such as bundled payments, episode-based payments, or other methods that recognize value or outcomes instead of volume; and (b) participate in multi-payer or Medicaid-specific delivery system reforms, such as pay-for-performance, quality-based payments, or population-based payment models. Both types of payment arrangements, known as "state-directed payments," must meet certain criteria to be approved by CMS (Neale 2017).[1]

To advance VBP, many states are using delivery system reform demonstrations aimed at providers and VBP contract requirements for MCPs. Yet, there is little experience or evidence on how states can best coordinate the two initiatives to successfully meet VBP goals. Many questions remain unanswered:

- How long should delivery system reforms be in place before MCPs are required to achieve VBP goals, which depend on provider readiness?

- Which entities should be eligible to receive financial incentives, or face financial penalties, based on their ability to meet VBP goals and requirements?

- Does the degree of alignment in payment models and performance metrics across providers and MCPs affect the scale and speed of VBP adoption?

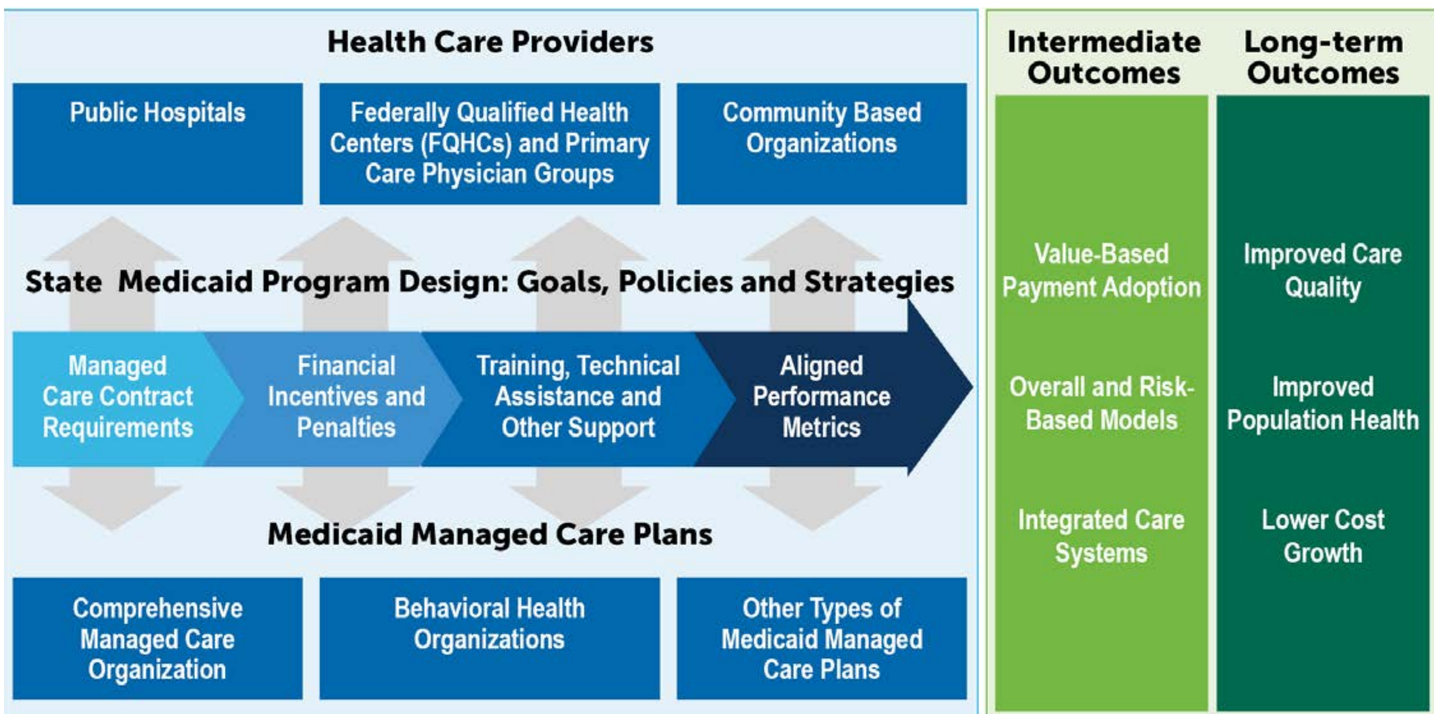
A conceptual framework (Figure I.1) shows how the interaction between various factors could speed the adoption of VBP by health care providers and MCPs. The framework is based on a systematic review of what determines VBP implementation success, including key design features and the context in which VBP programs are implemented (Damberg et al. 2014). The framework adds a dimension that is unique to Medicaid: the role that states play in setting the goals and rules for the use of VBP by payers (in this case, Medicaid MCPs) and providers, including contract requirements, payment models, and quality metrics. It theorizes that states can accelerate VBP adoption by setting common rules for both sets of organizations. In the long term, this can maximize the effect of payment incentives on quality of care, population health, and rates of cost growth.

> "Delivery system reform and value-based payment are two sides of the same coin; you have to have them both."
>
> –State policymaker

Other factors may impede progress towards VBP goals. For example, some states continue to make supplemental Medicaid payments to providers, which are typically lump sum payments made in addition to the standard base payment rate and are not based on services delivered to individuals (U.S. GAO 2016). Such payments may dampen the incentives for providers to negotiate VBP contracts with MCPs (Mann et al. 2016). State responses to new federal policies governing supplemental funds that "pass-through" MCPs to providers (CMS 2016) might also affect the degree to which these funds influence VBP progress. This issue is examined in a separate brief in this series (Lipson et al. 2019).

In this brief, we compare state Medicaid VBP goals and examine the policies used to advance the use of VBP through delivery system reform initiatives and MCP contract requirements. We

Figure I.1. Medicaid value-based payment: a conceptual framework



take a systematic look at how the incentives for providers making reforms to the delivery system are aligned with requirements for MCPs to achieve VBP goals in 10 states: Arizona, California, Massachusetts, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Texas, and Washington.

These states were selected after meeting two criteria: (1) they had active section 1115 demonstration waivers authorizing Medicaid delivery system reforms as of December 2017, and (2) they set specific VBP goals, either in section 1115 demonstration STCs or in Medicaid MCP contracts.[2] Table I.1 summarizes for each state (1) delivery system reforms, (2) demonstration periods, (3) where VBP goals are specified, and (4) the entities accountable for meeting VBP goals.

Data sources and methods. Between December 2017 and March 2018, we conducted a systematic analysis of similarities and differences in state program design features, based on a detailed review of publicly available state Medicaid policy and contract documents in the 10 study states. We extracted information from the following types of source documents: (1) Medicaid section 1115 waiver STCs; (2) attachments to the STCs that had more details about VBP; (3) model contracts between states and MCPs; (4) state VBP "roadmaps;" and (5) lists of performance metrics used in VBP programs. Sources and document dates for each state are listed in Appendix A. We also drew on interviews with state Medicaid officials and senior Medicaid managed care managers, which were conducted for a previous brief in this series, to understand why state officials made certain program design choices (Heeringa et al. 2018). State program staff reviewed a draft of this brief in June 2018 to check the accuracy of information about their state's policies and programs; except where noted, the data presented in this brief were accurate as of that date.

Roadmap to the report. Section II of this brief compares VBP goals and annual targets across the 10 states, including the share of VBP payments that involve higher levels of financial risk for providers, and describes which entities are accountable for meeting the goals. Section III compares key state policies and strategies to advance VBP, including managed care contract requirements and financial incentives, requirements of and support to safety net providers who engage in VBP arrangements, and alignment of performance metrics for providers and MCPs. Section IV explains how states planned to monitor their progress toward VBP goals. Section V discusses considerations in comparing states' success in advancing the use of VBP. Section VI concludes with implications for evaluations of the impact of VBP adoption on Medicaid costs, quality, and health outcomes.

DEFINITIONS AND TERMS USED IN THIS BRIEF

Value-based payment (VBP) refers to programs in which the state Medicaid agency holds providers or managed care plans accountable for the cost and quality of care.

