CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Value-Based Care Opportunities in Medicaid

State Medicaid Director Letter
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Section 1

Background and pathways to adopting value-based payment (VBP)

Background

- CMS has already made a strong commitment to advancing value-based care to over 61 million enrollees in Medicare.
- This guidance is designed to ensure that this same commitment can continue at the state level to the nearly 74 million beneficiaries in Medicaid.
- The goals of lower costs and better outcomes are the same across these programs, and many of the providers overlap – that is why an aligned strategy is important.

Value-based care

- Value-based care (VBC) seeks to:
  - Deliver high quality care efficiently
  - Reduce disparities in the healthcare system and improve beneficiary health
  - Align provider incentives across payers
- VBC can also help the healthcare system handle unexpected challenges and disruptions, such as the COVID-19 pandemic.

"…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."

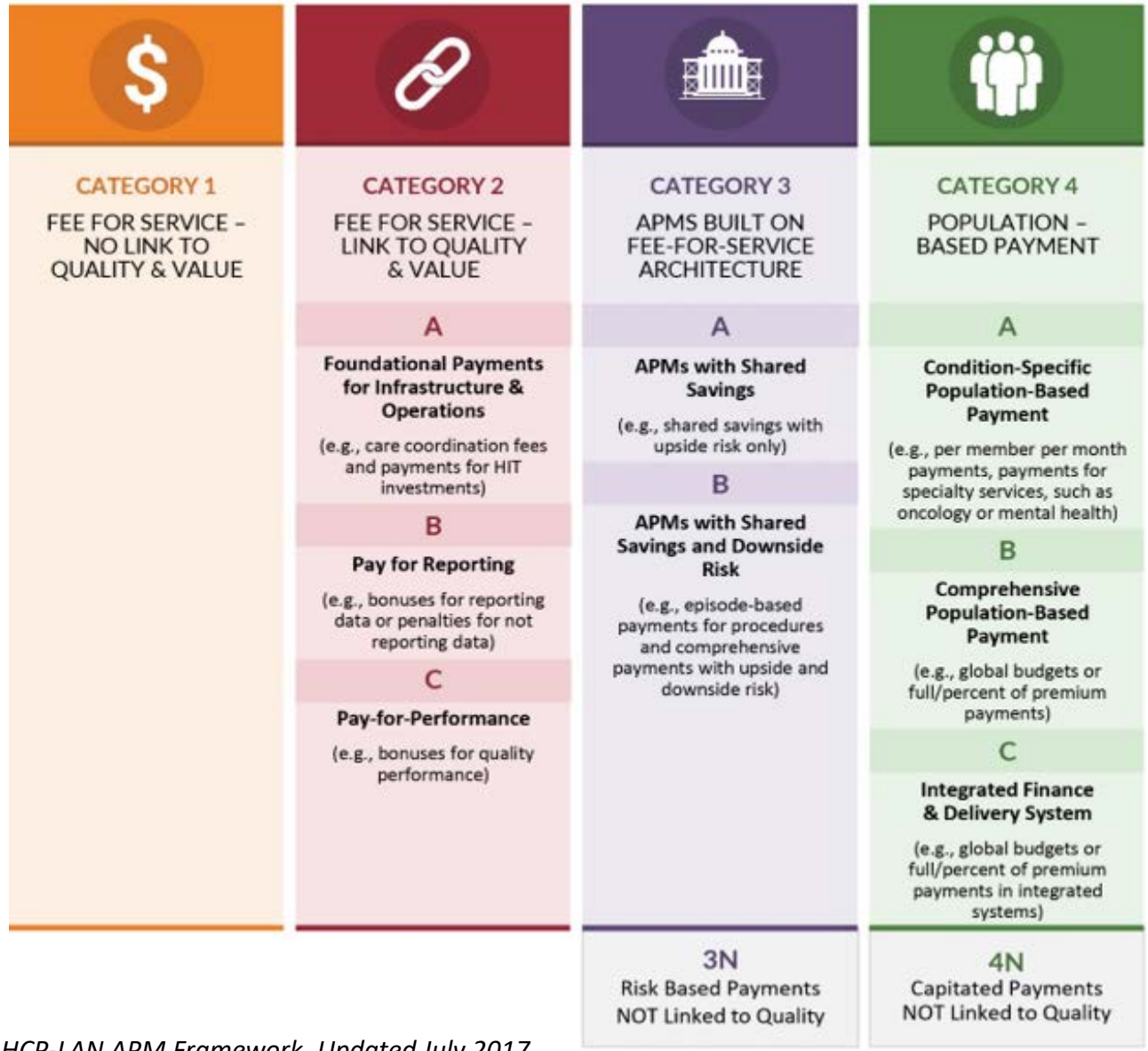
Administrator Seema Verma

June 3, 2020

Value-based payment and alternative payment models

- Value-based payment (VBP) is a key driver of VBC.
- Through VBP, a state Medicaid program or Medicaid managed care plan holds a provider accountable for the costs and quality of care provided.
- Alternative payment models (APMs) change the way Medicaid providers are paid, moving away from fee-for-service (which rewards volume), to methods that incentivize value.

