

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
200 Independence Ave. SW  
Washington, DC 20201



**SMD # 20-004**  
**RE: Value-Based Care**  
**Opportunities in Medicaid**

September 15, 2020

Dear State Medicaid Director:

The purpose of this letter is to provide information on how states can advance value-based care (VBC) across their healthcare systems, with a particular emphasis on Medicaid populations, and to share pathways for adoption of such approaches with interested states. VBC seeks to hold providers accountable for providing high quality care, and can also be a part of the solution to reduce health disparities in the healthcare system, to maximize benefits to patients, and to eliminate unnecessary procedures. Under VBC arrangements, providers are rewarded – based on specific evidence of performance on quality measures – for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives, as part of a larger healthcare system effort. The Centers for Medicare & Medicaid Services (CMS) believes that value-based payment (VBP) is a key driver of VBC. Value is more likely to improve across the larger healthcare system when provider incentives are aligned across payers. By advancing VBC in Medicaid, states have the opportunity to improve beneficiary health while reducing costs. This letter discusses pathways, including increased flexibility available under the state plan, towards the adoption of VBP models in Medicaid.

Value-based care has particular promise in helping America and its healthcare system handle unexpected challenges and disruption, including those recently experienced from the COVID-19 pandemic. During this time, providers have faced financial impacts from all directions including: delayed elective surgeries, disruption in revenue streams, and new costs from increased need for personal protective equipment. Value-based care may help ensure that our healthcare system is better prepared and equipped to handle similarly disruptive events in the future. As Administrator Seema Verma noted on June 3, 2020, "...by accepting value-based or capitated payments, providers are better able to weather fluctuations in utilization, and they can focus on keeping patients healthy rather than trying to increase the volume of services to ensure reimbursement. Value-based payments also provide stable, predictable revenue—protecting providers from the financial impact of a pandemic."<sup>1</sup>

---

<sup>1</sup> "New CMS Payment Model Flexibilities for COVID-19," Health Affairs Blog, June 3, 2020. Available at <https://www.healthaffairs.org/doi/10.1377/hblog20200602.80889/full/>.

## **Approaches to the Adoption of Value-Based Payment**

CMS understands that states face unique circumstances in their healthcare landscapes, and what works for one state may not necessarily work for another state. The Administration supports flexible approaches for states and does not expect a “one-size-fits-all” approach as states reform their delivery systems and move to VBC. Some states may prefer to join other multi-payer initiatives within their state, and others may instead take the lead in developing their own multi-payer initiatives. Providers may be more likely to adopt VBC if states promote the use of current, active CMS models instead of promoting many different strategies without clear coordination of efforts across strategies and other payers. States may wish to pursue more limited, incremental changes that primarily focus on improving specific drivers of costs and quality in their Medicaid programs. Whatever a state’s circumstance, CMS will work to meet states where they are to address and respond to local opportunities and barriers to VBC.

While many states have made progress in moving towards VBP, there is significant room to achieve a system that more effectively delivers outcomes commensurate with costs. For example, 2018 data from the Health Care Payment Learning and Action Network (HCP-LAN), a public-private learning collaborative (or network) in which CMS participates and which was created to drive aligned payment reform, showed that, while 90 percent of traditional Medicare payments were made as part of VBP arrangements, only 34 percent of Medicaid payments were made under such arrangements.<sup>2</sup> States have the opportunity to learn from Medicare and private payers in implementing VBC and should strongly consider aligning payment incentives and performance measures across their healthcare systems to reduce the burden on providers who participate in multiple programs. Alignment may also serve to improve the healthcare experience for individuals across their states, including those covered under Medicaid, Medicare, and commercial insurance products.

States have been moving away from less sophisticated fee-for-service (FFS) Medicaid payments toward per member per month (PMPM) payments, partly in order to improve the stability of state and provider budgets, but also with an interest in moving to VBC. Additionally, in both FFS and managed care delivery systems, states increasingly have included risk-bearing payments and opportunities for shared savings. For the purposes of this guidance and previous guidance regarding shared savings in the Medicaid context, the term “shared savings” is used in a manner generally understood by the field, which may differ from how this term is defined for purposes of *specific* initiatives in Medicaid or by other payers.<sup>3</sup> Innovative payment models warranting testing will continue to emerge. Encouraging providers to manage upside and downside performance risk through shared financial losses is critical for aligning their financial incentives

---

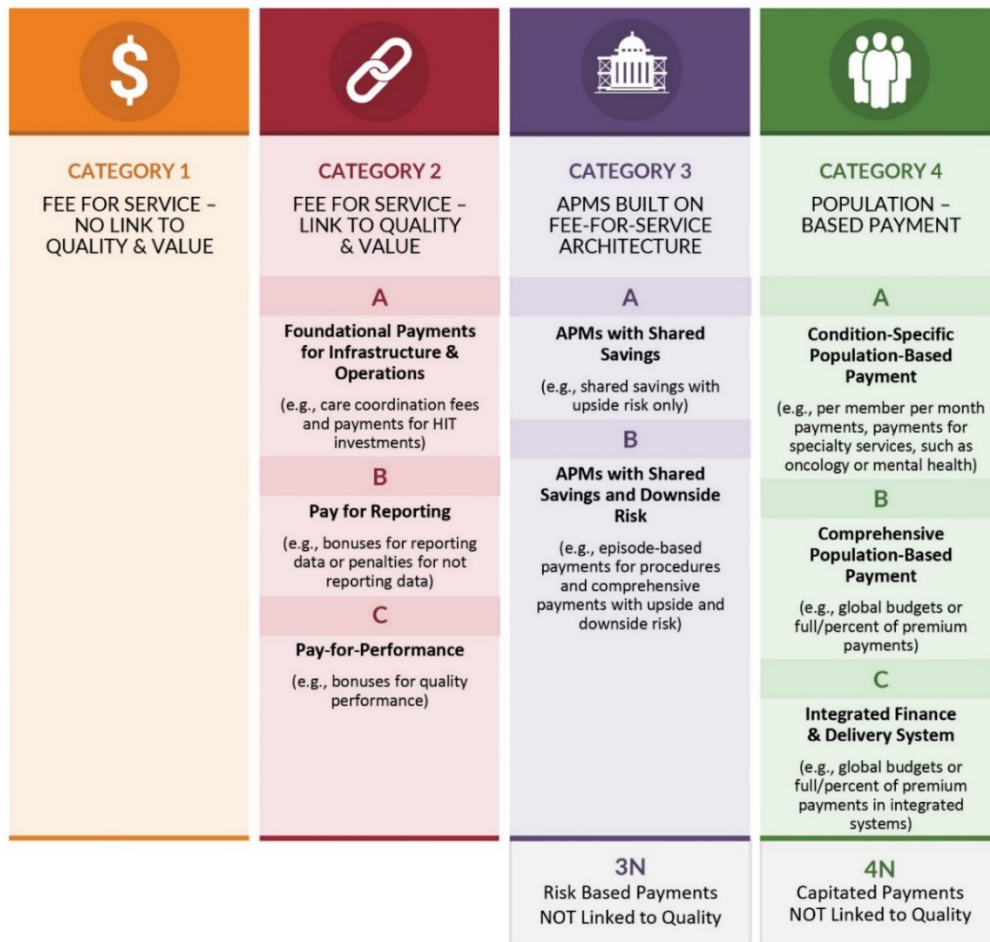
<sup>2</sup> These rates are calculated by summing HCP-LAN categories 2, 3, and 4 from the CY 2018 payment results tables (p.18 and 20) in the HCP-LAN 2019 Methodology and Results Report available at <http://hcp-lan.org/workproducts/apm-methodology-2019.pdf>.

<sup>3</sup> A shared savings methodology typically comprises four important concepts: a total cost of care benchmark, provider payment incentives to improve care quality and lower total cost of care, a performance period that tests the changes, and an evaluation to determine the program cost savings during the performance period. For a detailed discussion of shared savings in the Medicaid context, please review State Medicaid Director Letter #13-005 on “Shared Savings Methodologies” (Aug. 30, 2013) available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-005.pdf>.

with those of beneficiaries and payers, including states and managed care plans. Total cost of care approaches prioritize results rather than individual billable services.

Alternative payment methodologies (APM) aim to increase provider accountability for care by attributing patients to providers and linking payment to outcomes. Medicaid’s use of APM in this letter refers to the term as generally understood by the field, rather than the specific defined term under the Medicare Quality Payment Program. The HCP-LAN has created an APM framework that arrays models across four categories distinguished by the level of financial risk assumed by providers; Category 1 is limited to fee-for-service while Category 4 is designated population-based or global APMs, in which providers assume the greatest risk and are responsible for population health.<sup>4</sup> States frequently reference this categorical framework in considering and describing their strategic approach to drive value in healthcare delivery.

**Figure 1: HCP-LAN Alternative Payment Methodology Framework**



<sup>4</sup> Please review the HCP-LAN APM Framework 2017 Refreshed Report for details regarding each category (p. 23-29). The report is available at <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

The HCP-LAN sets ambitious goals for increasing the adoption of VBP across the nation and recently released revised adoption targets for different payers going into the future, including goals for downside risk or shared accountability.<sup>5</sup> HCP-LAN's new goals outline the percentage of healthcare payments that are tied to two-sided risk APMs; that is, payment arrangements that include both opportunities for shared savings and shared losses (i.e. Categories 3 and 4). HCP-LAN's Medicaid goals include 15 percent of healthcare payments to be tied to two-sided risk APMs by 2020, 25 percent by 2022, and 50 percent by 2025. The survey indicated Medicaid was only at 8.3 percent of payments in two-sided risk arrangements in 2018. HCP-LAN has documented the nation's current progress in a report released in mid-2019; CMS recommends states consult the HCP-LAN survey of APMs for an understanding of its methodology and findings.<sup>6</sup> States should give careful consideration to their own situational and provider landscapes when setting statewide APM adoption goals.