Alternative payment models (APMs) are the specific payment arrangements and methods used in VBP programs—for example, whether providers receive bonuses for achieving quality or reaching goals on performance measures, whether they share savings for delivering services at lower cost, or whether they are at risk of incurring financial losses for not meeting specified quality and cost benchmarks.

VBP and APM have different meanings, but states use these terms interchangeably. For simplicity, we usually refer to both here as VBP, except when describing a specific state program that uses the term APM.

Managed care plans (MCPs), as defined by CMS, include comprehensive managed care organizations (MCOs), prepaid inpatient health plans and prepaid ambulatory health plans. Many states contract only with MCOs, but we use the term MCPs to cover all plan types, except when describing a specific state program that uses the term MCOs.

Table I.1. Profile of Medicaid section 1115 delivery system reform demonstrations, where VBP goals are specified, and which entities are accountable for meeting VBP goals in the 10 study states

Section 1115 Delivery System Reform Demonstrations				VBP Goals and Accountable Entities				
				Where VBP goals are specified		Entities accountable for meeting VBP goals		
State	Demonstration name (and delivery system reform program, if different)	Current demonstration period	Providers eligible to receive delivery system reform incentive payments	1115 STCs	Managed care contracts	State	Providers	MCPs
Arizona	AHCCCS (Arizona Health Care Cost Containment System) Targeted Investment Program	10/01/2016-9/30/2021	Primary care, behavioral health, and hospital providers, and integrated clinics co-located with probation or parole office	No	Yes			X
California	Medi-Cal 2020 and PRIME (Public Hospital Redesign and Incentives in Medi-Cal)	12/30/2015-12/31/2020	Designated public hospitals and district municipal public hospitals	Yes	No	X		
Massachusetts	MassHealth DSRIP	07/01/2017- 6/30/2022	ACOs, community partners, and community service agencies	Yes	Yes	X	*	
New Hampshire	Building Capacity for Transformation	01/05/2016- 12/31/2020	Integrated delivery networks and partner providers	Yes	Yes	DPHs		
New Mexico	Centennial Care Safety Net Care Pool - Hospital Quality Improvement Incentive (HQII) Pool	01/01/2014- 12/31/2023 (HQII ends 12/31/2021)	Qualifying hospitals (sole community provider hospitals and the state teaching hospital eligible to participate in 2014)	Yes	Yes	X	*	X
New York	Medicaid Redesign DSRIP	12/07/2016- 3/31/2021 04/14/2014-03/31/2020	Performing provider systems and partner providers	Yes	Yes		*	X
Oregon	Oregon Health Plan	01/12/2017-6/30/2022	Coordinated care organizations	Yes	Yes			X

Section 1115 Delivery System Reform Demonstrations				VBP Goals and Accountable Entities				
				Where VBP goals are specified		Entities accountable for meeting VBP goals		
State	Demonstration name (and delivery system reform program, if different)	Current demonstration period	Providers eligible to receive delivery system reform incentive payments	1115 STCs	Managed care contracts	State	Providers	MCPs
Rhode Island	Comprehensive Demonstration Health System Transformation Project	12/23/2013- 12/31/2023	Accountable entities	Yes	Yes	X		X
Texas	Healthcare Transformation and Quality Improvement Program DSRIP	01/01/2018-09/30/2022 Ends 09/2021	Regional healthcare partnership anchor entities and performing providers	No	Yes			X
Washington	Medicaid Transformation Project	01/09/2017- 12/31/2021	Accountable communities of health and partner providers; managed care organizations, and tribes	Yes	Yes	X		X

Source: Mathematica analysis of section 1115 demonstration STCs and state Medicaid contracts with MCPs.

ACO = accountable care organization

DSRIP = delivery system reform incentive payment

MCPs = managed care plans

STCs = special terms and conditions

VBP = value-based payment

* Massachusetts' ACOs, like other provider-based ACO models, are accountable for meeting total cost of care and quality metrics to qualify for shared savings, but the ACOs are not accountable for meeting specific VBP goals. New Mexico's HQII Pool, similar to DSRIP programs, allocates a portion of funds based on performance but does not require eligible hospitals to meet specific VBP targets. In New York, a few providers, such as those that participated in the New York State VBP pilot program, are also accountable for meeting specific VBP goals.

II. State VBP Goals

This section describes each state's annual VBP goals and targets, the payment models that count toward state VBP goals, the share of VBP arrangements that have to be in risk-based payment models, and the entities that are accountable for meeting these goals.

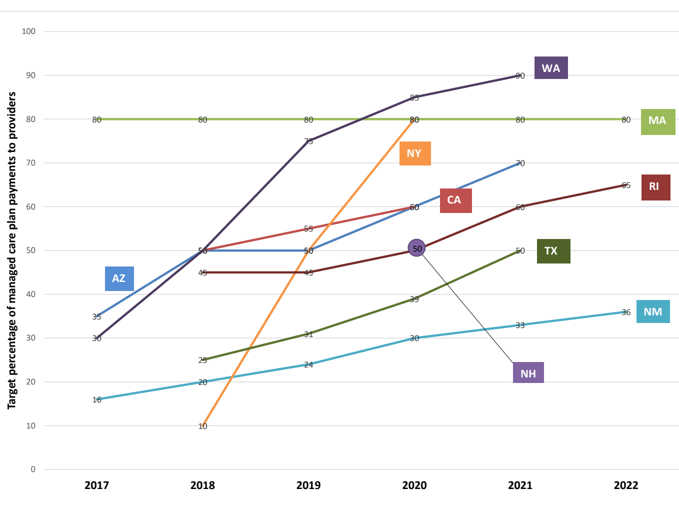
A. Annual VBP goals and targets

CMS and states consider a number of factors when they set Medicaid VBP goals. For example, policymakers often seek to align Medicaid goals with Medicare APM targets announced by CMS in January 2015: 30 percent of Medicare FFS payments tied to quality or value through APMs by the end of 2016, and 50 percent by the end of 2018 (Burwell 2015; CMS 2015). Aligning goals gives providers consistent financial incentives to improve care for all patients and can streamline reporting of quality measures (New York State Department of Health 2015; NAMD 2016). Medicaid officials may also set VBP goals that reflect the challenges safety net providers face when they take part in VBP arrangements, especially at higher levels of financial risk. For example, several states specify exceptions or different timetables for providers with little or no experience with pay-for-performance, shared savings, or capitated risk payment.[3]

At the time of this study, nine of the 10 study states established measurable VBP goals that applied to all MCPs, or to specified providers. Annual VBP targets for these entities, and the rate of change over time, varied substantially across the nine states (Figure II.1).

The one exception was Oregon, which required Medicaid MCPs—called coordinated care organizations (CCOs)—to implement APMs with network providers but allowed each CCO to establish its own targets regarding the total compensation paid to providers through APMs.[4] Beginning in July 2016, CCOs also were required to consistently track and monitor their progress toward increasing the percentage of compensation dedicated to APMs.[4] Starting in 2020, Oregon plans to set statewide and CCO-specific VBP payment targets to be achieved by the end of the demonstration period.

Figure II.1. State VBP target percentages by year



Source: Mathematica analysis of value-based payment (VBP) goals documented in 1115 demonstration special terms and conditions and managed care contracts.

Notes: For most states, the year listed corresponds to the demonstration year (DY), which matches the calendar year (CY). However, there are a few exceptions, including Arizona (CY17 corresponds to October 1, 2016 – September 30, 2017), Rhode Island (Contract Period 2 corresponds to 7/1/17 – 6/30/18), and New York (DY2 corresponds to 4/1/16 – 4/1/17).

Arizona established a 20 percent target in 2016, which is not shown on this chart. The Arizona targets pertain to Arizona Health Care Cost Containment System (AHCCCS) Complete Care, for non-disabled children and adults, and Arizona Long Term Care System (ALTCS) plans for elderly and disabled enrollees; different targets are set for plans serving other populations.

California's target is measured as the percentage of Medicaid patients assigned, or attributed, to designated public hospital systems that receive all or part of their care paid by a VBP arrangement with any MCP.