HCP-LAN APM Framework



The APM Framework from the Health Care Payment Learning and Action Network (HCP-LAN) outlines models across four categories based on the financial risk borne by providers.

HCP-LAN APM Framework, Updated July 2017

APM risk levels

Category 2B and 2C: Pay for reporting/ Pay-for-performance

No provider risk.

Category 3A: APMs with shared savings

Only "upside risk"- if savings are achieved providers receive a percentage of the savings.

Category 3B: APMs with shared savings and downside risk

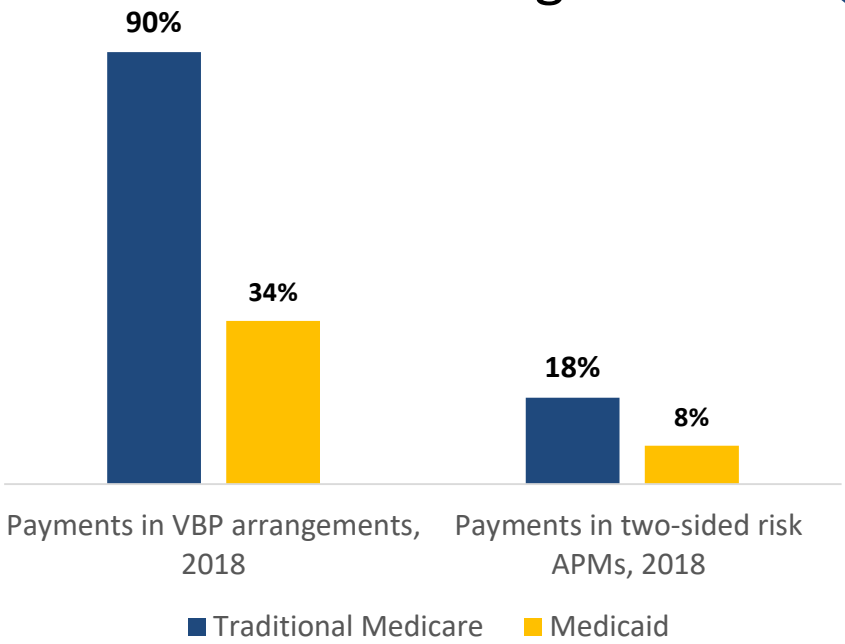
"Upside" and "downside" risk- if savings are achieved providers receive a percentage of the savings, but if costs increase, providers absorb a portion of those losses.

Category 4: Population-based payment

Full risk- providers are accountable for cost and quality, if savings or losses occur, they bear significant financial risk for those outcomes.

VBP in Medicaid

- The HCP-LAN survey showed that fewer Medicaid payments take place through VBP arrangements than in traditional Medicare.[1]
- The HCP-LAN set ambitious **goals** for increasing adoption of two-sided risk VBP arrangements.



HCP-LAN APM adoption targets[2]:

- **15%** of Medicaid payments by 2020
- **25%** of Medicaid payments by 2022
- **50%** of Medicaid payments by 2025

[1]https://hcp-lan.org/workproducts/apm-methodology-2019.pdf
[2]https://hcp-lan.org/workproducts/apm-methodology-2019.pdf

Pathways to adopting VBP

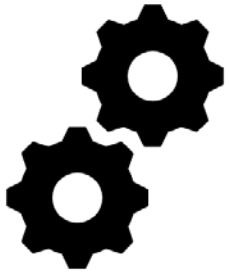
- In the VBC SMDL, CMS offers a roadmap to adopt VBP in Medicaid, including:
  - Joining other multi-payer initiatives within their state, such as VBP models administered by the CMS Innovation Center
  - Using Medicaid managed care authorities
  - Using options available through the Medicaid state plan
  - Testing approaches through Medicaid section 1115(a) demonstrations
- States that elect to advance VBP through Medicaid authorities should consider alignment with Innovation Center models to accelerate VBP adoption.