### **Key Considerations for States Pursuing Value-based Payment**

#### *Building on Lessons Learned*

CMS, in partnership with states and providers, continues to support and test various payment and service delivery models that aim to achieve better care for patients, smarter spending, and healthier communities. Beginning in 2010, CMS committed significant federal investments through Delivery System Reform Incentive Payment (DSRIP) demonstration programs authorized under section 1115 of the Social Security Act (the Act). DSRIPs were intended to be one-time investments, with states sustaining delivery reforms upon DSRIP completion without reliance on additional federal funds. CMS is phasing out DSRIP funding at each state's scheduled DSRIP completion date. DSRIP programs provided states with resources to catalyze significant reforms through the development of infrastructure, workforce enhancements, redesign of systems and processes, and provider incentives to change behavior. A recently completed federal evaluation of DSRIP demonstrations showed overall mixed results from these programs (evaluation report is forthcoming). The mixed results from this federal evaluation supports CMS' decision to allow DSRIP demonstrations to end as planned and no longer approve DSRIP investments, reinforcing CMS' new direction for state approaches to VBC. Federal rapid cycle DSRIP reports focus on topics such as designing incentive programs, implementing measure requirements, beneficiary attribution, care coordination, physical and behavioral health integration, adopting VBC, infrastructure and capacity, and supplemental payments, which may be found at this [link](#). Findings from these reports inform the critical elements, considerations, and expectations listed below.

In addition, the CMS Center for Medicare and Medicaid Innovation (referred to hereafter as the "Innovation Center") is testing a growing portfolio of various payment and service delivery models. The Innovation Center and the Center for Medicaid and CHIP Services (CMCS) jointly launched the Medicaid Innovation Accelerator Program (IAP), a five-year initiative designed to

---

<sup>5</sup> HCP-LAN October 24, 2019 Press Release available at <http://hcp-lan.org/workproducts/2019-APM-Progress-Press-Release.pdf>.

<sup>6</sup> HCP-LAN 2019 Methodology and Results Report is available at <https://hcp-lan.org/workproducts/apm-methodology-2019.pdf>

provide technical assistance to support Medicaid agencies' delivery system reform activities, among other policy areas.<sup>7</sup>

Another source of information on new model development is the Physician-Focused Payment Model Technical Advisory Committee (PTAC), created to review stakeholder-submitted payment model proposals and make recommendations to the Secretary of Health and Human Services (HHS). The comments, recommendations, and other information deriving from PTAC's expert review of these proposals have been useful resources for the Innovation Center and other policymakers who are interested in VBP. Additional information about PTAC, the proposals that PTAC has reviewed, and resources that PTAC has developed to assist stakeholders can be found [here](#).

Based on experience to date, including federal evaluation and rapid cycle reports, CMS has identified critical elements of VBP design and operations:

- *Level and scope of financial risk.* CMS models include a broad spectrum of accountability for outcomes. For example, current CMS models include both long-term accountability for cost and episode-based models, in which providers are held accountable for patient outcomes for a defined period related to a triggering event, such as a hospitalization or diagnosis. Models may also include comprehensive accountability for total cost of care or for a more narrowly defined set of services, such as a joint replacement. Finally, models may include varying levels of financial risk. For example, the Direct Contracting Model offers different risk-sharing options in order to attract participation by a range of healthcare providers. The Professional option includes 50 percent savings/losses and provides a capitated, risk-adjusted monthly payment for enhanced primary care services called Primary Care Capitation Payment, while the Global option includes 100 percent savings/losses and allows participants to elect to receive either Primary Care Capitation Payment or a capitated, risk-adjusted monthly payment for all items and services called Total Care Capitation Payment. In general, more comprehensive models incentivize high quality services in the most efficient healthcare setting and promote prevention and primary care over more costly acute care. Other, less comprehensive VBP models create efficiencies associated with services inside of the defined episode (e.g., services associated with joint replacements).
- *Benchmarking.* Many VBP arrangements compare provider financial performance against a target price or benchmark. Benchmarks typically reflect a combination of provider-specific historical trends, regional trends, and adjustments (e.g., risk adjustment). Payers may set a discount against a benchmark, which will result in savings if the benchmark is accurate. If benchmarks are not accurate and are set too high, then model participants will earn more than anticipated in reconciliation payments and the model will not result in program savings. For example, the results from the first two years of CMS' Comprehensive Care for Joint Replacement Model (CJR) indicate that there was a 3.7 percent reduction in gross Medicare payments; however, after taking into account reconciliation payments to participants, there were no significant net savings to

---

<sup>7</sup> The Medicaid IAP website may be found here: <https://www.medicaid.gov/resources-for-states/medicaid-innovation-accelerator-program/index.html>. Please note that the Medicaid IAP ends in September 2020.

Medicare. Voluntary models exacerbate this challenge. In voluntary models, providers may choose not to participate if they believe that they will not financially benefit, or providers may drop out if the model reduces payments. Additionally, voluntary models increase the risk of adverse selection, in which only providers who will benefit from benchmark design elect to participate. Models like CJR, in which provider participation is mandatory in selected geographic areas, are intended to reduce adverse selection and ensure that providers remain engaged even when the model results in lower payments (e.g., due to low quality or high cost relative to the benchmark).

- *Payment operations.* A central component of VBP is provider accountability for cost and quality. Providers need to be able to identify a specific cohort (or “panel”) of patients for whose care they will be accountable. Patients generally obtain care from multiple providers, so payers must determine how beneficiaries will be attributed to providers. Many VBP arrangements include capitated and/or shared savings payments. Operationally, making these payments typically requires determining which providers are participating, which patients are attributed to these providers, and what the provider’s quality score is prior to making payments.

Implementing VBP reflects a significant change to provider business models. States can facilitate successful shifts to VBP through:

- *Multi-payer participation.* Multi-payer participation amplifies the impact of new innovative models and drives care transformation across the healthcare system. States should consider, when designing their programs, aligning the incentives employed in their Medicaid program with those developed by the Innovation Center, as well as those available in other public and private programs. Primary Care First, a new Innovation Center model starting in 2021, continues CMS’ efforts to foster multi-payer participation and offers another opportunity for states to align their Medicaid programs with Medicare in support of primary care delivery. States could also consider an incremental approach, which might take the form of aligned performance and outcome measures, possibly allowing performance on measures used in another public or private program to be applied to their Medicaid program (e.g., Medicare’s Merit-based Incentive Payment System (MIPS)), as well as population health performance across payers. Such alignment may ease the administrative burden on providers as they choose to participate in multiple programs.
- *Assessment of delivery system readiness.* States should consider the capabilities of their delivery systems to drive performance improvement when designing and implementing payment methodologies, recognizing their sophistication in influencing up- and downstream providers,<sup>8</sup> as well as community-based organizations. Experience has shown that safety net providers, in particular, are at varying levels of readiness for adopting VBC. Payers may wish to provide a range of payment incentives to be matched to the amount of performance risk the delivery system can manage, where experienced providers assume more risk, and less experienced providers assume less risk. Reformed

---

<sup>8</sup> Upstream and downstream providers in the Medicaid context are, generally, related network partners for providing and coordinating services to Medicaid members. Upstream providers are considered to be the lead entities that coordinate with the downstream providers in these network partnerships.



payment mechanisms that hold healthcare professionals increasingly accountable for cost and quality and that allow more flexibility in care delivery are central to any efforts to transform care delivery. Payers may be able to increase provider participation and facilitate improved performance by incentivizing greater financial accountability, providing data, supporting infrastructure development, and offering continuing opportunities for stakeholder engagement. Payers need to address provider needs, such as ensuring providers receive all the necessary data (as permitted by law) to inform performance metrics and outcomes, and offer technical assistance that aids willing providers in preparing for VBP. In the development of VBC arrangements, states should note they, as well as payers and providers, must comply with all applicable law and regulations, including, but not limited to, federal and state fraud and abuse laws. States and providers should ensure systems are prepared to accommodate data needs associated with VBP, and systems should be constructed to be helpful and designed not to be especially burdensome on any participants.

- *Robust health information exchange and technology.* States are positioned to promote health information technology (HIT) implementation through a variety of means, such as through support of standardized technologies and data formats, or amending regulations to facilitate data-sharing. Providers need real-time, reliable data in order to support APMs, which pay for value over volume. Having advanced HIT is important for knowing the health of patients and being able to track quality measures. Accordingly, providers should also be capable of exchanging data with states, other providers, and community-based organizations. Providers should also be able to report and analyze their quality data. States should consider requesting 90/10 enhanced system funding through the Advanced Planning Document process to provide more resources to address HIT and other technology needs associated with pursuing VBP.
- *Stakeholder engagement.* States' experiences emphasize the importance of transparency in setting VBC reform goals and programmatic specifications, and upfront engagement with relevant stakeholders. The goals of any reform should be clearly articulated and participation requirements should be transparent and predictable for payers, providers, and beneficiaries. As part of this process, states should consider ongoing structures and processes to support the engagement of beneficiaries in designing VBC reform goals. States should assess implementing reforms that do not unnecessarily exclude beneficiaries with certain health conditions, as appropriate. To the extent that reforms are aimed at addressing individuals in need of long-term services and supports, these processes should take into account person-centered planning consistent with requirements under 1915(c) waivers and 1915(i), 1915(j), and 1915(k) state plan options for home and community-based services. Finally, the intent behind VBP is for beneficiaries to be provided better, more efficient care; the effect of a model on beneficiaries should not be considered only as an afterthought in model design.
- *Quality measure selection.* To ease the adoption of VBC arrangements and promote multi-payer alignment, we encourage states and payers to pick established metrics to reduce provider burden, prioritizing those that are useful across payers and promote service integration across care settings. Measures that are part of broader state VBP efforts and that are used in other CMS programs or initiatives (e.g., Medicare Advantage, MIPS, or Innovation Center models) are critical to easing provider participation and

engagement in state-driven VBP, reducing the burden associated with participation in models. In addition, provider incentives may be most impactful on changing clinical behaviors when they closely follow the incentivized activity without a significant time lag.