The first year of Massachusetts' alternative payment model (APM) target, also not shown on this chart, was July 2013, when it started at 25 percent, rising to 50 percent in July 2014, and 80 percent in July 2015, as required by a 2012 state law (Chapter 224).

Rhode Island's targets can also be met if the MCP demonstrates 5 percent increase from previous contract period until 2022, and then 10 percent increase from previous contract period after that.

Oregon is excluded from this chart because it had not yet set targets for Coordinated Care Organizations (CCOs) at the time of this study but planned to do so starting in 2020.

- **First-year targets.** In the first year of VBP timetables in eight states,[5] the target percentage of total payments made through qualifying VBP arrangements, or the percentage of patients/members whose care is delivered under VBP, ranged from 10 percent in New York to 80 percent in Massachusetts. The first year of Massachusetts' target was 2013 (not shown in Figure II.1), after the state enacted a law in 2012 requiring the Medicaid program to move from FFS to APMs, setting goals of 25 percent of eligible members in APM contracts in 2013, 50 percent in 2014 and 80 percent in 2015.

- **Final-year targets.** In the final year (2020, 2021, or 2022) of the VBP timetable in 9 of 10 states, the maximum target percentage of total payments to providers, or the target percentage of patients whose care is delivered under VBP arrangements, ranged from 36 percent in New Mexico to 90 percent in Washington.[6]

> "Moving to 90 percent of contracts being in VBP agreements by 2021 is a little bit optimistic, but in the current climate [in our state] and nationally, the only way to keep the system functional and able to serve underserved clients is to do arrangements like VBP."
>
> –State policymaker

- **Time period and rate of change.** Six of the nine states that set annual percentage targets did so over a four- to six-year period. In the remaining three states, New Hampshire set a target for the final year only; California set targets for public hospitals over a three-year period; New York also set targets for MCPs over a three-year period. The slope, or rate of change over time, is steepest in New York, increasing from 10 percent in the first year of specified targets to 80 percent in the third year. However, like Massachusetts, the first year of New York's VBP targets occurred after three years of DSRIP investment, which gave providers time to transition to VBP. Washington also has a fairly steep rate of increase in the percentage targets, but it applies over a five-year period. Although California has a lower rate of increase, the initial percentage target was significantly higher than those in other states.

B. Defining payment models that count toward VBP goals

States typically specify the types of payment models and levels of risk that count toward meeting VBP goals. Many states have chosen to align these payment methods and models with those defined by the Health Care Payment Learning & Action Network (HCP-LAN), a federal initiative created in 2015 to support alignment of payment approaches across public and private sectors. Using a common framework and definitions for payment models makes it easier for providers and MCPs to align their efforts and helps states monitor progress toward VBP goals. The HCP-LAN APM framework (Figure II.2) defines four APM categories (HCP-LAN 2017a).

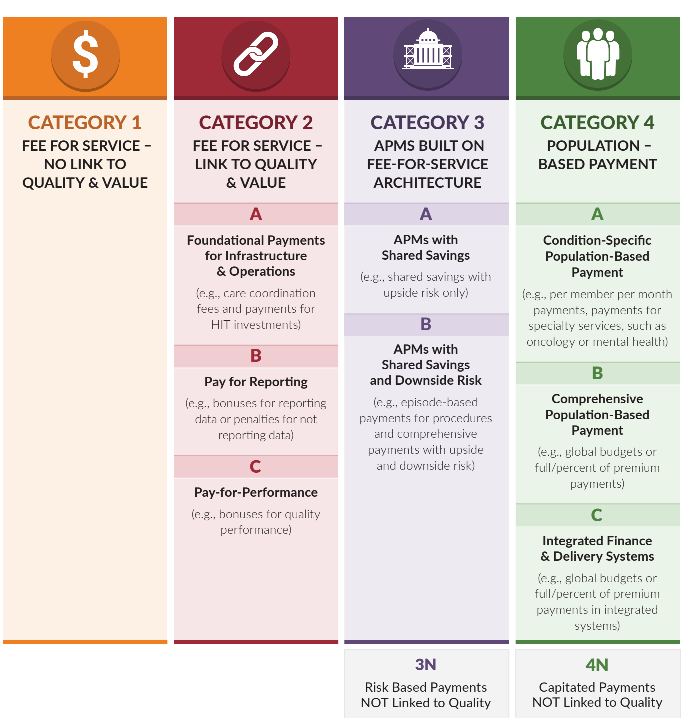
- **Category 1** is purely FFS and no payments are tied to quality.

- **Category 2** covers models built on FFS that pay providers to invest in infrastructure, report quality metrics, and achieve specified quality improvement targets. These models are similar to those used by state DSRIP and other types of delivery system reforms in that the funds support provider investments in primary care, information systems, and workforce training, and help build their capacity to track performance against quality benchmarks.

- **Category 3** includes two types of APMs: shared savings (upside shared savings only) and shared savings as well as downside risk.

- **Category 4** covers population-based payments, in which providers are paid a fixed amount for individuals with certain health conditions, or capitated payments covering a defined set of services or a global budget covering all services.

Figure II.2. Health Care Payment Learning & Action Network, APM framework



Source: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf.
APM = alternative payment model

Although most states in this study have adopted the HCP-LAN framework to define what constitutes VBP for the purposes of meeting state goals, some states modified the HCP-LAN framework categories to fit the structure and goals of their VBP initiatives. For example, New York's VBP levels are based on the HCP-LAN framework but were modified to reflect the state's higher expectations for levels of risk (described below). New Mexico's APM levels also differ from those of HCP-LAN.[7]

C. Risk-based VBP goals

Seven of the ten states set goals for the share of VBP payments that must be risk-based. In risk-based arrangements, providers can share in savings if they (1) meet both quality and total-cost-of-care benchmarks ("upside risk"), (2) are at risk of financial loss for not meeting benchmarks ("downside risk"), or (3) are paid on a per-member or per-patient amount for a defined set of services. These models correspond to those in categories 3 and 4 of the HCP-LAN APM framework (Figure II.2). Setting separate goals for risk-based VBP creates more ambitious targets

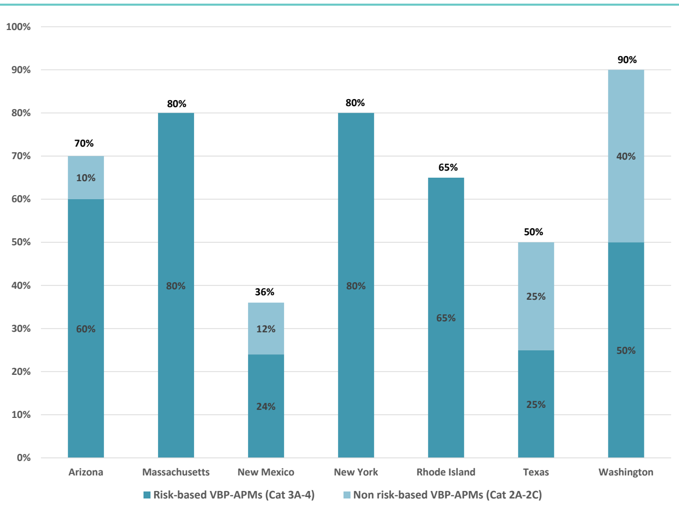
To compare states' risk-based goals, we calculated the percentage of payments required to be risk-based in the final year of each state's VBP timetable (Figure II.3). In Massachusetts, New York, and Rhode Island, risk-based models are the only ones that count toward VBP goals by the final year of the timetable, making them the most ambitious.

- Massachusetts defines qualifying payment models as (1) those in which managed care enrollees are attributed to a network provider, ACO, or other entity for the purposes of a shared savings/shared risk arrangement, (2) bundled payments, or (3) another APM model certified by the state.

- In New York, at least 80 percent of MCP payments to providers must be made through some form of risk-based arrangement, with 35 percent of payments at Levels 2 or 3, which correspond to HCP-LAN category 3B (shared savings and downside risk) and categories 4A, B, and C (population-based payment). The remaining payments must be at Level 1 which corresponds to category 3A (shared savings with upside risk only).