State variation in adopting VBP

- States' goals for, and approaches to, adopting VBP will be different.
- When choosing the best approach for VBP and setting statewide APM adoption goals, states should consider their unique context, including:
  - Provider landscape
  - Market characteristics
  - Concurrent VBP or other payment initiatives
  - Beneficiary needs

Section 2

Critical elements for VBP design and successful shifts to VBP



Building on lessons learned

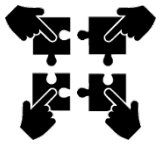
- CMS supports testing payment and service delivery models that provide insights into best practices for VBP design, implementation, operations, and adoption.
- Valuable lessons have been learned from VBP-related programs and resources such as:
  - Delivery System Reform Incentive Payment (DSRIP) demonstration programs
  - Medicaid Innovation Accelerator Program (IAP)
  - CMS Innovation Center models
  - CMS Duals Office demonstrations

Critical elements of VBP design and operations

Level and scope of financial risk	Financial performance benchmarking	Payment operations
• Provider accountability for outcomes can be comprehensive (e.g., the total cost of care) or narrow (e.g., a defined set of metrics). • Providers could be held accountable for outcomes in the long-term or for a defined period related to a triggering event, such as a hospitalization or diagnosis.	• Many VBP arrangements compare provider financial performance against a target price or benchmark. • Benchmarks typically reflect provider-specific historical trends, regional trends, and adjustments (e.g., risk adjustment). • If benchmarks are set too high, participants will earn more than anticipated in reconciliation payments, and the model will not generate savings.	• A specific cohort (or "panel") of beneficiaries should be identified or assigned to providers, for whose care they will be accountable. • Capitated and/or shared savings payments involve determining participating providers, the beneficiaries attributed to these providers, and the provider's quality score prior to making payments.

Components for successful shifts to VBP

States can facilitate successful shifts to VBP through:


Multi-payer participation


Quality measure selection


Assessment of delivery system readiness


Robust health information exchange technology (HIT)


Stakeholder engagement


Designing with sustainability in mind during program planning and development

Components for successful shifts to VBP: Multi-payer participation

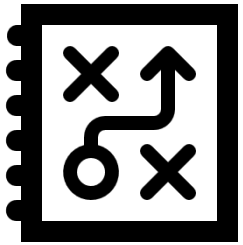
- Multi-payer participation amplifies the impact of new innovative models and drives care transformation across the healthcare system.
- When designing their programs, states should consider:
  - Aligning provider incentives and outcome measures for the Medicaid population with those used in other programs
  - Measuring population health performance across payers
- These strategies may ease administrative burden on providers who participate in multiple programs.

Components for successful shifts to VBP: Quality measure selection

- To facilitate the adoption of VBP arrangements, states should consider choosing established metrics to reduce provider burden.
  - States should consider adopting 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)
- Incentives to change clinical behaviors may be most impactful when they closely follow the incentivized activity without a significant time lag.

Section 3

Strategies and mechanisms for advancing VBP



Innovative payment strategies and models

- States may adopt multiple payment strategies to promote VBP.
- Innovative payment strategies may involve
  - Payment models built on FFS architecture
    - Including *advanced payments under FFS*
  - Managed care plan strategies
  - Episode of care payments
  - Payments involving total cost of care accountability

Innovative payment strategies and models: Payment models built on FFS architecture

- State or payer pays healthcare provider directly on a FFS basis for all populations or sub-populations for some or all services received, either retrospectively, or prospectively based on value-based APMs.
- Adjustments (usually retrospective) for the cost and quality of services provided relative to benchmarks.
- Models include the potential of "upside" or "downside" risk (meaning two sided risk)
  - under "upside" risk providers receive a percentage of savings, if achieved, and under "downside" risk providers absorb a portion of the losses, if costs increase.

Examples

Primary care case management (PCCM), PCCM-entity (PCCM-E)

Primary Care Medical Homes (PCMH) (e.g., South Dakota health home benefit)

Shared Savings models (e.g., Arkansas, Maine, and Ohio)

Massachusetts Model B (Primary Care Accountable Care Organization [ACO])

Home Health Value-Based Purchasing (HHVBP) Model (a Medicare model)

Advanced payments under FFS

- States may also use advanced payment methodologies under FFS in the state plan to promote VBP.
- Through this approach, providers receive a monthly advanced payment amount that represents the costs of expected care for individuals attributed to them.
- Can have either “upside” and/or “downside” risk.
- States may add incentive payment structures, using state-funded supplemental payment pools, to monthly payments in order to incent and reward providers who meet quality and outcomes performance requirements.