- *Sustainability.* Finally, states should proactively plan for a pathway to long-term sustainability for VBP as part of the selection of payment models. For models to meaningfully contribute to reducing the cost and improving the quality of care into the future, payers and providers should be incentivized to permanently reorient their methods and practices from volume to value.

### **Examples of Innovative Payment Models to Achieve Value-based Payment**

CMS is committed to helping states prepare Medicaid providers for the transition to VBP methodologies with an agile, staged approach to sustainable transformation. To facilitate the advancement of APMs and support state efforts, CMS has identified key features, as well as applicable Medicaid authorities for VBP models, as described herein and noted in Table 1 (Innovative Payment Strategies and Key Features). States should consider the adoption of models in the context of the lessons described above, particularly in the areas of delivery system readiness and multi-payer alignment. These models are not mutually exclusive. The APMs as outlined may be applicable to a mixture of payers, provider types, and state goals. Ultimately, states should consider aligning payer and provider incentives as they pursue VBP models. Each payment model links payment changes to quality improvement and introduces better financial accountability in a unique way.

The payment models listed below are organized by magnitude of complexity and risk, and states should consider their specific circumstances before selecting models for adoption. States may adopt multiple payment strategies noted below in order to promote VBP. Incorporated in each of these payment strategies are shared savings or other similar arrangements. These arrangements may allow providers to share in a portion of savings they generate relative to pre-established spending targets, given providers meet or exceed quality targets.



**Table 1: Innovative Payment Strategies and Key Features**  
*Models listed below may (and often do) fit into multiple payment categories.*

Payment Strategy	Key Features	Examples of Models <sup>9</sup>	Social Security Act Authority Necessary for Medicaid Implementation	HCP-LAN Category <sup>10</sup>
Payment models built on fee-for-service architecture	<ul style="list-style-type: none"> <li>State or payer pays healthcare provider directly on a fee-for-service basis for all populations or sub-populations for some or all services received, either retrospectively, or prospectively based on value-based advanced payment methodologies.</li> <li>Adjustments (usually retrospective) for the cost and quality of services provided relative to benchmarks.</li> </ul>	<ul style="list-style-type: none"> <li>Primary care case management (PCCM), PCCM-entity (PCCM-E)</li> <li>Primary Care Medical Homes (PCMH) (e.g. South Dakota health home benefit)</li> <li>Shared Savings models (e.g. Arkansas, Maine, Ohio)</li> <li>Massachusetts Model B (Primary Care Accountable Care Organization (ACO))</li> <li>Home Health Value-Based Purchasing (HHVBP) Model*<sup>11</sup></li> </ul>	<p><i>To implement through fee-for-service: 1905(t) – primary care case management<sup>12</sup></i></p> <p><i>To implement through managed care:</i></p> <ul style="list-style-type: none"> <li>1915(a) – voluntary via contract</li> <li>1932(a) – State Plan option</li> <li>1915(b) – managed care via waiver</li> </ul>	Categories 2-3

<sup>9</sup> Innovation Center models are denoted via asterisk. Descriptions of Innovation Center models can be found at the following website: <https://innovation.cms.gov/initiatives/#views=models>

<sup>10</sup> Category 1 – FFS with no link to quality and value; Category 2 – FFS with link to quality and value; Category 3 – APMs built on FFS architecture; Category 4 – Population-based payment. For detailed definitions of HCP-LAN categories, please consult the APM Framework 2017 Refreshed Report (p. 23-29) available at <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

<sup>11</sup> The HHVBP Model is a Medicare model.

<sup>12</sup> States may use the authority under section 1905(t) of the Social Security Act to offer coordinating, locating, and monitoring activities broadly and create incentive payments for providers who demonstrate improved performance on quality and cost measures, including PCCMs and PCCM entities as defined under 42 CFR part 438.2.

<b>Payment Strategy</b>	<b>Key Features</b>	<b>Examples of Models<sup>9</sup></b>	<b>Social Security Act Authority Necessary for Medicaid Implementation</b>	<b>HCP-LAN Category<sup>10</sup></b>
	<ul style="list-style-type: none"> <li>Providers may be eligible for payments based on performance for a subset of total care (“upside risk”), for example on primary care services, if they also meet related performance and quality targets. Providers may also owe money (“downside risk”) if they do not meet performance and quality targets.</li> </ul>			
Episode of care payments	<ul style="list-style-type: none"> <li>States or payers pay healthcare providers a bundled payment for some or all services associated with episodes of care during a defined period of time, the amount of which may be established by comparing actual</li> </ul>	<ul style="list-style-type: none"> <li>Bundled Payments for Care Improvement (BPCI) Advanced*<sup>13</sup></li> <li>Oncology Care Model (OCM)*<sup>14</sup></li> <li>Comprehensive Care for Joint Replacement (CJR)*<sup>15</sup></li> <li>Arkansas Medicaid Health Care Payment Initiative Episodes of Care</li> </ul>	<p><i>To implement through fee-for-service: 1905(a)</i></p> <p><i>To implement through managed care:</i></p> <ul style="list-style-type: none"> <li>1915(a) – voluntary via contract</li> <li>1932(a) – State Plan option</li> </ul>	Categories 2-3

<sup>13</sup> BPCI Advanced is a Medicare model.

<sup>14</sup> OCM is a Medicare model.

<sup>15</sup> CJR is a Medicare model.

<b>Payment Strategy</b>	<b>Key Features</b>	<b>Examples of Models<sup>9</sup></b>	<b>Social Security Act Authority Necessary for Medicaid Implementation</b>	<b>HCP-LAN Category<sup>10</sup></b>
	<p>episode expenditures to an established benchmark price.</p> <ul style="list-style-type: none"> <li>• Allows state or payer to use benchmark price to determine savings.</li> <li>• Incentivizes quality over volume of services.</li> <li>• Conducive to multi-payer alignment.</li> <li>• Providers may be eligible for payments (“upside risk”) or may owe money (“downside risk”) based on performance relative to the benchmark price for the episode of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Tennessee Medicaid Delivery System Transformation Episodes of Care Program</li> </ul>	<ul style="list-style-type: none"> <li>• 1915(b) – managed care via waiver, specifically for PCCMs and PCCM entities</li> </ul>	
<p>Payments involving total cost of care accountability</p>	<ul style="list-style-type: none"> <li>• Payers may pay providers a number of different ways – bundled payments, fee-for-service, capitated payments, or global payments.</li> </ul>	<ul style="list-style-type: none"> <li>• ACO initiatives (e.g., Medicare Shared Savings Program, Next Generation ACO Model*<sup>16</sup>)</li> <li>• Maryland Total Cost of Care Model*</li> </ul>	<p><i>To implement through fee-for-service: 1905(a)</i></p> <p><i>To implement through managed care:</i></p> <ul style="list-style-type: none"> <li>• 1915(a) – voluntary via contract</li> </ul>	<p>Categories 3-4</p>

<sup>16</sup> The ACO initiatives within this bullet are specific to Medicare.

<b>Payment Strategy</b>	<b>Key Features</b>	<b>Examples of Models<sup>9</sup></b>	<b>Social Security Act Authority Necessary for Medicaid Implementation</b>	<b>HCP-LAN Category<sup>10</sup></b>
	<ul style="list-style-type: none"> <li>• Healthcare providers are held accountable for all populations or sub-populations for some or all services.</li> <li>• Healthcare providers may be responsible and at risk for all aspects of a patient’s care, or just specific condition(s).</li> <li>• Provides flexibility to payers and healthcare providers in addressing community needs.</li> <li>• Healthcare providers may be eligible for payments (“upside risk”) and/or may owe money (“downside risk”) based on their performance.</li> </ul>	<ul style="list-style-type: none"> <li>• MassHealth ACO Model A (Accountable Care Partnership Plan)</li> <li>• Vermont All-Payer ACO Model*</li> </ul>	<ul style="list-style-type: none"> <li>• 1932(a) – State Plan option</li> <li>• 1915(b) – managed care via waiver</li> </ul>	

### ***Payment Models Built on Fee-For-Service Architecture***

CMS recognizes that a number of states have not adopted capitated managed care, and that even those states that have adopted managed care may not have sub-capitated payments (meaning payments from managed care plans to providers that are capitated). As a result, FFS payments still remain, even among the portfolio of VBP models that states use. States may apply more advanced models built on FFS architecture for all populations or sub-populations (e.g., people with specific conditions) for some or all services received. While a FFS approach involves individual payments for individual services, more sophisticated FFS models permit states to introduce elements of value when directly reimbursing providers for services.

The Medicaid state plan allows flexibility for states to draw down federal financial participation (FFP) for incentivizing value-based payment in an FFS system.<sup>17</sup> As one path towards value-based care, states have implemented state plan payment methodologies that pay providers for a course of treatment or for treating or managing a specific clinical condition, rather than on an individual FFS basis. For example, states have defined episodes associated with medical, surgical and behavioral health treatments over a defined length of time. Using historical spending and quality metrics to establish a baseline, states have rewarded providers that meet or exceed cost savings and quality targets within a performance period. Specifically, states have established performance periods for an episode of care associated with clinical conditions and determined the anticipated costs that would usually be paid for care within the period. Providers that hold care cost below the anticipated cost within the performance period and improve quality may be rewarded with incentive payments, while providers that do not improve quality and reduce cost may be held at risk. Arkansas and Ohio have approved state plan payment methodologies for episodes of care.