- In Rhode Island, 65 percent of managed care payments must be made through contracts with state-certified Accountable Entities, which are paid on a total-cost-of-care, shared savings model. At least 10 percent must be shared savings and downside risk (HCP-LAN category 3B) in the last two years of the timetable, but the remaining share in APM arrangements can be shared savings with upside risk only (category 3A); all non-risk infrastructure and pay-for-quality performance arrangements sunset as of June 30, 2020.

Figure II.3. State risk-based VBP goals for MCPs: percentages in risk- and non-risk models, by the final year of the VBP timetable



Source: Mathematica analysis of value-based payment (VBP) goals documented in 1115 STCs and managed care contracts, matched to corresponding Health Care Payment Learning Action Network (HCP-LAN) alternative payment model (APM) categories. This figure excludes study states that do not set specific targets for risk-based VBP arrangements (California and New Hampshire) and Oregon, which had not set VBP goals for all MCPs at the time of this study.

Notes: State VBP goals are expressed as the percentage of total Medicaid payments to providers by MCPs made through VBP models. Percentages represent the highest VBP targets in the last year of the timetable: 2020 in New York; 2021 in Arizona, Texas, and Washington; and 2022 in Massachusetts, New Mexico, and Rhode Island.

Although HCP-LAN category 3A models represent shared savings (that is, no downside risk), many states count these models as risk-based. This figure reflects this interpretation: all models that fit in categories 3 or 4 are considered risk-based.

Arizona's VBP target for risk-based arrangements in this chart applies only to AHCCCS Complete Care for non-disabled children and adults and ALTCS for elderly and people with physical disabilities; lower targets apply to plans serving other types of enrollees. New York's VBP target for a subset of risk-based models (category 3B and higher, which involve upside and downside risk) is 35 percent. The VBP target for managed long-term care plans is 15 percent in upside and downside risk sharing by 2020. In Texas, the overall VBP percentage must be 50 percent, but does not need to be 25 percent non-risk and 25 percent risk; it could all be risk-based arrangements.

New Mexico requires MCPs to meet VBP percentages at three levels, which vary by level of provider risk; MCPs may "substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1 as the overall minimum percentage targets (total for Level 1–3) are met for the contract year" (New Mexico managed care model contract Attachment 3.A). In Texas, the goal for risk-based arrangements in the last year of the timetable is at least half (25 percent) of the overall goal of 50 percent. Washington requires MCPs to make 50 percent of Medicaid payments in HCP-LAN Category 3A (shared savings with upside risk only) or higher, compared to 90 percent for all types of VBP.

D. Entities accountable for achieving VBP goals

MCPs and providers. Nationally, 69 percent of all Medicaid beneficiaries were enrolled in comprehensive managed care organizations (MCOs) in 2017, and all but one of the 10 study states had comprehensive MCO enrollment shares near or above this level (in Massachusetts, it was 45 percent) (CMS and Mathematica Policy Research 2019). Because the majority of Medicaid payments to providers are made through managed care, MCPs are commonly held accountable for achieving VBP goals. In three states, provider organizations as well as MCPs are accountable for meeting VBP goals, including Massachusetts, New Mexico, and New York. Although California holds designated public hospital systems (safety net hospitals eligible to receive DSRIP funds) accountable for meeting VBP goals, it planned to set such goals for MCPs in the future.

States. In 5 of the 10 study states, the state is also accountable for meeting VBP goals established in section 1115 demonstration STCs (Table II.1): California, Massachusetts, New York, Rhode Island, and Washington. These states are at risk for the loss of federal demonstration funds if they do not meet VBP goals, usually starting at the midpoint of the demonstration period. If the state loses demonstration funds, these losses are typically passed down to participating providers. Because providers share in the risk of potential funding losses, these statewide performance goals are meant to create shared accountability for VBP progress.

In three of the five states—California, New York, and Rhode Island—achievement of VBP targets is a distinct statewide performance goal. In Massachusetts and Washington, state accountability for meeting VBP goals is grouped with other statewide performance targets. For example, in Washington, up to 20 percent of annual federal DSRIP incentive funds are at risk in 2021 based on VBP goal achievement, in addition to statewide performance measures such as outpatient emergency department visits and antidepressant medication management.

Table II.1. Percentage of federal demonstration funds at risk based on state VBP performance

State	Statewide VBP goal by end of demonstration	Maximum percentage of funding at risk				
		2018	2019	2020	2021	2022
VBP goals						
California	60%		5%	5%		
New York	80-90%	5%	10%	20%		
Rhode Island	30%	15%	10%	10%		
VBP goals grouped with other statewide performance measures						
Massachusetts	45%*		5%	10%	15%	20%
Washington	90%		5%	10%	20%	

Source: Mathematica analysis of section 1115 demonstration special terms and conditions. This table excludes states that are not at risk of losing a share of federal demonstration funds if they do not meet VBP goals. Arizona is at risk of losing a portion of federal funding if the state does not meet performance measures and targets in the Targeted Investment Program, but this is not tied to achieving specific VBP goals.

* In Massachusetts and Rhode Island, VBP goals for purposes of state accountability differ from those that apply to MCPs. In Massachusetts, 45 percent of MassHealth ACO-eligible members must be attributed to ACOs, or receive service from providers paid under APMs (STC DSRIP Protocol Attachment N, pp. 49-50). In Rhode Island, MCPs must have at least three contracts (or 10 percent of covered lives) with certified Accountable Entities in an APM by 2018, and at least two contracts (or 20 percent of covered lives) must be in an approved APM by 2019, and at least three contracts (or 30 percent of covered lives) in an approved APM by 2020 (STCs Attachment T Deliverables Chart).

III. State Policies and Strategies to Advance VBP Adoption

In addition to delivery system reform demonstrations, states have many levers to promote VBP use by Medicaid MCPs and build the capacity of safety net providers to participate in VBP arrangements (CMS 2017). This section describes state policies and strategies that help MCPs and safety net providers meet each state's VBP goals. Specifically, we examine: (a) contract requirements and financial incentives that apply to MCPs; (b) requirements, financial incentives, and other types of support for safety net providers; and (c) alignment of performance metrics across providers and MCPs.

A. MCP requirements and financial incentives

MCP contract requirements. States vary in terms of how prescriptive they are regarding MCP VBP contract requirements. For example, New Mexico, New York, and Washington set standards or requirements regarding the types of payment arrangements that qualify toward the VBP goals and the percentage of MCP payments that must be tied to each level or category of APM. [8]

In contrast, Arizona, New Hampshire, Oregon, Rhode Island, and Texas give MCPs more discretion in the types of VBP models they can use. CCOs in Oregon, which are MCPs that in most cases cover non-overlapping regions in the state, are not yet subject to state-defined VBP targets but are expected to have CCO-specific targets starting in 2020; in the meantime, they must develop transformation plans to implement VBP arrangements, establish their own VBP improvement targets, and report on their progress. MCPs in Arizona were able to implement any combination of VBP payment models, including primary care incentives, shared savings, bundled and episodic payments, and capitation with performance-based elements, but that changed when targets for risk-based arrangements went into effect October 1, 2018 in the new contract. New Hampshire and Texas also give MCPs latitude to use different VBP models, based on examples provided by the state, although this may change in New Hampshire's next contract period. Although Rhode Island requires MCPs to devote a certain amount of their payments to Accountable Entities through a total-cost-of-care model, it also gives plans the discretion to use other VBP models to meet the overall VBP targets.