Advanced payments under FFS in state plan amendments

- When considering whether to approve a State Plan Amendment (SPA) for advanced payment methodologies under FFS authority, CMS will assess how the state's request addresses the following:
  - Data, payment, claims tracking, and quality
  - Overview of advanced payment methodologies
  - Mechanics of advanced payment methodologies
  - Attribution
  - Claims tracking
  - Reconciliation process
  - Quality
- Each of these elements should also be considered when states design VBP approaches under managed care and 1115 authorities

Advanced payments under FFS in SPAs: Reconciliation process

- The reconciliation process should be similar to protocols for payment of actual incurred costs and cost reporting.
- Reconciliation protocols must include and identify:
  - Source(s) of data related to providers, claims, payment, attributed beneficiaries, and quality
  - Service period during which claims data will be collected for reconciliation
  - Which services are included in claims data that will be used to reconcile against advanced payments
  - How quality performance will impact reconciliation of advance payments to actual services furnished
  - Timeframes and procedures for conducting reconciliation and returning federal financial participation (FFP) to CMS, as required in regulation

Advanced payments under FFS in SPAs: Quality

- In designing the quality measurement and outcomes component of an advanced payment methodology, a state should:
  - Determine which providers and services will be subject to the quality and outcomes component
  - Develop a timeline for implementation of the quality and outcomes component
  - Choose quality and outcomes measures that are relevant, non-discriminatory, and appropriate to the services provided by practitioners receiving advanced payments
  - Ensure that providers are being held accountable only for their performance and, in the case of attributed beneficiaries, only their attributed beneficiaries

Managed care authorities for VBP

- Medicaid managed care regulations allow states to implement VBP initiatives through their managed care plan contracts.
- As part of their procurement or pre-procurement strategies, states may require managed care plans to describe their experience with VBP models, interest in advancing VBP principles, and/or require states to implement VBP.

Managed care authorities for VBP

State directed payments	•States can require their managed care plans (MCPs) to adopt certain VBP models, such as ACOs, pay-for-performance and incentive payments for targeted provider classes.
MCP incentive payments	•MCPs can receive incentive payments above and beyond their capitation payments for accelerating provider adoption of VBP if performance targets specified in the MCP contract are met.
MCP withhold arrangements	•A portion of a capitation payment is withheld from MCPs, which can be earned back for meeting performance targets specified in the MCP contract, including the implementation of a performance improvement project that focuses on adoption of VBP models.
Contracting strategies	•States may require MCPs to: (1) make a specific percentage of payments through state-defined VBP models, or submit proposed VBP arrangements, and (2) participate in a VBP model that reflects the state's goals for VBP, including a multi-payer VBP initiative.

Innovative payment strategies and models: Episode of care payments

- States or payers pay healthcare providers for some or all services associated with an episode of care during a defined period (e.g., knee replacements or giving birth).
- These models are conducive to multi-payer alignment because episodes can be defined consistently across payers, creating clear incentives for providers.
- These are “downside” and/or “upside” risk models.

Examples

Bundled Payments for Care Improvement (BPCI) Advanced*

Oncology Care Model (OCM)*

Comprehensive Care for Joint Replacement (CJR)*

Tennessee Medicaid Delivery System Transformation Episodes of Care Program

*Innovation Center models

Innovative payment strategies and models: Total cost of care accountability payments

- Healthcare providers are held accountable for all populations or sub-populations for some or all services.
- Healthcare providers may be responsible and at risk for all aspects of a beneficiary's care, or just specific condition(s).
- Payers may pay providers in several different ways – bundled payments, capitated or capitation-like payments, or global payments.
- Provides flexibility to payers and healthcare providers in addressing community needs.
- These are "upside" and/or "downside" risk models.

Examples

ACO initiatives (e.g., Medicare Shared Savings Program*, Next Generation ACO Model*)

Maryland Total Cost of Care Model*

MassHealth ACO Model A (Partnership Plan)

Vermont All-Payer ACO Model*

*Innovation Center models

Section 1115(a) demonstration opportunities

- States can pursue VBP through section 1115(a) demonstrations if they would like to test geographically limited payment and delivery system models, limit benefits to certain populations, and/or offer benefits not available under any other regulatory authority.
- CMS can offer technical assistance to states interested in exploring possible approaches through a demonstration.

Questions

For further information

- The VBC SMDL fact sheet is posted here: Link
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- Please submit any follow up questions to this email box: 1115MonitoringandEvaluation@cms.hhs.gov
  - Or, reach out to your CMS contact for additional information.