States have also designed quality-based pay for performance methodologies that incentivize improved care associated with a Medicaid service rather than increased volume. Examples of these approaches may include: shared savings payment methodologies that reward providers for lowering the cost of care beneath the benchmark through improved quality and care coordination, sometimes through Medicaid ACOs; primary care medical homes; and health homes for enrollees with chronic conditions. States have designed these models using upside only arrangements for providers that meet performance goals for cost savings and quality improvement or as risk-based models involving downside risk for the provider if the provider does not meet performance goals. CMS has approved shared savings methodologies within state plans in several states, including: Arkansas, Connecticut, Idaho, Maine, Minnesota, Ohio, and Vermont.

Depending on a state's goals for value-based payment and the population(s) to be targeted under those efforts, existing state plan and waiver options are available for coverage of a wide array of services. Highlighting one example, section 1945 of the Act authorizes states to elect to cover a package of case management and care coordination services for individuals with chronic

---

<sup>17</sup> Please note that, like non-VBP payments, any VBP model payment requires an appropriate source of the non-federal share of the payment, consistent with all applicable requirements for permissible sources of the non-federal share of Medicaid expenditures.

conditions in a Health Home under the state plan. States have flexibility to identify the chronic conditions to target under a Health Home program, and to determine which providers are qualified to furnish Health Home services. For example, South Dakota's health home benefit includes four payment acuity tiers and a quality incentive payment to incentivize providers with small caseloads, usually in rural and frontier areas, to continue to participate and to reward providers performing above the mean on clinical outcome measures.

Two examples of models utilizing FFS payments are listed below.

- *Medicaid Model Example: Minnesota ACO*

Minnesota received approval in 2012 for ACO-like model services under the state's "Integrated Health Partnership (IHP)." Under the IHP, providers deliver primary care case management services as defined in section 1905(t) of the Act, and are paid risk- and complexity-adjusted quarterly payments for coordinating, locating, and monitoring healthcare services for attributed beneficiaries. The Minnesota IHPs may also receive shared savings payments when their attributed beneficiaries' healthcare quality, outcomes, and healthcare expenditures meet state-specified targets.

- *Dually Eligible Model Example: Washington Managed FFS*

Washington uses Medicaid health homes to coordinate services for high-cost, high-risk beneficiaries, including those who are dually eligible for Medicare and Medicaid. Equipped with a powerful predictive modeling infrastructure, health home care coordinators work with beneficiaries to set health action goals and improve self-management skills, while the state pays for health home services on a per-person-per-month basis. In partnership with CMS, the state is eligible to share in savings where health home activities improve quality and reduce costs for Medicare and Medicaid – total-cost-of-care accountability across both programs – for dually eligible beneficiaries. Preliminary results from the first four demonstration years in Washington show gross Medicare Parts A and B savings of approximately 10 percent, with evidence of positive beneficiary experience and quality trends. Based on these results, we have already made interim performance payments of over \$50 million to the state of Washington.<sup>18</sup>

### ***Managed Care Authorities for Value-based Payment***

CMS recognizes that the majority of Medicaid beneficiaries are served in managed care arrangements. More than two thirds of Medicaid beneficiaries, or around 55 million people, are enrolled in comprehensive managed care organizations (MCOs) through arrangements that allow private health plans to administer state Medicaid benefits.<sup>19</sup> In 38 states, at least 50 percent of all Medicaid beneficiaries, and in 33 states, about 79 percent of CHIP children, are enrolled in comprehensive MCOs, as growth in managed care enrollment has continued. The Medicaid

---

<sup>18</sup> The Washington model operates through the Medicare-Medicaid Financial Alignment Initiative. Through this initiative, CMS is working with states to test models that better align care delivery and financing for individuals dually eligible for Medicare and Medicaid. These state-CMS partnerships aim to better integrate primary, acute, behavioral health, and long-term services and supports for dually eligible beneficiaries. See SMDL #19-002.

<sup>19</sup> <https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html>

managed care regulations in 42 CFR part 438 permit a variety of mechanisms that states can utilize for VBP initiatives through their managed care plan contracts. Specifically, these initiatives may be implemented through states' contracting with Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs), herein referred to as managed care plans.

*State Directed Payments (42 CFR §438.6(c))*

Federal Medicaid managed care regulations include requirements for how states may implement delivery system and provider payment initiatives through Medicaid managed care. With limited exceptions, Medicaid managed care regulations generally prohibit states from directing a managed care plan's expenditures to providers for services that are covered under contract. States must develop actuarially sound rates that cover the costs for delivery of services under the contract; managed care plans, as risk-bearing entities, have the responsibility to manage risk for delivery of those services. In order to do that, managed care plans must be able to fully utilize the payment under the contract for the delivery of services. When states direct managed care plan expenditures under the contract, doing so can undermine the risk-based nature of the contract and distort payments made from the plan to providers in ways that do not relate to service utilization or provider performance. However, 42 CFR §438.6(c) sets forth exceptions to the general prohibition on state direction of how much and through what kind of arrangement a managed care plan pays providers who furnish covered services. The exceptions include state directed implementation of value-based purchasing models and other service payment models intended to recognize value or outcomes over volume of services, participation in delivery system reform or performance improvement initiatives, and certain minimum fee schedules. The payment arrangements identified in 42 CFR §438.6(c) permit states to direct specific payments made by managed care plans to providers under certain circumstances ("state directed payments") and can assist states in furthering the goals and priorities of their Medicaid programs, including to promote VBP initiatives. For example, a state may require managed care plans to adopt specific VBP models (e.g., Accountable Care Organizations) or provider pay for performance or incentive payments (e.g., payments based on reducing potentially preventable readmissions).

State directed payment arrangements under 42 CFR §438.6(c) are required, among other things, to be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract rating period; to direct expenditures equally for a defined class of providers using a common set of performance measures; and to advance at least one of the goals and objectives in the state's quality strategy.<sup>20</sup> States are required to receive written prior approval from CMS using the preprint form posted on the Medicaid.gov website. In addition, all payment arrangements approved under 42 CFR §438.6(c) are required to conform to federal regulatory requirements, including that they be incorporated into managed care contracts and rate certifications. Approval of a state directed payment under 42 CFR §438.6(c) does not constitute

---

<sup>20</sup> Approval under 42 CFR § 438.6(c) provides authority for states to include contract requirements directing a plan's expenditures. The payments must tie to the delivery of services that occur during the rating period (e.g., not historical utilization). Approval under 438.6(c) does not grant authority to cover services; states must already have Medicaid authority for the underlying services either under the Medicaid state plan or through a Medicaid waiver or demonstration program.



approval of the financing mechanism for the non-federal share, and states will need to work with the appropriate CMCS staff to obtain the necessary approvals of a financing mechanism.

An example of a provider pay for performance or incentive payment arrangement includes states that contractually require 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. The incentive payment is determined based on both the incremental improvement of the individual hospital from the previous rating period to current rating periods and achievement of a statewide benchmark.

States interested in incorporating state directed payments into their managed care programs, including those that accelerate VBP, should consult the resources available at <https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html> including the Appendix to our November 2017 CIB on State Directed Payments, which provides more detail on the Accountable Care Organization model as well as the incentive payments based on reducing potentially preventable readmissions mentioned above. We encourage states to reach out early for technical assistance to expedite CMS' review of preprint proposals, including to discuss essential parameters such as evaluation and quality metrics. Please email [StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov) with questions or requests for technical assistance.

*Managed Care Plan Incentive Payments and Withhold Arrangements (42 CFR §438.6(b))*

States may also use incentive payments to reward managed care plans that accelerate provider adoption of VBP in line with performance targets specified in the managed care plan contract, including implementation of a mandatory performance improvement project under 42 CFR §438.330(d) that focuses on adoption of VBP models and percentage of plans' provider payments through VBP arrangements. These incentive payments represent additional funds *over and above the capitation rates*. Incentive payments must comply with all requirements in 42 CFR §438.6(b)(2), including that managed care plan contracts incorporating incentive payments must not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

In the 2016 managed care final rule (81 FR 27498, 27530 (May 6, 2016)), CMS specified that incentive payments made to a managed care plan in accordance with 42 CFR §438.6(b)(2) should not be included in the denominator of the medical loss ratio (MLR) as such payments are in addition to the capitation payments received under the contract. However, these MLR standards can support states and managed care plans in their efforts to design and implement comprehensive VBP acceleration strategies by ensuring amounts can be appropriately identified and classified within each managed care plan's MLR.

States can also implement a withhold arrangement with their managed care plans as well. For a withhold arrangement, a portion of a capitation payment is withheld from the plans, which can be earned back by the plan for meeting targets specified in the contract such as meeting quality performance targets specified in the managed care plan contract. This could include implementation of a mandatory performance improvement project under 42 CFR §438.330(d)

that focuses on adoption of VBP models and percentage of plans' provider payments through VBP arrangements.<sup>21</sup> Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary in accordance with 42 CFR §438.6(b)(3). Withheld amounts that are paid to the managed care plan are included in the MLR denominator. For example, Washington State withholds up to two percent of MCO payments until MCO/provider VBP contracting goals are met.