Beyond setting VBP targets and defining payment models, states may place additional requirements on MCPs (Table III.1) For instance, Massachusetts MCPs must submit detailed explanations of their VBP methodologies, including attribution algorithms, enrollee and utilization data, and payment bundling logic. As part of New York's VBP Innovator Program, the state requires MCPs to modify their contracts with certain providers that achieve Innovator status through a multi-department application process.[9]

MCP penalties. Seven of the 10 study states apply financial penalties if MCPs do not meet the annual VBP targets. Texas sets penalties of up to $0.10 per member per month if overall and risk-based VBP targets are not met; these penalties can be waived if the MCPs show "exceptional performance" on preventable hospitalizations and emergency department visits. Three states—Arizona, Rhode Island, and Washington—use, or intend to use, capitation withholds that can be earned back in part by meeting VBP goals. For example, Washington MCPs can earn back up to 25 percent of a 1 percent capitation withhold if they meet the annual VBP targets and qualifying provider incentive payments. (The remaining 75 percent of the 1 percent capitation withhold is tied to achieving quality improvement targets.) New York scales penalties to MCP spending; if less than 80 percent of their expenditure is in Level 1 or higher, and if less than 35 percent of a fully capitated MCP's expenditures are made via Level 2 or higher contracts in 2020, the state will apply a penalty of 2 percent on the marginal difference between 35 percent of MCP's expenditures and total expenditures in Level 2 or higher contracts.

MCP bonuses. Some states also award financial bonuses to stimulate faster adoption of VBP contracting by MCPs and reward plans that have more contracts at higher levels of risk. For instance, New York's 2018 rate-setting process increased capitation rates for MCPs that directed more provider payments into VBP arrangements at higher risk levels; MCPs could then decide how these incentives were shared with providers when advancing to VBP. However, New York also requires MCPs to submit all provider VBP contracts to the state for review and approval to ensure that providers do not take on more risk than is financially sustainable; the level of review depends on the degree of financial risk involved. Rhode Island created an incentive pool to reward plans that contracted with more than the minimally required number of Accountable Entities by August 2018; the MCOs could earn additional funds by performing well relative to a defined set of milestones.

Table III.1. Additional VBP requirements, penalties or withholds, and bonuses for MCPs

State	Requirements other than VBP percentage targets*	Penalties or withholds	Bonuses
Arizona	Direct enrollees to providers with VBP contracts	x	
California	**	**	**
Massachusetts	Provide VBP contract details and report on VBP payments		x
New Hampshire	Submit payment reform plans and reports		x
New Mexico	Develop VBP strategic plans	x	
New York	VBP contracting with providers***	x	x
Oregon	Develop VBP strategic plans		
Rhode Island	VBP contracts with accountable entities		x
Texas	Data sharing with providers to support VBP	x	
Washington	Develop VBP strategic plans	x	

* These are examples of MCP contract requirements, not a complete list.

** According to California's STCs, the state will include VBP requirements in its updated MCP model contract. Penalties and incentives that could be tied to these requirements are not yet clear.

*** New York requires MCPs to modify their contracts with VBP Innovator Program providers identified by the state. The program is for providers who are prepared for advanced Level 2 and Level 3 VBP models and who enter into the Total Care for General Population and/or Subpopulation arrangements described in New York's VBP roadmap.

B. Safety net provider requirements, financial incentives, and other support

Safety net providers, which serve a disproportionate share of Medicaid and/or uninsured patients, tend to have limited financial resources and socially and clinically complex patient populations. To ensure their financial viability and offset low Medicaid base payment rates, many states make different types of supplemental payments to safety net providers to compensate them for this shortfall (MACPAC 2015). Due to limited financial reserves and access to capital, many safety net providers with the exception of some large integrated health systems and some federally qualified health centers, lack the data, software, staff, and workflow processes needed to participate in VBP contracts (Bachrach et al. 2012; Crawford et al. 2015; McGinnis and Van Vleet 2012; Maxwell et al. 2014).

The incentive payments to providers made through delivery system reform demonstrations are intended, by design, to build the capacity of safety net providers to engage in VBP arrangements. For example, states gradually increase the share of incentive funds that are awarded based on provider performance. Typically, eligible providers start out by earning incentive payments for infrastructure investments and project implementation.[10] In subsequent years, they receive funds for reporting quality and other metrics, and in the final years of the demonstration, they are rewarded for their performance on these metrics. By the end of the demonstration period, the share of DSRIP funding tied to performance rises to 75 percent in Washington, 85 percent in New York, and 98 percent in California. To the extent that such payments substitute in full or in part the funds they received previously as supplemental payments, safety net providers face stronger incentives to improve quality and value (Heeringa et al. 2018).

In some states, as a condition of receiving funds available through delivery system reform demonstrations, eligible providers are also subject to VBP requirements. For example, DPHs in California are required to receive payment through a VBP contract with at least one MCP. Massachusetts requires ACOs that are eligible to receive DSRIP funds to submit plans describing how they will enter into VBP arrangements with their primary care providers. Rhode Island's certification process for Accountable Entities status requires providers to agree to participate in VBP arrangements; once the Accountable Entities execute a total cost of care contract, they are eligible to earn demonstration incentive funds. To spur providers to engage in VBP, New York allows MCPs that cannot achieve their VBP goals to pass on penalties to providers judged to be able but unwilling to enter into VBP arrangements.

Eight of the 10 study states take additional steps to prepare providers for VBP adoption—for example, by helping them to understand what it means to assume higher levels of financial risk and to create organizations that are legally allowed to contract with payers through risk-based payment models. Both individual providers and provider organizations may be eligible for this support. Examples of the latter are ACOs in Massachusetts, Integrated Delivery Networks (IDNs) in New Hampshire, and Accountable Entities in Rhode Island.

Support for safety net providers falls into three categories:(1) upfront funding to enable providers to develop a plan or invest in the infrastructure needed to enter into VBP arrangements, (2) incentive payments to reward providers for meeting VBP milestones or targets, and (3) non-financial support, including training sessions and work groups, technical assistance, and data analytic support (Table III.2). The amount of funding associated with each of these categories is as important as the type of support, but funding amounts were not readily available for all 10 states; consequently, we focused on the type of support offered.

Table III.2. Types of support states give to providers to support VBP, other than DSRIP or delivery system reform payments*

Source of support	Financial support for VBP infrastructure and planning: Funds paid directly to providers	Financial support for VBP infrastructure and planning: MCP-administered funds	Reward for meeting VBP milestones: DSRIP funds	VBP Goals and Accountable Entities: Provided by state	VBP Goals and Accountable Entities: Provided by MCPs
Massachusetts	X			X	
New Hampshire			X	X	
New Mexico	X				X
New York		X		X	
Oregon				X	
Rhode Island		X			
Texas					X
Washington	X		X	X	

*Arizona and California are not included in this table because the descriptions of state support in their delivery system reform demonstration documents were not detailed enough for us to determine what type of support is provided.

Financial support for VBP infrastructure and planning. Four states set aside a portion of demonstration funds to support accountable entities in building the infrastructure needed to accept higher levels of risk-based VBP. For example, Massachusetts' APM preparation fund gives providers funding to "develop, expand, or enhance shared governance structures and organizational integration strategies linking providers across the continuum of care" (Massachusetts DSRIP Protocol p. 96). Rhode Island awards incentive payments through MCPs to Accountable Entities, "to develop the governance, technology, skills, and capacity to enter into risk-based contracts with Medicaid MCOs" (Rhode Island EOHHS, Medicaid Infrastructure Incentive Program: Attachment L 2: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities, 2018). New York's Quality Improvement Program (QIP) provides funding to hospitals in severe financial distress so they can maintain operations and vital services while they work toward long-term sustainability. The state channels QIP funding through the MCPs and requires the MCPs to work with regional performing provider systems (PPS) and with qualifying hospitals to improve quality and prepare to enter into VBP contracts. QIP funding in state fiscal year 2017–2018 totaled nearly $455 million and was distributed to 10 MCPs paired with 25 hospitals (Felland et al. 2018).

Financial rewards for meeting VBP milestones. Two states, New Hampshire and Washington, reward provider organizations for meeting or exceeding performance milestones specifically related to VBP. In New Hampshire, IDNs are awarded performance-based incentive payments tied to four VBP milestones.[11] Washington offers funding to accountable communities of health (ACHs) to help providers in their regions prepare for VBP. Demonstration funding also supports an MCO Challenge Pool and an ACH Reinvestment Pool, which together make up 15 percent of the yearly available DSRIP funds to reward MCOs and ACHs that meet "exceptional standards of quality and patient experience" (Washington section 1115 waiver STCs pp. 28–29). ACHs, in turn, can use the funds to reward partnering providers undertaking new VBP arrangements within the region.

