Appendix A: Examples of State Directed Payment Arrangements

	State Proposal A	State Proposal B	State Proposal C
Proposal Overview	The state is directing and contractually requiring their managed care plans to pay an enhanced minimum fee schedule for professional services provided to Medicaid beneficiaries in an academic medical center by faculty physicians through a sub-capitated payment arrangement. The terms of the payment arrangement include a utilization band used to reconcile projected utilization included in the sub-capitated payment with actual utilization under the contract. The state also requires the managed care plans to have network provider agreements with all academic medical centers in the state.	The state is directing and contractually requiring their managed care plans to pay quality incentive payments to acute care hospitals that are network providers rendering services to Medicaid beneficiaries covered under the contract in order to reduce potentially preventable readmissions. There are two components to determine the incentive payment a hospital can earn: 1) Incremental Improvement – a hospital's performance compared to its performance in the previous year; and 2) Benchmark Achievement – a hospital's performance compared to a statewide benchmark.	The state is directing and contractually requiring their managed care plans to pay Accountable Care Organizations (ACOs) operating in their networks a per-member per-month (PMPM) rate for Medicaid beneficiaries covered under the contract. The ACOs are reimbursed to manage the total cost of care for a defined set of Medicaid services and improve the overall quality of care for Medicaid managed care enrollees. A portion of this PMPM rate is withheld and can be earned based on ACOs' performance across a standard set of quality and performance measures. This is part of a multi-payer delivery system reform effort.
State Objectives	The state seeks to ensure that all Medicaid managed care enrollees have timely access to high-end specialty care.	The state seeks to incentivize acute care hospitals to reduce potentially preventable readmissions through better discharge planning, coordination with ambulatory care providers, and follow-up.	The state seeks to incentivize providers to form ACO structures in order to assume accountability for the total cost of care and the quality of care for attributed Medicaid managed care enrollees.
Type of Payment Arrangement	Minimum Fee Schedule	Quality Payments / Pay-for-Performance	Value-Based Purchasing / Accountable Care Organizations (ACOs)
Targeted Provider Class	Academic Medical Centers and Faculty Physicians	Private Hospitals	ACO networks, including hospitals, physicians, critical access hospitals, and FQHCs/RHCs

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Tie to Utilization and Outcomes	The utilization band ensures that actual utilization by Medicaid beneficiaries during the contract rating period falls within a specific corridor consistent with projections. If the actual utilization exceeds the utilization band by more than 3%, the managed care plans must reimburse the academic medical centers at contractually negotiated rates. If the actual utilization by Medicaid beneficiaries falls more than 3% below the utilization band, the state requires the managed care plans to recoup a portion of the sub-capitated payment and remit that amount to the state.	Hospitals earn the quality payments based on hospital performance during the contract rating period in addition to their negotiated payment rates. Potentially preventable readmissions will be identified using specific software.	ACOs receive a PMPM for each attributed patient based on their eligibility group to manage the total cost of care for a defined set of Medicaid services. There is also a payment withhold that the ACOs can earn back based on the ACOs' performance during the contract rating period.
Quality Goals, Objectives, and/or Performance Criteria	• Improve Access to Specialty Care • Improve Timeliness of Care • Increase Participation of Specialists and Subspecialists in Medicaid Managed Care Networks	• Reduce Potentially Preventable Readmissions • Reduce Unnecessary Hospitalization • Encourage Better Coordination Across Care Settings for Individuals After Admission	• All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (CMS ACO #38) • 30 Day Follow-Up after Discharge from the ED for Mental Health / for Alcohol and Other Drug Dependence (NQF #2605) • Adolescent Well Care Visits (NCQA) • Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) (NQF #0059) • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)

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	State Proposal A	State Proposal B	State Proposal C
Funding Source	The state has a dedicated pool of funding from intergovernmental transfers (IGTs) from some of the academic medical centers[1]. The state may not condition specific academic medical centers' participation in the payment arrangement on entering into or adhering to IGT agreements.	The state has a dedicated pool of funding from a hospital provider tax.	The state has dedicated funding through state general revenue and legislative appropriations made to the state Medicaid agency.

[1] Consistent with section 1903(w)(6) of the Social Security Act and 42 CFR 433.51, the academic medical centers that can provide intergovernmental transfers (IGTs) are limited to governmental entities as defined by the state.