### *Managed Care Plan Contracting Strategies*

States may also develop and implement specific managed care plan procurement and contracting strategies to promote VBP goals. For example, states may require managed care plans, through their plan contracts, to adopt a specific VBP model that was developed by the Medicaid agency or other stakeholders and payers, including requiring participation in a multi-payer VBP initiative, provided that applicable requirements in 42 CFR §438.6(c) are met. Such an approach – particularly if aligned with commercial, Medicare, Marketplace, and other payers with longer term contracts – may promote consistency, reduce the burden on providers to participate, align incentives, and enable the state to accelerate VBP across Medicaid and beyond. For example, the state of Tennessee requires managed care plans to implement the state's patient-centered medical home and retrospective episode-of-care models.

States also may contractually implement a generic requirement for managed care plans to utilize VBP or alternative payment arrangements when the state does not mandate a specific payment methodology and managed care plans retain the discretion to negotiate with network providers the specific terms for the amount, timing, and mechanisms of such VBP or alternative care arrangements. While states may design the specific requirements in line with their VBP goals, states may consider an approach whereby the proportion of each managed care plan's provider payments tied to VBP models increases over time (e.g., 5 percent in Year 1; 10 percent in Year 2; 15 percent in Year 3, etc.). In addition, or as an alternative to the state defining specific VBP goals, states may allow managed care plans to submit proposed VBP arrangements for approval and demonstrate achievement of the contracted benchmark by providing supporting data, as requested and required by the state. For example, South Carolina requires managed care plans to meet VBP contracting targets with their network providers; originally set at 5 percent of provider payments in Year 1, the target increased to 20 percent in Year 3.

States may also require managed care plans, through their plan contracts, to advance VBP along with parameters essential to the state's broader VBP strategy, such as to achieve aligned performance metrics; consistent phasing-in of more sophisticated VBP models; and specific provider data analysis. Similarly, states may require plans to launch VBP pilots and related initiatives, subject to state approval, that reflect the state's broader VBP strategy, including specific goals. For example, New Mexico approved a subset of complementary VBP projects of its choosing based on the submitted proposals of its contracted managed care plans. To align

---

<sup>21</sup> The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

these selected VBP pilot projects, the state selected uniform quality and cost metrics and created a template for managed care plans to use to report quantitative and qualitative results for each project.

States also may, as part of their procurement or pre-procurement strategies, help assess managed care plan interest in and experience with VBP. Specifically, a state may inquire, through its request for proposals or a pre-procurement request for information (RFI), about plans' experience with various VBP models, interest in advancing VBP principles in provider contracts, and specific proposals for achieving a state's VBP goals. A state may complement such efforts by inquiring, including through an RFI, into other essential stakeholders' interest in, and ideas for, advancing VBP. Such an approach may be informed by a state's broader strategy for accelerating VBP, which could inform its procurement and contracting strategies. For example, requirements for capitation rate development to use data from the three most recent complete rating periods may reduce incentives for plans that reduce utilization to continue to operate efficiently in future years, as they will not be able to retain those earned savings in future rating periods. This is an important principle of actuarial soundness to ensure that rates paid to plans are appropriate, reasonable, and attainable. States may consider strategies to incentivize continued efficient plan performance by providing incentive payments to plans that achieve certain results, including lower costs and improved health outcomes. Such strategies could provide plans with an incentive for continued improvement. States establishing strategic VBP goals, including having a majority of provider payments in VBP models by a date certain, may consider such an approach for sustaining VBP investment over time. If a state uses multiple strategies, an analysis and evaluation of these employed strategies that determine the financial and quality impacts may be helpful to the state. Such an evaluation may be helpful to determine both the effectiveness and scalability of the state's efforts, with the goal of scaling the most successful components of its strategy and evolving others.

### **Exploring Additional Pathways to Approval of Value-based Payment Strategies**

Outside of a managed care environment, CMS will consider state plan payment methodologies that include downside risk for providers through value-based advanced payment strategies, where providers receive an advanced payment amount to care for individuals attributed to them based on historic Medicaid expenditures as well as care patterns and outcomes of care.<sup>22</sup> CMS' position is that the statute does not prohibit states from articulating advanced payment models in the state plan and through a direct relationship with providers. States will be expected to ensure, through an approved reconciliation process, that total payments are consistent with "efficiency, economy and quality of care," and are also "sufficient to enlist enough providers..." to meet the statutory access requirements of section 1902(a)(30)(A) of the Act. In reviewing state proposed methodologies, CMS will ensure payments are consistent with all requirements in section 1902(a)(30)(A) of the Act, including "efficiency, economy, and quality of care." CMS is willing

---

<sup>22</sup> Section 1902(bb)(6) allows for states to develop APMs that are agreed to by the state and a Federally-qualified health center (FQHC), and that result in payment no less than the FQHC's prospective payment system (PPS) rate. States may develop APMs that align with the policies discussed in this letter, but where the APM affects payments to FQHCs, the APM must provide for reconciliations to ensure that total payments to each FQHC are not less than the payments the FQHC would have received under its PPS rate.

to work with states to develop reconciliation processes that would comport with applicable statutory requirements.

Depending on the model developed by a state and approved by CMS, including an Innovation Center model, states potentially could hold providers at risk for losses in the event that actual care expenditures for attributed beneficiaries exceeded the monthly payments that were paid over a defined period. States also could reward providers when quality is improved and care expenditures fall below the monthly payments made to providers by allowing them to retain some or all of the amount identified through reconciliation as exceeding actual care expenditures. Importantly, to ensure consistency with section 1902(a)(30)(A), when care expenditures fall below monthly payments and quality improvements are not evident, a provider would need to return the portion of the monthly payments to the state representing the monthly payments paid in excess over actual care expenditures. States may define reasonable thresholds for what may be acceptable provider losses or gains in such arrangements, to ensure that provider gains and losses are moderated where appropriate or necessary to satisfy the requirements of section 1902(a)(30)(A) of the Act. Moreover, CMS will review state proposals to ensure state defined thresholds are consistent with requirements in section 1902(a)(30)(A).

We would like to note that through existing flexibilities under the Act, CMS has approved state plan payment methodologies consistent with 1902(a)(30)(A) that make monthly payments to providers for delivering Medicaid services and that reward providers for meeting performance requirements. Section 1905(t) of the Act authorizes primary care case management services which states have used to implement a medical home concept under Medicaid state plan authority.<sup>23</sup> Under this authority, states may make monthly payments for case management services, as well as hold providers accountable for beneficiary service costs through upside (shared savings<sup>24</sup>) and downside risk arrangements. In addition, the Health Homes authority of section 1945 of the Act permits flexibility in payment, including making monthly payments for Health Homes services.<sup>25</sup> States may layer incentive payment structures that are funded by state-budgeted supplemental payment pools upon monthly payments to incentivize and reward providers who meet quality and outcomes performance requirements. We note all federal statutory and regulatory requirements on state financing to fund the non-Federal share apply under VBP methodologies. The combination of monthly advanced payments and incentive payment pools may be employed by states to develop numerous VBC strategies under existing Medicaid state plan authorities. States should be mindful of how payments made to providers work in a complementary manner to improve care and outcomes and to ensure that such payments are not duplicative. Along with the existing flexibilities under the Act, there are a number of considerations and expectations of states considering advanced payment methodologies that are discussed below.

---

<sup>23</sup> Please see State Medicaid Director Letters #12-001 and #12-002 for a discussion on the use of Section 1905(t) authority in state plans (July 10, 2012) available at <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD-12-001.pdf> and <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>.

<sup>24</sup> For a detailed discussion of shared savings in the Medicaid context, please review State Medicaid Director Letter #13-005 on “Shared Savings Methodologies” (Aug. 30, 2013) available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-005.pdf>.

<sup>25</sup> Please find Health Homes information available at <https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html>.

*Considerations and Expectations for Advanced Payment Methodologies*

We encourage states to work closely with CMS when developing advanced payment methodologies to achieve their intended goals for VBP reform. As always, state plan amendments must be consistent with federal requirements and should advance improved care for beneficiaries, smarter spending, and healthier communities. Within this letter, we offer states planning and methodological considerations that should be factored into any of these proposals, as well as technical guidance that CMS expects states will address in their submissions. We expect states to consider each of the methodological components described in this letter to ensure consistency with section 1902(a)(30)(A) as states develop a proposal for CMS to review. We do not foresee a “one size fits all” approach to advanced payment methodologies, and at this time believe it is too early to determine if there are criteria and universal standards that can apply to all Medicaid models. Our goal is to work in partnership with states to develop methodologies that address the expectations below. Importantly, consistent with the VBP strategies discussed within this letter, we expect advanced payments to improve quality and health outcomes and for states to have meaningful quality strategies in place to ensure the methods are not detrimental to quality and access to care, which would be inconsistent with section 1902(a)(30)(A) of the Act. Advanced payment methods should not be based only on cost savings or result in harm to Medicaid beneficiaries.

We are eager for states to continue pursuing advanced payment opportunities, and CMS understands that there is a spectrum of state experience with advanced payment methodologies; states less experienced with comparable VBC approaches may feel challenged in designing and successfully implementing these valuable reforms. For these states, CMS may consider providing section 1115(a) authority so states may pilot advanced payment strategies under FFS as part of a demonstration.

In determining whether to approve a state’s state plan amendment (SPA) contemplating advanced payment methodologies under FFS authority, we will examine how the state’s request addresses the following criteria.

Data, payment and claims tracking, and quality: In order for states to implement an advanced payment strategy under state plan FFS authority, states must have the capability to collect, track, and analyze all data needed to reconcile advanced payments made with claims and evaluate provider quality and outcomes performance. For example, states should address the following question:

- What claims and payment data will be used to determine advanced payments, including the data source, the time period of the data, and how the data will account for population cost variation?