Non-financial support for VBP participation. Seven of the study states offer non-financial support to help safety net providers prepare for VBP, recognizing that funds are necessary but not sufficient to achieve ambitious VBP goals. To help safety net providers climb a steep learning curve, these states provide technical assistance, data and analytics support, and VBP training and work groups. For example, New York organized "VBP boot camps" for providers and MCPs to teach providers about VBP and share best practices, organized an on-line learning series known as VBP U, and made these materials publicly available on the state's VBP Resource Library website. In addition, New York created a data analytics tool for providers to compare the cost of various VBP arrangements, building on experience with VBP pilots. New York also developed an online VBP resource library and a data analytics tool for providers to compare the cost of various VBP arrangements. New Mexico and Texas contractually require MCPs to support providers through technical assistance and workgroups.

C. Alignment of performance metrics across providers and MCPs

States can help providers become more prepared to participate in VBP arrangements with MCPs by aligning performance metrics for the two sets of organizations. Alignment helps the two groups reduce the costs associated with data collection and measure reporting and focuses system-wide improvement efforts on quality goals that are important to each state. According to a survey on VBP in Washington State, both providers and health plan respondents identified "aligned quality measurements

and definitions" as one of the top enablers to VBP adoption (Washington Health Care Authority 2018).

For each of the 10 study states, we compared performance metrics for providers participating in delivery system reform demonstrations, with those used to hold Medicaid MCPs accountable for quality, usually through capitation withholds or bonuses. Among the 10 study states, four states have made concerted efforts to align the performance metrics of provider organizations and MCPs by using two strategies: (1) promoting integrated finance and delivery systems and (2) developing common measure sets for use in VBP arrangements between providers and MCPs in order to meet state VBP goals.

Integrated finance and delivery systems. In Massachusetts and Oregon, delivery system reform demonstrations have supported the creation of integrated finance and delivery systems. Such systems were recently recognized as a new category (4C) in the HCP-LAN APM framework because of their potential to promote alignment of value-based financial incentives among plans and providers. The integrated organizational structure increases the opportunity to align the performance metrics across the two types of organizations.

- Massachusetts' DSRIP program supports three types of ACOs. The most common of the three are accountable care partnership plans, which are MCPs vertically integrated with ACO delivery systems—creating a greater incentive for them to use the same performance metrics.[12] The state recently updated the slate of ACO quality measures, and all but one overlaps with those for which MCPs are held accountable. The exception is a health-related social needs screening measure that applies only to ACOs.

- Oregon's CCOs are also integrated finance and delivery systems. As risk-based MCPs, the CCOs contract with a network of providers to deliver a comprehensive set of physical, behavioral health, and dental services. Oregon CCOs are paid via a global budget and held to a set of 34 quality and access performance metrics specified in the demonstration waiver terms. CCOs are also held to a separate set of 17 state-specific incentive metrics; if they meet the targets or benchmarks, they can receive a bonus payment through a CCO Quality Pool. The state-specific metrics change somewhat from year-to-year (for example, by having higher benchmarks or new population health priorities) to encourage continuing improvement.

Developing common measure sets for VBP arrangements. New York and Washington have made great strides in developing common quality measure sets for use in VBP contracts between providers and MCPs.

- New York, which focused specifically on metrics for Medicaid VBP contracting, convened clinical advisory groups (CAGs) to recommend quality metrics for six VBP arrangements, including two episode-based arrangements (maternity and integrated primary care) and four population-based arrangements (total cost of care for general population, behavioral health subpopulation, HIV/AIDS subpopulation, and managed long-term care subpopulation.).[13] To select metrics, CAGs considered DSRIP quality metrics for system transformation and clinical improvement projects, Quality Assurance Reporting Requirements (QARR—the measures that have been used to reward Medicaid MCP quality since 1993), other nationally recognized metric sets such as Medicaid core sets and Healthcare Effectiveness Data and Information Set (HEDIS) measures, and condition-specific metrics such as those for HIV/AIDS. The CAGs reviewed metrics for relevance, reliability, validity, and feasibility and assigned them to three categories: (1) ready for use by VBP contractors, (2) requiring feasibility testing in VBP pilots, and (3) inappropriate for use. Because measure specifications change frequently, the CAGs reconvene annually to update the metric sets and consider the addition of new measures. The state may also form new CAGs to select measures for other conditions and groups (NY VBP Roadmap 2016).

> "The starting point for this Roadmap is sustaining the achieved DSRIP results. The overall goals of the DSRIP program and payment reform are the same: to improve population health and individual health outcomes and to reward high value care delivery. The selection of the VBP arrangements, and the selection of accompanying quality measures, therefore needed to be closely aligned."
>
> –New York VBP Roadmap

- Washington's Common Measure Set for Health Care Quality and Cost, initially developed by a coalition of public and private organizations in 2014 and regularly updated since then, serves to promote aligned measurement across public and private payers, health plans, hospitals, and physician groups, and "serves as the basis for purchasing health care based on better value." (Washington Health Alliance and Healthier Washington 2017). Among the 63 quality-related measures from the Common Measure Set, nine are used in Medicaid MCO contracts and 19 measures are used in a multi-payer pilot (Washington VBP Roadmap 2018).

Although both states seek to align quality measures for MCPs and providers participating in delivery system reform, complete alignment is not necessarily appropriate. For example, at the provider level, the number of beneficiaries to which certain measures apply may be too small to construct statistically valid and reliable measures. Conversely, some measures used in provider pay-for-performance programs are not appropriate for use with MCPs, if data to risk-adjust the measures at the plan level are not available.

IV. Monitoring Progress Toward VBP Goals

At the time of this study, the 10 study states collected (or planned to collect) standardized reports and data on the use of VBP models in a manner consistent with the states' definitions and expectations.[14] These reports are used for several purposes:

- To monitor progress relative to state-established goals and targets
- To determine whether MCPs and providers are fulfilling contractual requirements, are eligible for additional incentive payments (as applicable), or are subject to any penalties
- To prepare and submit quarterly and annual progress reports to CMS, if any of the section 1115 demonstration STCs concern VBP
- To conduct an evaluation of the degree to which state mandated VBP to providers by MCPs, which qualify as state-directed payments under 42 CFR 438.6(c)(1), achieve their quality improvement goals and objectives (Neale 2017)

Among the 8 states in this study that hold MCPs accountable for meeting specified VBP goals, the most common unit of measurement is the percentage of total Medicaid managed care payments to providers that are made through VBP arrangements.[15] In Massachusetts, enrollees are considered to be receiving care under a VBP arrangement if they are attributed for some portion of the contract year to a network provider, ACO, or other entity with a shared savings/shared risk, bundled payment, or global payment arrangement. California assesses DPH performance on meeting VBP goals based on the percentage of Medicaid patients assigned, or attributed to them, who receive all or part of their care through a VBP contract with any MCP.

Most states are developing reporting templates, many of them modeled on national VBP measurement frameworks, such as the one developed by HCP-LAN (HCP-LAN 2017a). However, most states have modified the tools to fit their own needs, particularly when state-defined VBP categories differ from those specified by HCP-LAN, or when states need more information to track which providers are participating in VBP arrangements and to assess compliance with MCP contract requirements. For example, in contrast with national VBP tracking efforts, state Medicaid agencies often want to understand how VBP contracts affect the financial stability of safety net providers and track payments to provider entities that were created to advance delivery system reforms, such as those in Rhode Island. In addition, the HCP-LAN survey does not ask health plans to report the share of payment tied to an incentive, only the overall amount. States that want to track the amount of payments specifically for quality bonuses (or penalties) or shared savings have had to modify their tools accordingly.

