

Appendix 1. Targeted Initiatives for Special Populations

	Children	Pregnant women	Adults with chronic conditions	Substance use disorders	Foster children	Homelessness/ Supportive housing
California	✓ ¹		✓ ¹⁴	✓ ²³		✓ ⁴⁰
Colorado	✓ ²		✓ ¹⁵		✓ ³²	
Connecticut	✓ ³	✓ ⁹	✓ ¹⁶	✓ ²⁴		✓ ⁴¹
Maryland	✓ ⁴	✓ ¹⁰	✓ ¹⁷	✓ ²⁵	✓ ³³	✓ ⁴²
Massachusetts	✓ ⁵	✓ ¹¹	✓ ¹⁸	✓ ²⁶	✓ ³⁴	✓ ⁴³
Michigan	✓ ⁶	✓ ¹²		✓ ²⁷	✓ ³⁵	
Minnesota	✓ ⁷		✓ ¹⁹	✓ ²⁸	✓ ³⁶	
New York	✓ ⁸		✓ ²⁰	✓ ²⁹	✓ ³⁷	✓ ⁴⁴
Ohio		✓ ¹³	✓ ²¹	✓ ³⁰	✓ ³⁸	
Washington			✓ ²²	✓ ³¹	✓ ³⁹	✓ ⁴⁵
Total	8/10	5/10	9/10	9/10	8/10	6/10

- ¹ Children with special health care needs, early intervention services for children under 3 years old, and school-linked Child Health and Disability Prevention services.
- ² Foster children; children; the physically disabled; non-English speakers; those with complex behavioral or physical health needs; and members released from the state or county jail system.
- ³ Children and youth with special health care needs.
- ⁴ Children with special health care needs; School-Based Health Centers.
- ⁵ Early intervention services; children with special health care needs; maternal and infant health; and special health care needs.
- ⁶ Child & Adolescent Health Centers and Programs (CAHCP); Children's Multidisciplinary Specialty (CMDS) Clinic.
- ⁷ Children and young adults with severe emotional disorders; Early Intensive Developmental and Behavioral Intervention (EIDBI) Services for children under 21 years old; Assessment and diagnostic services for children in the Child Protection System.
- ⁸ Children with special health care needs.
- ⁹ High risk pregnancy assessment and intervention.
- ¹⁰ Complex maternal and infant health conditions.
- ¹¹ Early intervention services; children with special health care needs; maternal and infant health; and special health care needs.
- ¹² Maternal and infant health, home visitation.
- ¹³ Maternal and infant health.
- ¹⁴ High risk adults, autism, HIV and STD-related care.
- ¹⁵ People with physical disabilities, Medicare and Medicaid dually enrolled, non-English speakers; people with complex behavioral or physical health needs; and discharged prison and jail inmates.
- ¹⁶ Adults with chronic conditions.
- ¹⁷ People with special needs; people with physical disabilities, and people with rare and expensive conditions.
- ¹⁸ Adults with special health care needs. Includes needs pertaining to behavioral health and long term services and supports, as well as Disease Management Programs.
- ¹⁹ People with physical disabilities or chronic illness.
- ²⁰ People with serious and chronic health conditions; people with HIV/AIDS.
- ²¹ Hypertension and aimed to increase the percentage of African Americans with controlled blood pressure.
- ²² People with chronic conditions; people in need of medication therapy management.
- ²³ People identified as high users of multiple systems with ongoing poor health outcomes.
- ²⁵ People with substance use disorders.
- ²⁵ Substance use services are carved out, but the MCO is still required to make referrals. See <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.65.14.htm>.
- ²⁶ People with substance use disorders, with particular focus on services for opioid-dependent individuals.
- ²⁷ People with substance use disorders.
- ²⁸ People with substance use disorders.
- ²⁹ People with select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses with serious behavioral health issues will be eligible to enroll in Health and Recovery Plans (HARP), and if determined eligible, will be able to access to a benefit package and person-centered care plan of Home and Community Based Services (HCBS).
- ³⁰ Redesigning behavioral health program by unbundling services, particularly SUD-related services; Maternal Care Home model in which obstetrician monitors and coordinates opioid-related services and treatments for pregnant women.
- ³¹ People with substance use disorders.
- ³² Foster children; children; people with physical disabilities; non-English speakers; people with complex behavioral or physical health needs; people released from prisons and jails
- ³³ Foster care children.
- ³⁴ Children with highly complex care needs and in foster care placements. MA's Special Kids Special Care program provides integrated complex care management, in-home clinical care and BH services to children with highly complex care needs who are in a foster care. This program is administered by one of the state's contracted Managed Care Entities.
- ³⁵ Foster care children with complex needs.
- ³⁶ Foster care children with behavioral and mental health needs.
- ³⁷ Comprehensive assessment procedures.
- ³⁸ All foster care children.
- ³⁹ Track enrollment of foster children, including those receiving adoption support or in kinship care.
- ⁴⁰ People identified as high users of multiple systems with ongoing poor health outcomes.
- ⁴¹ People who experience barriers related to lack of stable housing.
- ⁴² Homeless individuals.
- ⁴³ Housing stabilization and supports.
- ⁴⁴ State is planning and evaluating how to use the Section 1115 Medicaid waiver as a funding source for new investment in affordable/supportive housing specifically targeted at high-need, high-cost Medicaid members. Examples of potential initiatives include but are not limited to: colocating behavioral and health services in housing, expanding and improving independent senior housing, evaluating ways to create opportunities for diversion from hospitals, ensuring coordination with Health Homes, streamlining community siting processes, ensuring the viability of existing housing resources, and designing a Moving On initiative to help move individuals to more independent settings to free up resources for those most in need. See https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf.
- ⁴⁵ Targeted supportive housing and supported employment benefits.