Overview of advanced payment methodologies: States must submit and receive CMS approval for their advanced payment methodology. The submission must comprehensively describe the advanced payment methodology, including: which providers qualify for the payment, how they

qualify, how the payment amount is calculated, how the payment will be distributed, when the payments will be made (e.g., weekly, monthly, or quarterly), how beneficiaries will be attributed to providers, and when the total advanced payment revenue will be reconciled with total claims from the same period. Additionally, the methodology must describe the process a state will employ to ensure the advanced payment does not result in reductions to quality of care or access. We note that advanced payment revenue should include only payments received for the Medicaid services that the advanced payment is meant to pay and should not include general revenue paid to providers. Specifically, advanced payment revenue should not include any supplemental or bonus payments or payments for other services that are not covered under the advanced payment methodology. We note this because the reconciliation process must compare claims for the same services as the advanced payment during the same time period. CMS will review proposed advanced payment methodologies to ensure they comply with all statutory and regulatory financing requirements.

Mechanics of advanced payment methodologies: States may only make advanced payments to eligible providers who can be identified at the billing provider's claims-paid level in order to be able to reconcile claims paid with advanced payments made to the same provider. Importantly, section 1902(a)(32) of the Act requires, with limited exceptions, "that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service..." States should be mindful of this requirement when determining the providers that are eligible for the advanced payment. CMS notes that while states must make direct payment and may not mandate that providers share their advanced payments, providers may enter into voluntary agreements outside of the Medicaid state plan to share payments with downstream providers who are part of the VBC model's health team.

Advanced payments for which FFP will be claimed must be processed through the state's Medicaid Management Information System (MMIS). Additionally, in establishing how the advanced payments will be determined and processed, states should consider:

- The factors that are used to determine the advanced payment amounts, such as: the providers' previous period of Medicaid FFS claims and the number of FFS Medicaid beneficiaries attributed to providers. If based on claims, the state must specify the timespan of the past period claims and any inflation factors used to estimate current period claims amounts.
- Risk adjustments made to the payments to account for the health and social/demographic status of the attributed beneficiaries. States should document how risk adjustment for the attributed beneficiaries will occur.
- The processes in place to ensure the advanced payments processed in MMIS can be matched with actual services rendered by a provider receiving advanced payments during the payment period. For example, in order to reconcile advanced payments with provider claims, the state could instruct providers receiving advanced payments to submit claims to the state for the amounts the providers otherwise would be paid except for their participation in an advanced payment methodology, which claims would be recorded in MMIS, for the services paid for by the advanced payments during the payment period.

The state would not make payment on these claims for services covered by the advance payment, but would retain the claims for reconciliation purposes. Alternatively, the state could instruct providers to submit “zero dollar” claims, which also could be used as the basis for advance payment reconciliation whereby a state would calculate the total amount that would have been paid had the claims been paid on an individual basis and compare this amount with the advanced payment amount.

States should also address the following questions in their methodology:

- Does the methodology apply to services available statewide to all individuals under the state plan or does it limit benefits to geographic regions or to populations residing in geographic regions in the state? If a state intends to add new benefits via this methodology and geographically limit their provision, the state may need to obtain 1115 waiver authority.
- Are the payments under the methodology available to all Medicaid providers or are they limited based on provider eligibility criteria? What are the provider eligibility criteria?
- Does the methodology partially or fully align with an Innovation Center model? What are any material differences? If the methodology aligns with an existing Innovation Center model, could the state use existing Medicaid authorities to replicate or simulate the model in their program?

Attribution: At the time of submission of the SPA, states must submit and receive CMS approval for their attribution methodology. States may determine if the advanced payment model will align with an Innovation Center model’s attribution methodology or a state designed model and must comprehensively describe the attribution methodology in the state plan.

- If advanced payment will be made based on the number of beneficiaries attributed to a provider, the state must specify the attribution methodology. For example, will beneficiaries be attributed based on plurality of claims, most recent visit, geographic locality, etc.?
- States must specify how providers will be notified of the beneficiaries attributed to them, how often they will receive beneficiary rosters, and when the rosters will be revised to account for any beneficiary eligibility changes.
- States must specify whether data for attributed beneficiaries will be risk adjusted to account for differences in beneficiary health and social/demographic status.
- States must specify how the attribution methodology avoids duplicate advanced payment to multiple providers for the same beneficiary. States will have to attest to CMS that there is no duplication of payments.

Claims tracking: States must have claims systems that allow them to track individual providers who receive advanced payments and those providers’ individual claims. For states paying based on attributed beneficiaries and reconciling beneficiary claims to provider advanced payments, states must be able to track claims at the provider and beneficiary levels, and match the services



provided to a beneficiary to the provider receiving advanced payment for those attributed beneficiaries. If providers are prepaid for certain services, such as for primary care services, states must be able to track service-level claims.

Reconciliation process: At the time of the submission of the SPA, states must submit and receive CMS approval for the reconciliation process. For example, states must describe if advanced payments will be reconciled to total provider claims, claims for attributed beneficiaries, or claims for specific services (e.g., evaluation and management codes for primary care), and if reconciled amounts will be adjusted based on performance on quality and outcomes measures. (Note that if advanced payments exceed the amount of revenue that would have been paid based on FFS claims and these overpayments are to be offset by performance on quality and outcomes measures, states must submit to CMS a comprehensively described methodology that details the way in which performance on these measures will reduce overpayments.) The reconciliation process should be similar to protocols for payment of actual incurred costs and cost reporting. At a minimum, reconciliation protocols must include and identify:

- Source(s) of data related to providers, claims, payment, attributed beneficiaries, and quality, as applicable to the state's requested advanced payment methodology.
- Eligible providers.
- Claims payments, services, or attributed beneficiaries for which advanced payment is made.
- Prior period timespan for claims payment totals used to calculate advanced payment amounts, as applicable to the state's requested advance payment methodology.
- Service period during which claims data will be collected for reconciliation.
- Claims run out period.
- Which services are included in claims data that will be used to reconcile against advanced payments. (Please note, the state must perform claims reviews to ensure that providers are delivering and appropriately coding for necessary care and not restricting their provision of care to limit expenditures for attributed beneficiaries.)
- How quality performance will impact reconciliation of advanced payments to actual services furnished. (Please note, in the case of an excess of advanced payments in relation to actual services furnished, states must return the federal share of amounts repaid by providers in accordance with 42 CFR Part 433, Subpart F. Claims for FFP for advanced payments and any related reconciliation payments are subject to the two-year timely filing requirements described at 45 CFR Part 95, Subpart A.)
- Timeframes and procedures for conducting reconciliation and returning FFP to CMS, as required in regulation.

Quality: As discussed above, we expect advanced payment methodologies to promote VBC and ensure that quality and access to care are not reduced as a result of the advanced payment. At the time of the submission of the SPA, states should submit their quality strategy for CMS review and approval. In order to ensure that providers are delivering necessary care, states should include a quality strategy to assess and improve the quality of care of services paid for using

advanced payment methodologies. The state's request should specify how the quality measurement and outcomes strategy is incorporated into the state's advanced payment methodology. As part of the quality measurement and outcomes component of the advanced payment methodology, a state should:

- Determine which providers and services will be subject to the quality and outcomes component.
- Determine how quality and outcomes performance will impact payment. For example, could providers qualify for incentive payments above and beyond the advanced payment amounts? Will performance on quality and outcomes impact any advanced payments made to providers that, upon reconciliation, are determined to exceed payment amounts attributable to the services actually furnished?
  - States must have a comprehensively described methodology that details how the performance on quality and outcomes offsets any excess advanced payments. In addition, the quality and outcomes measurement period must align with the time period in which advanced payments were made.
  - Quality measures should include person-centered planning and reflect input from people with disabilities and individuals with chronic conditions.
- Develop a timeline for implementation of the quality and outcomes strategy. The timeline should include when the measures go into effect, if initial measurement will be used to establish baseline performance, and when providers will be held accountable for performance.
  - CMS acknowledges that states and providers may need to learn and adapt to a new quality measurement program. States should consider how prepared providers are and ensure data systems can accommodate collection and evaluation of performance data. As such, states can contemplate ramping up their quality and outcomes strategy by including an initial “pay for reporting” period. CMS expects the providers to transition to full pay for performance over a reasonable time period.
- Choose quality and outcomes measures that are relevant, non-discriminatory, and appropriate to the services provided by practitioners receiving advanced payments and that align with the state's quality improvement goals.
  - The performance requirements should be set at levels appropriate to achieve performance improvement goals. States may select goals that challenge providers to improve performance, maintain a minimum level of performance, compare providers to their peers or their own prior period performance, etc. (CMS notes that we have approved SPAs that allow providers to select performance measures from a list of measures a state has chosen; states could adopt this approach to advanced payments.) The selected measures should aim to improve performance and states should guard against setting low performance expectations. States should have a strategy for increasing performance expectations and changing measures if providers are meeting expectations too easily. In addition, while the chosen measures can include process measures, the majority generally should be outcome measures. States should also

consider multi-payer alignment when selecting measures, as to incentivize provider participation in models and not add unnecessary burdens related to reporting.

- States should ensure that providers are being held accountable only for their performance and, in the case of attributed beneficiaries, only their attributed patients. The quality and outcomes strategy should reasonably align measurement with accountability. Providers should not be held accountable for measures that the provider is unable to affect or control.

The quality and outcomes measures that states use should be valid and reliable. CMS encourages states to use the Medicaid Adult and Child Core Sets, but also acknowledges that there may be other measures not included in the Core Sets that are part of a state's strategy. Ideally, the measures that are used should be endorsed by an accrediting body such as the National Quality Forum.