Initial versus ongoing data collection. To establish a baseline on each entity's use of VBP according to the states' definitions, many states conduct surveys for the period(s) before the performance of each MCP or provider is assessed against the VBP targets. Once the VBP targets become effective, most states create standardized templates for the MCPs, providers or other entities to complete on a specified schedule, annually or more often. To ensure that VBP arrangements are reported consistently, states commonly develop standard definitions and common formats for data files and narrative reports.[16]

For example, Texas developed a detailed report form, modeled on the HCP-LAN framework, which MCPs must use to prepare annual VBP reports starting in calendar year (CY) 2018.[17] The "VBP Data Collection Tool" contains five worksheets, including (1) definitions, (2) data on current value-based contracts, (3) narrative on current value-based contracts, (4) proposed or planned value-based contracts, and (5) a certification page. Plans must give detailed information about all value-based contracts with providers, including: VBP contract type, level of financial risk for the plan and/or providers, service delivery areas, provider service type, estimated number of members impacted, estimated total claims paid through VBP, whether a DSRIP partnership is involved, performance metrics used, and the frequency of VBP payment.

Common data elements and types of information collected in 8 of the 10 study states are summarized in Table IV.1.[18] All eight states with available information about their VBP monitoring reports collect the amounts and share of total MCP payments made to providers in each of the payment models defined by the state. These data are then used to determine whether the MCPs meet annual VBP goals. When MCPs can receive bonuses for exceeding the annual targets, or incur penalties for not meeting the goals, states may audit the reports to validate the data, as is done in Washington.

Five of the eight states also collect data on the number of Medicaid enrollees and/or providers covered by each VBP contract and payment model. Five states require MCPs to submit lists of VBP contracts with providers, and in some cases, they must submit the actual contracts. Four states require MCPs to submit annual plans describing VBP strategies and goals for the next contract year, and one state requires plans to submit a report on the effects of the previous year's activity, as well as lessons and challenges, which informs discussions between the state and each MCP about potential improvements and how to address any negative impacts on providers.

Table IV.1. Information included in MCPs' VBP reports

State	VBP plans, strategies, and goals	Amount of payments to providers in each defined payment model	VBP contracts with providers	Number of members and/ or providers covered by each payment model or contract	Effects of VBP initiatives, lessons, and challenges
Arizona	X	X			X
Massachusetts		X	X	X	
New Hampshire	X	X		X	
New Mexico	X	X	X		
New York		X	X	X	
Rhode Island		X	X	X	
Texas	X	X	X	X	
Washington		X			

Source: Mathematica analysis of Medicaid managed care contracts and other state documents. Two study states—California and Oregon—are excluded from this table because detailed information on state reporting requirements was not available at the time of this study.

Monitoring challenges. As states gain experience with collecting and analyzing the information and data in VBP reports, it might be useful to compare the results with HCP-LAN reports that track national APM adoption across payers. For example, HCP-LAN has reported that health plans found it difficult to classify all payment arrangements into single categories and that it needed to take a "high-touch, interactive approach to ensure the classifications are appropriate as the data is collected" (HCP-LAN 2017b). States and Medicaid plans may face similar challenges distinguishing among the payment models that count toward state VBP goals, particularly if MCPs have multiple VBP contracts with large health systems. In addition, the HCP-LAN cautioned against making direct comparisons between health plans and across states due to differences in "market dynamics related to supply and demand, urban and rural environments, provider or plan readiness and the like." To the extent such differences exist within states and across provider classes and types, states might also need to consider the factors that help or hinder adoption of VBP in different regions and for different types of providers in the state.

In addition, Medicaid agencies are likely to face other challenges that HCP-LAN has not yet addressed. For example, HCP-LAN does not collect data on how VBP incentive payments flow to downstream providers, because health plans say they cannot track how health systems pay individual practitioners. HCP-LAN also excludes reporting of VBP for long-term services and supports and for dual-eligible beneficiaries. Moreover, the HCP-LAN reporting format counts total payments that are made through a VBP arrangement and does not track the percentage of payment linked to value and quality, such as pay-for-performance bonuses and shared savings payments. Understanding how Medicaid agencies tackle these challenges can offer useful lessons on how to track the use of VBP for specific types of safety net providers, Medicaid services, and beneficiary groups.

V. Comparing State Progress Toward VBP Goals

At the time this study was conducted, it was too early for most states to evaluate the extent to which the adoption of VBP had achieved their ultimate goals—improved quality and health outcomes for Medicaid beneficiaries and lower cost growth.[19]

However, results from a few states were available to determine change in the use of VBP by providers and MCPs, or progress toward state VBP goals as of 2018, when this study was conducted. States had just begun to collect information and report on the results of VBP progress. For example, New York reported that at the end of its third demonstration year (March 2018,) almost 35 percent of total MCP expenditures were made through qualifying VBP arrangements, exceeding its goal of 10 percent by that time. (New York State Department of Health 2018).[20]

During 2018 and 2019, most of the 10 study states planned to hold health plans, providers, or the state Medicaid agency accountable for reaching substantially elevated levels of VBP use. Five states—California, Massachusetts, New York, Rhode Island, and Washington—were expected to meet VBP targets specified in section 1115 demonstration STCs that tied federal funding to the state's achievement of VBP goals, and 2018 was the first year states were at risk of losing federal demonstration funds if they failed to reach these goals. In addition, 2017 was the first year that MCPs in 4 of the 10 states could lose a portion of capitation payments if they did not meet the goals. Information on how many MCPs met their goals, and how much they gained or lost in capitation withholds, is an important yardstick of progress.[21]

To make fair comparisons of states' success in meeting VBP goals, it is important to consider the design of each state's VBP

policies and strategies, including: (1) the levels of risk-based VBP required and the timeline for achieving the highest level; (2) whether the state, safety net providers, MCPs, or all three parties are financially accountable for reaching VBP goals; (3) the degree to which state policies and strategies align financial incentives, payment models, and performance metrics across safety net providers and Medicaid MCPs; and (4) the type and amount of support offered to safety net providers to engage in VBP, especially in payment models that come with higher financial risk.

Although each of these factors are likely to affect the pace of delivery system and payment reform in each state, many questions remain about the size of their effects on VBP adoption. For example, the mix of VBP goals and policies in these 10 states can be categorized as either ambitious or moderate (Table V.1). States with ambitious VBP goals tend to give both MCPs and providers bonuses for meeting or exceeding goals, provide financial support to safety net providers, and promote alignment of performance metrics across providers and MCPs. States with moderate VBP goals offer bonuses to MCPs or providers, but generally not both, apply no or minimal penalties for failure to achieve VBP goals, and provide non-financial support to providers.

When setting VBP goals, each state must make a careful assessment of safety net provider readiness, operating margins, and the health information technology capabilities needed to engage in VBP arrangements, particularly at higher levels of financial risk. States with more ambitious VBP goals that require safety net providers and other Medicaid providers to take on increasing levels of financial risk over time may accelerate the pace of change—or they may be basing those goals on unrealistic expectations and see progress lagging. On the other hand, states with more moderate goals may be more successful in achieving them if they have taken into account low levels of VBP adoption and the safety net providers' vulnerable financial positions. Consequently, as part of evaluating state progress, it is also important to monitor providers' operating margins and other measures of financial health to ensure the shift to VBP does not come at the expense of providers accepting more financial risk than they can manage.

Finally, when comparing states' progress towards VBP adoption, it also might be useful to assess whether giving all parties a financial stake in the outcome leads to greater success than only one. For example, in New York, the state and the PPSs that qualify for DSRIP incentive funds can receive a greater share of federal demonstration funds by meeting the VBP goals. MCPs in New York can also earn a greater share of the capitation withhold by meeting VBP goals and can pass on penalties to providers who are able but unwilling to enter into VBP arrangements. Thus, all three parties in the state stand to gain financially (or avoid loss) by meeting VBP goals. In contrast, Oregon, New Hampshire, and Texas, whose section 1115 demonstration STCs did not tie federal funding to state achievement of VBP goals, may have less impetus to achieve the goals, and performance may be variable across MCPs and providers.

Table V.1. Comparison of state value-based payment (VBP) goals and policies

State VBP goals and policies	Ambitious	Moderate
VBP goals, including the share of VBP that is risk-based	• Ambitious VBP goals to be reached within a few years • Separate goals for advanced models involving financial risk	• Moderate VBP goals that can take longer to achieve • Do not include advanced risk-based payment models
Bonuses (and/or penalties) to meet or exceed annual targets	• Apply to both managed care plans (MCPs) and providers • Penalties for not meeting goals increase over time	• Apply to MCPs or providers, but not both • No penalties, or minimal penalties, for not meeting goals
Type (and amount) of state support to safety net providers	• Both funding and non-financial support • Targeted funding in addition to DSRIP incentive payments	• Non-financial support only
Alignment of performance metrics	• Process for aligning performance metrics across MCPs and providers	• Allow each MCP to use its own quality and performance metrics

VI. Conclusion

As the results of state monitoring reports and evaluation studies emerge, it will become possible to examine how, and to what extent, states' success in advancing the use of VBP is associated with the strategies and program designs deployed.

- Do states that simultaneously align provider-led delivery reforms with managed care payment reform achieve higher levels of VBP adoption than states that wait until delivery reforms mature before they require MCPs to reform their payment methods?
- Do states with ambitious policies and strategies designed to accelerate the adoption of VBP achieve higher levels of VBP than states with moderate policies do?
- Do states that give all parties a shared financial stake in achieving VBP goals reach them more quickly?
- Do states with a mix of VBP features—such as common payment methods and quality metrics, and shared financial risk by all parties—achieve higher levels of VBP adoption than states that allow a thousand flowers to bloom and put the financial onus on MCPs alone?

Ultimately, payment reform is a means to an end, not the end itself. Higher rates of VBP adoption are the means by which state Medicaid agencies are striving to achieve their overall goals: better health care quality, improved health outcomes for the Medicaid populations, and sustainable cost growth. Findings from evaluations of these demonstrations will shed light on whether states that achieve higher levels of VBP also have better care quality and outcomes for Medicaid beneficiaries and lower per capita cost growth than states with lower levels of VBP adoption.

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ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica, IBM Watson Health, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) demonstrations, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports informed an interim outcomes evaluation in 2018 and will inform a summative evaluation report in 2020.

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Endnotes

[1] 42 Code of Federal Regulations (CFR) 438.6(c). State Medicaid agencies do not need CMS approval if they (1) require MCPs to use VBP but do not mandate a specific payment methodology, and (2)give MCPs discretion in negotiating the amount, timing, and mechanism of VBP arrangements with providers.

[2] Three states—Kansas, New Jersey, and Vermont—also had delivery system reform demonstrations operating under section 1115 authority as of December 2017. We excluded them from this study because they did not specify VBP goals or requirements, either in 1115 demonstration STCs or in MCP contracts. New Jersey was required to develop and submit a plan to CMS by June 30, 2018, describing how its DSRIP program will transition to an alternative payment system by June 30, 2020, but that plan was not available at the time this study was conducted.

[3] For example, LTSS may be excluded from VBP requirements and goals or granted lower targets. Arizona, for example, sets lower targets for Regional Behavioral Health Authorities and LTSS plans for people with developmental disabilities. New Hampshire excludes LTSS entirely, and New York excludes partially capitated managed long-term care plans from its Level 2 minimum targets. New York also excludes payments to specified types of "financially challenged providers" from VBP goal calculations.

[4] Oregon section 1115 demonstration STC 36 (p. 29–33), 2017 and CCO Contract, 2016, Exhibit B – Statement of Work – Part 6 – Alternative Payment Methodologies, p. 84; and Exhibit K – Attachment 1, Areas of Transformation, p. 199. The state planned to publish information in 2019 regarding each CCO's APM baseline, improvement targets, or systems for tracking and monitoring progress to increase APMs.

[5] New Hampshire set a target only for one year, 2020. Because that year coincides with the final year of the DSRIP waiver period, we regard it as the final year's target. Oregon had not set statewide VBP targets at the time of this study but planned to do so starting in 2020.

[6] New York's section 1115 waiver STC indicates that the state's ultimate goal is 80 to 90 percent (§39).

[7] New Mexico's Level 1 is defined as FFS with bonuses or incentives and/or withhold (at least 5 percent of provider payment); Level 2 is upside-only shared savings (but may include downside risk), and two or more bundled payments for episodes of care; and Level 3 is FFS or capitation with at least 5 percent risk sharing (upside and downside), and/or global or capitated payments with full risk.

[8] When states direct MCPs to implement specific value-based payment models, either for Medicaid alone or as part of multi-payer initiatives, CMS review and approval is needed to ensure they are based on the delivery and utilization of services provided to Medicaid beneficiaries, and on the quality and outcomes of care, as required by federal rules under [42 CFR 483.6(c)(1)]. Whether such arrangements qualify as "state-directed payments" depends on the specific terms and arrangements (Neale 2017).

[9] New York's VBP Innovator Program promotes early adoption of VBP arrangements by ACOs, Independent Practice Associations, or other providers, who can participate in risk-based (Levels 2 and 3) VBP arrangements starting in 2016, by rewarding participants with up to 95 percent of the total dollars that are otherwise paid to MCOs.

[10] In most DSRIP demonstrations, providers implement projects designed to improve clinical quality, care coordination, and population health.

[11] The APM milestones for IDNs include: (1) completion of a baseline assessment of current use of and capacity to use APMs among partners; (2) participation in the development of a statewide APM roadmap; (3) development of an IDN-specific roadmap for using APMs; and (4) achievement of IDN-specific measures in the roadmap that measure progress toward meeting APM goals, including financial, legal, and clinical preparedness and engagement with MCOs (New Hampshire section 1115 waiver STC 24 and Attachment C DSRIP Planning Protocol).

[12] The other two ACO models are (1) primary care ACOs, which are provider-led health care systems or provider-based organizations that contract directly with the Medicaid program using a shared savings and risk payment arrangement; and (2) MCO-administered ACOs, which are also provider-led health systems or provider-based organizations that contract with MCPs using a shared savings and risk payment arrangement.

[13] The Integrated Primary Care arrangement consists of primary care services and 14 chronic conditions, which were selected to allow primary care providers to reap the savings that accrue from better managing care for people with these conditions. Additional CAGs are selecting measures for two more population-based arrangements: for people with intellectual and developmental disabilities and for children.

[14] At the time of this study, some of the 10 states had not yet established specific reporting requirements, but indicated that MCPs or providers would have to submit any information needed for the state to monitor the use of VBP or APM arrangements.

[15] Oregon also expects to frame its VBP goals as a percentage of total compensation paid to providers attributed to alternate payment methods when it begins to hold CCOs accountable in 2020.

[16] Quality and performance metrics are usually reported in separate data files and systems, such as MCPs' submission of HEDIS and CAHPS measures, ACO quality measure reports, and other mechanisms.

[17] Texas MCPs also had to report their VBP contractual arrangements in CY 2017. Although there were no VBP targets for that time period, the experience was intended to prepare the plans to meet CY 2018 reporting requirements when the targets went into effect.

[18] A report by Bailit Health (2018) has more information on the approaches used in New York, Rhode Island, and Texas, as well as a few states not examined in this study, including Michigan and Pennsylvania.

[19] When states require MCPs to adopt specific payment methods for VBP-APM, they are required to plan and conduct evaluations measuring the degree to which these state-directed payments advance at least one goal or objective of the managed care quality strategy. However, the federal rule requiring such evaluations, 42 CFR 438.6(c)(2)(i)(D), does not take effect until the managed care program rating period beginning July 1, 2017.

[20] New York set its VBP goals without knowing the level of managed care plans' VBP contracting. A baseline survey later found that in CY 2014, before the demonstration began, 25 percent of MCP payments to providers were already made through VBP, well above the demonstration year 3 VBP target of 10 percent (Felland et al. 2018).

[21] Reporting on VBP arrangements may lag six months or more after the end of a contract year, so the results were not available at the time of this study.

Appendix A. State Documents

ARIZONA

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WASHINGTON

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