As states develop proposed advanced payment methodologies, they should also consider:

- What beneficiary notification and protection processes (e.g. beneficiary complaint lines, state Medicaid ombudsman, etc.) are in place to ensure no harm results from the advanced payment model, and how program integrity will be ensured (e.g. maintenance of free provider choice, no reduction in amount, duration and scope of a medically necessary service, etc.)?
- What will be the state process for claims reviews conducted to prevent up-coding and inappropriate restrictions on care (e.g. providers are providing and appropriately coding for necessary care, and not restricting their provision of certain expensive procedures to limit expenditures for attributed beneficiaries)?
- What are the quality measures, reporting processes and appropriate incentives to maximize the likelihood that the methodology will result in better care and better value?
- Does the state conduct reviews at least annually and make necessary adjustments to the methodology to ensure consistency with economy, efficiency and quality care, as well as sufficient access to covered services for beneficiaries?

### *Payments for Episodes of Care*

Many insurers have begun paying providers for a bundle of services associated with a single episode of care (also known as bundled payments) or a related package of care (maternity, for example). Through a single, bundled payment or an average target cost per episode, providers bear the financial risk of keeping an episode's service costs under the bundled payment amount or target. Bundled payments in Medicaid have not historically been tied to value-based payment; instead, they have primarily been an instrument of administrative simplification via bundling services without any associated quality or cost adjustments.

Bundled payments are increasingly common in cases of childbirth, joint replacement, and other discrete treatment episodes that generally include an expected set of services for treating a condition. However, costs incurred by the payer may substantially vary due to the approach to

delivering those services, without adequate reason for the variance. Bundled payments may be established at the setting level, procedure level, or condition level.<sup>26</sup> Payers should consider the evidence and available data associated with treating a condition when contemplating the creation of a bundled payment. Payers, especially Medicare, continue to experiment with expanding the application of payment bundles to longer episodes that now can also include more than one type of provider and/or domain of services (e.g. both physical and behavioral). The bundle of care is typically still focused on the treatment of a particular condition but includes more components of that care. Some payers may be considering using bundled payments for certain sets of psychiatric services associated with behavioral health disorders. Given states' interests in increasing behavioral health options for beneficiaries, states may look to bundling payments for serious mental illness that includes psychotic disorders, such as First Episode Psychosis (FEP) programs, Assisted Outpatient Treatment (AOT) programs, and Assertive Community Treatment (ACT) programs, in order to effectively promote evidence-based practices through team-based services.<sup>27</sup>

Bundled payments that advance value-based payment allow for the possibility of both upside and downside financial risk. If an episode of care delivered by a provider costs less than the estimated bundled payment, and the provider meets the required quality measure targets, the provider may keep a portion of the difference or receive a performance payment. However, if the costs exceed the bundled payment amount or the provider fails to meet quality measurement goals, the provider may be financially liable for some or all the difference between the payment amount and an episode's cost.

Payers are able to construct episodes of care that include only necessary services according to evidence based standards of care, to be provided in appropriate settings, and by efficient providers. If the bundles are designed correctly, participation should be mutually beneficial across both the payer and providers.

- *Bundled Payments for Care Improvement (BPCI) Advanced*

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is an Innovation Center model continuing efforts in implementing voluntary episode payment models. The BPCI Advanced Model aims to support healthcare providers who invest in practice innovation and care redesign to better coordinate care and reduce expenditures, while improving the quality of care for Medicare beneficiaries. As of the BPCI Advanced Model's third model year (calendar year 2020), it includes 35 different inpatient and outpatient clinical episodes. Examples of these episodes include treatment of renal failure, bariatric surgery, and transcatheter aortic valve replacement. The Innovation Center is actively assessing the BPCI Advanced payment methodology for adjustments to better account for selection effects inherent in

---

<sup>26</sup> Accelerating and Aligning Clinical Episode Payment Models White Paper (p. 6) available at <https://hcp-lan.org/workproducts/cep-whitepaper-final.pdf>.

<sup>27</sup> For additional information on these programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), please visit: <https://www.samhsa.gov/ebp-resource-center/mental-health-treatment/first-episode-psychosis-co-occurring-substance-use>; <https://www.samhsa.gov/grants/grant-announcements/sm-16-011>; <https://www.samhsa.gov/grants/grant-announcements/sm-18-013>.

voluntary models. BPCI Advanced qualifies as an Advanced APM under the Quality Payment Program; Advanced APM providers may be eligible for additional incentives for meeting applicable criteria.<sup>28,29</sup>

- *Tennessee Episode of Care Program*

The state of Tennessee has approached VBP by applying the episodes of care approach to reward high quality and cost-effective acute and specialist-driven care. The Episodes of Care program, which was first implemented in 2014, continues to align provider incentives with patients' desired outcomes resulting in maintained or improved quality of care across most episodes while achieving savings.<sup>30</sup>

### ***Payment Models Involving Total Cost of Care Accountability***

There is a number of ways in which states, insurers, and providers have endeavored to effectuate payment models involving total cost of care (TCOC) accountability. These payment models reflect the TCOC of treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population.<sup>31</sup> Both population-based payment models and comprehensive payment models, discussed below, involve TCOC accountability.

### ***Population-Based Payment Models***

Under population-based payment models, healthcare providers (rather than managed care plans) receive some or all of their payment at some periodic basis upfront, in a lump sum payment. This is different from managed care capitation payments, which are actuarially sound payments made per member per month to a plan to manage the risk associated with delivering services to populations as specified under the contract between the state and the managed care plan. Population-based payments can be used by managed care plans or states as a method to compensate network providers or FFS providers, respectively, and as a vehicle for driving the delivery of VBC.

Capitation-like payments<sup>32</sup>, under population-based payment models, are one of the most flexible payment models, and are appropriate for numerous delivery and payment scenarios. Capitation-like payment arrangements for healthcare providers may include one or both of “shared savings” (also called upside reward) and “shared losses” (also called downside risk). In certain capitation-like payment arrangements with shared savings, providers may be eligible to

---

<sup>28</sup> <https://innovation.cms.gov/initiatives/bpci-advanced/>

<sup>29</sup> <https://qpp.cms.gov/apms/advanced-apms>

<sup>30</sup> “TennCare’s Delivery System Transformation Shows Savings and Improved Outcomes.” Press Release (p. 2) available at <https://www.tn.gov/content/dam/tn/tenncare/documents2/DeliverySystemTransformationReleaseForAnalyticsReport.pdf>.

<sup>31</sup> Alternative Payment Model Framework Final White Paper (p. 16) available at <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

<sup>32</sup> CMS’ use of the term “capitation-like payments” is meant to refer, in a generic sense, to per-person payments, and not to “capitation payments” as defined in 42 CFR 438.2, to which requirements under 42 CFR part 438 would apply.

share in the savings if they reduce spending relative to what the managed care plan and/or state calculated as the expected cost of care for a patient. Providers are thus incentivized to deliver cost-effective and high quality care, as they could share savings stemming from such care. In arrangements with shared losses, providers are financially held to account for adverse quality and health and wellness outcomes by having their payments reduced by a specified factor. For instance, in downside risk, providers take responsibility for an attributed population of patients over a period of time and bear financial liability for costs that exceed a specified threshold. Under such an arrangement between a provider and a managed care plan, if care costs more than the set amount, the provider may be responsible for reimbursing the difference to the plan.

States and payers need to carefully weigh the level of financial risk introduced to providers alongside capitation-like payments, or any risk-bearing payment methodology. While downside risk is an important way to align the incentives of providers with the needs of payers and beneficiaries, its use must be measured given the potential to disrupt the financial solvency of certain providers or provider types. For instance, safety net providers are a core part of delivering services to the Medicaid population, and may not have the financial resources to accept high levels of downside risk. Smaller provider entities may also not be well positioned to accept financial risk. Other types of providers may not have historically borne risk, and may need time to reorient their practices as necessary.

In comparison to comprehensive capitation models, whereby providers deliver or arrange for all healthcare services under the relevant authority, partial capitation, where providers deliver or arrange for a defined subset of services (e.g., primary care, inpatient care, care coordination, etc.) may be a way for providers to participate in value-based payment when the providers are less ready to adopt full capitation. A number of states have partially capitated payments to providers as a way to introduce providers to more sophisticated payment strategies. For instance, certain states pay for primary care benefits through traditional managed care capitated payments, but still pay for long term services and supports through FFS. Behavioral health services have often been carved out of traditional managed care capitation arrangements.<sup>33</sup> While CMS encourages providers to utilize more sophisticated payment methodologies, partial capitation-like payments may be considered a step during a broader transition to risk-bearing payments.

Payers have two primary tools to manage financial risk among providers compensated through capitation-like payment models: risk corridors and risk adjustment. Risk corridors create boundaries around the actual cost experience of the provider's patient panel in order to apply the payment incentives to the cost of care that providers likely can control rather than to extreme costs that likely represent care needs outside of the provider's control. Risk adjustment separately adjusts the PMPM amount to be paid to a provider to account for the average differences in illness burden across providers' patient panels – that is, some providers typically have sicker patients who therefore need more costly care compared to the average illness burden of other providers' patient panels. Risk adjustment essentially levels the ratio of cost to reimbursement across providers. As risk adjustment models often utilize diagnosis or procedure

---

<sup>33</sup> Please note that behavioral health carve-outs may impact the ability of states to comply with Mental Health Parity and Addiction Equity Act (MHPAEA) provisions. Additionally, current standards of care promote greater integration of behavioral health (SUD/MH) into primary care settings.

codes from claims, it is important for payers to account for potential changes in coding practices that can potentially cause under- or over-payments. As coding guidance is updated and providers increase their coding sophistication, potential inaccuracies can be mitigated through the implementation of mechanisms such as caps on year over year risk score changes, normalization of risk scores to an index value, and/or the application coding intensity adjustments.

While capitation-like payments encourage the delivery of appropriate care to beneficiaries, it is important to monitor the implementation of capitation-like payments to make sure that providers provide high-value care, as opposed to cutting corners on the provision of essential care. As such, states should consider how they will ensure that discouraging or delaying appropriate utilization of services is not used as a lever for reducing costs at the provider level, and monitor for any undesirable reductions to utilization. For example, states are strongly encouraged to avoid “fail first” approaches that promote less expensive services that may not be the most effective treatment option according to evidence-based treatment standards. States should also determine whether their implementation of outcome-based payments would have the potential to jeopardize patient access, given that providers potentially could seek to manage the financial risk involved in treating sicker patients by inappropriately excluding them from their panels.

### Comprehensive Models

Comprehensive payment models are among the most innovative and effective ways to align incentives across payers and providers. These models generally include comprehensive population-based payments, often in the form of providers receiving a capitated, flat PMPM payment and being responsible for some or all aspects of a member’s care via a TCOC arrangement. These models encourage providers to deliver well-coordinated, high-quality, person-centered care within either a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system.<sup>34</sup>

The scale of a payment model may be tailored to the needs and capabilities of the payer. There are a number of examples of condition-specific comprehensive payment models, wherein providers receive prospective capitated payments for comprehensively treating the needs of a patient with a specific condition (e.g. cancer or heart disease). Some payers have also begun using up-front payment for certain primary care services, associated with care delivered to a specific and attributed population. Going further, larger and more sophisticated provider networks may be able to accept prospective payments from payers for handling all aspects of beneficiaries’ healthcare needs. The most advanced way of delivering value-based payment involves the integration of the roles of both payers and providers, which jointly manage all healthcare needs of attributed beneficiaries.

A subset of comprehensive payment models includes All-Payer models and Multi-Payer models that establish a set of alternative payment parameters for Medicare and with which other payers in the state or region may align, with the aim of reducing expenditures and improving health

---

<sup>34</sup> HCP-LAN APM Framework 2017 Refreshed Report (p.27) available at <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.



outcomes across populations. Providers participating in these models may receive stable streams of funding from multiple payers, and may be held accountable for performance on a set of quality and outcomes measures that are relatively standardized across participating payers. Maryland and the Innovation Center operated the Maryland All-Payer Model between 2014 and 2018, which tested whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis and under global budgets is an effective model for advancing better care, better health, and reduced costs. The Model successfully reduced total expenditures for Medicare beneficiaries and reduced hospital expenditures for both Medicare beneficiaries and commercial plan members. The model also reduced hospital admissions and potentially avoidable hospitalizations for Medicare beneficiaries.<sup>35</sup> The Maryland TCOC Model, launched in 2019, builds on the success of the Maryland All-Payer Model by creating greater incentives for healthcare providers to coordinate with each other and provide patient-centered care, and by committing the State to a sustainable growth rate in per capita total cost of care spending for Medicare beneficiaries.

Flexibility and aligned incentives are key characteristics that comprehensive payment models offer both payers and providers. When providers receive flat payments for handling all aspects of a patient's care, they are incentivized to deliver quality care at lower costs, so that they may share in resulting savings relative to an expenditure target, and avoid unnecessary utilization. Providers are also allowed to depart from traditional billing and service delivery practices, and do not depend on continually furnishing services paid on a FFS basis to maintain cash flows. With a consistent cash flow, providers are granted additional stability when pursuing reforms that might otherwise disrupt existing billing incentives and practices.

Providers may also be financially rewarded for making investments to benefit population health that otherwise may have been outside their normal scope of activities – for instance, a hospital network that is accountable for the health of significant populations within the community might make investments in health-related activities meant to help reduce or avoid inpatient stays. In the absence of a population-based payment model, the hospital system would not have an incentive to make these investments because they could run counter to the hospital system's financial interest in filling inpatient beds. Instead, when granted a flat population-based payment, accountable systems are rewarded for investing in lower cost ways of delivering necessary care and averting unnecessary care. This often takes the form of community investments, such as interventions that address social determinants of health that may not be reimbursable by many payers. As a result of these service delivery flexibilities, the financial incentives of providers and payers are even more aligned with one another. Both parties benefit from population health improvements, and are incentivized to make investments that might avert costly care that otherwise could be needed.

As in the case of all risk-sharing payment methods, payers should consider creating boundaries around the risk they and providers take under such models. Certain providers may not be able to assume significant risk-based payments. Particularly in the case of high-cost unpredictable events like heart transplants or the market entry of an extraordinarily expensive drug, providers

---

<sup>35</sup> Evaluation of the Maryland All-Payer Model Final Report available at <https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf>.

receiving global payments under a population-based payment model can sometimes be financially destabilized without state or other payer intervention. Providers should also receive payments that take into account the health status of their attributed population; sicker populations merit higher, risk-adjusted payments from payers.

Comprehensive payment models, especially as states contemplate the most integrated models, should not be pursued lightly – they require sophisticated provider-provider and provider-payer relationships, and state leadership in convening a wide variety of stakeholders. For these models to succeed, all parties involved must be aligned in vision and goals, as well as in the approach to tackling practical concerns, such as governance structure and technology.

While comprehensive payment models certainly involve an enormous amount of work from a variety of stakeholders, they bring corresponding opportunities to payers and providers. CMS is eager for states, payers, and providers to work together and pursue sophisticated ways of delivering VBC.

One example of a model involving total cost of care accountability is described below.

- *Massachusetts Medicaid Model ACO (Partnership Plan)*

Massachusetts has enrolled 80% of its Medicaid managed care beneficiaries into its ACO program, in which providers take significant two-sided risk for cost, quality, and member experience. The program has three different ACO models. One model, the Partnership Plan ACO, is fully integrated between a health plan and delivery system, and provides a full range of physical and behavioral health services. Massachusetts regulates the ACO like a health plan and requires the ACO to meet Medicaid network adequacy standards, which it may do by contracting with providers not part of an ACO (e.g., local specialists and facilities). The Commonwealth currently has 13 Partnership Plan ACOs operating, which receive prospective risk-adjusted capitated payments for beneficiaries enrolled in the ACOs as health plans.

## **Other Medicaid Regulatory Authorities**

### **Section 1115(a) Demonstration Opportunities**

CMS acknowledges that there may be instances when a state requires additional flexibility to adopt an Innovation Center model or pursue other delivery system reforms that are not available through the Medicaid state plan or waiver authorities under section 1915 of the Act. These instances generally should be limited to when a state wants to pilot a geographically limited payment or delivery system model, limit benefits to certain populations, and/or offer benefits not available under any other regulatory authority. In such circumstances, CMS welcomes the opportunity to work with states on state-driven proposals that take into account their unique needs and capabilities, consistent with the principles and reflecting the lessons outlined above. If a state is interested in pursuing more sophisticated state plan payment methodologies but lacks historical experience with value-based care models or the necessary resources for design and implementation, CMS may consider providing targeted section 1115(a) authorities to a state to pursue this option. These authorities may permit additional federal technical assistance and

involvement if a state requests CMS involvement, relative to what might be established without section 1115(a) authorities.

Under the demonstration authority granted by section 1115(a) of the Act, CMS can waive certain federal requirements and authorize federal matching for expenditures that otherwise could not be matched so that states can test innovative ways to deliver and pay for healthcare services when the demonstration is likely to promote the objectives of the Medicaid program. Through section 1115(a) demonstrations, states have an opportunity to explore programmatic flexibilities in pursuit of value-based payment. States may propose section 1115(a) demonstration authority to test alternative payment methodologies that may not be implemented under the state plan, for example, or to pilot their reform initiatives, targeting particular geographic areas or populations.

Section 1115(a) demonstrations must be budget neutral, meaning that the federal costs associated with the proposed reforms cannot exceed the federal Medicaid costs that would be incurred absent the demonstration. States pursuing value-based payments under an 1115(a) demonstration will be required to provide the necessary state share of expenditures, consistent with all applicable federal statutory and regulatory requirements, in order to draw down federal financial participation in authorized spending.

Any federal investments to test value based purchasing as part of section 1115(a) demonstrations will be time-limited and, as part of the application, states will be required to provide a plan to sustain successful initiatives, after the demonstration period, absent ongoing federal investments. In addition, consistent with statutory requirements, states proposing to implement value-based payments through section 1115(a) demonstrations will be required to assure robust monitoring and evaluation.

CMS has developed a variety of resources to support state monitoring and evaluation, which are available at <https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html>. States undertaking value-based payment models through section 1115 demonstrations will be expected to consider how they will track whether state interventions are achieving their proposed objectives. States should ensure mechanisms exist for rapid cycle feedback and monitoring of value-based payment initiatives.

### **Next Steps**

CMS looks forward to continuing to work with states in making sustainable, transformational improvement in their Medicaid programs. We have described a variety of potential pathways - partnering with the Innovation Center in a multi-payer model, adopting options available through the state plan and managed care authorities, and testing innovative approaches through section 1115 demonstrations. In addition, we encourage states to visit the [Medicaid IAP website](#) to access various tools, resources, and webinar slides related to Medicaid payment and service delivery models. CMS will work with states interested in pursuing value-based payment methods and will offer assistance in identifying the pathways to best meet their unique needs.

For more information, please contact Ms. Judith Cash, Director, State Demonstrations Group at 410-786-9686.

Sincerely,

/s/

Anne Marie Costello  
Acting Deputy Administrator and Director  
Center for Medicaid and CHIP Services

/s/

Brad Smith  
Deputy Administrator and Director  
Center for Medicare and Medicaid Innovation

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

Health Care Payment and Learning Action Network

Health Affairs

Inside Health Policy

*The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.*