Data: State-provided standard Medicaid managed care contract agreements or personal communications with state officials.

Appendix 2. Provider Networks — Special Considerations

	Requires provider expertise for special populations	Night and weekend availability	Safety-net providers	Centers of excellence
California		✓ ⁷	✓ ¹⁶	✓ ²⁰
Colorado	✓ ¹	✓ ⁸	✓ ¹⁷	
Connecticut*				
Maryland	✓ ²	✓ ⁹		
Massachusetts	✓ ³	✓ ¹⁰	✓ ¹⁸	
Michigan	✓ ⁴	✓ ¹¹		✓ ²¹
Minnesota	✓ ⁵	✓ ¹²		
New York	✓ ⁶	✓ ¹³		✓ ²²
Ohio		✓ ¹⁴	✓ ¹⁹	
Washington		✓ ¹⁵		
Total	6/10	9/10	4/10	3/10

* Connecticut operates its own plan through a single administrative organization rather than purchasing care through MCOs and its Medicaid plan includes all participating Medicaid providers. As a result, the specifics of this exhibit do not apply.

- ¹ Special populations include physically or developmentally disabled; children and foster children; adults and seniors; non-English speakers; members with complex behavioral or physical health needs; members with HIV; members recently released from incarceration.
- ² State regulations require plans to ensure certain specialties are included in network, including: children with special health care needs; individuals with a physical disability; individuals with a developmental disability; pregnant and postpartum women; individuals who are homeless; individuals with HIV/AIDS; and children in state-supervised care. See COMAR 10.09.65.04 and COMAR 10.09.66.01 et al.
- ³ Current MCO contract requires plans to have providers in their network with expertise and familiarity with working with certain populations, including physical or mental disabilities; limited English proficiency; women's health; homeless persons; persons with special health care needs; deaf, hard of hearing, and blind persons; and children in state custody.
- ⁴ Special populations include individuals with special health care needs. Plan networks must demonstrate networks with 24/7 capabilities related to post-stabilization emergency transfers and communication with emergency room personnel.
- ⁵ Special populations include people with Serious and Persistent Mental Illness (SPMI); people with a physical disability or chronic illness; abused children and adults, "abusive individuals;" enrollees with language barriers; cultural and racial minorities; people with dual Mental Illness/Developmental Disabilities or Mental Illness/Chronic Disease diagnoses; lesbian, gay, bisexual and transgender people; people with hearing impairment; enrollees in need of gender-specific MI and/or CD Treatment; children and adolescents, including children with severe emotional disorders and children involved in the child protection system; people with a developmental disability (DD); American Indians.
- ⁶ Special considerations for provider expertise (e.g., behavioral health, long term services and supports) and the state has plans working with safety net hospitals on moving towards VBP. See https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf and https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/related_links/docs/bh_policy_guidance_10-1-15.pdf.
- ⁷ Plan must include network or contracting physician available 24/7 to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.
- ⁸ Plan networks must offer extended night and weekend hours, as well as alternatives for emergency room visits for after-hours urgent care.
- ⁹ COMAR 10.09.66.04.
- ¹⁰ Plans must ensure extended hours for primary care and urgent care as well as 24/7 emergency services.
- ¹¹ PCPs must have a system to provide or arrange for coverage of services 24/7 when medically necessary and that enrollees have access to evening and weekend hours of operation in addition to scheduled daytime hours.
- ¹² Plans must include access to medical emergency services, post-stabilization care services and urgent care on a 24/7 basis and must provide a twenty-four (24) hour, seven day per week MCO telephone number that is answered in-person by the MCO or an agent of the MCO.
- ¹³ Plans must provide access to medical services and coverage to enrollees, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour a day, seven (7) day a week basis and must instruct enrollees on what to do to obtain services after business hours and on weekends.
- ¹⁴ Plans must ensure that services are available 24/7, when medically necessary.
- ¹⁵ Plans must ensure the following services have 24/7 availability by telephone: medical or mental health advice; triage or emergency medical or mental health conditions; authorization for emergency services; emergency prescriptions filled by pharmacy.
- ¹⁶ Plans must ensure participation and broad representation of traditional and safety-net providers within a service area and must maintain the percentage submitted and approved by DHCS of traditional and safety-net provider within a service area.
- ¹⁷ Networks must include essential community providers.
- ¹⁸ Networks may include providers that are safety-net hospitals.
- ¹⁹ MCPs are required to ensure member access to any federally-qualified health centers (FQHCs) and rural health centers (RHCs), regardless of contracting status.
- ²⁰ Network inclusion of centers of excellence for children with special health care needs.
- ²¹ Network inclusion of centers of excellence for children with special health care needs.
- ²² Network inclusion of centers of excellence for children with special health care needs.

Data: State-provided standard Medicaid managed care contract agreements or personal communications with state officials.

Appendix 3. Clinical Performance Measures Tied to Financial Incentives

	Well-child visits	Emergency department/Ambulatory care utilization rate	Dental visits	Hospital utilization	Hospital readmission	Adolescent well-care visits	Infant and maternity visits	Adult BMI	Immunizations
California ¹	✓	✓			✓		✓	✓	✓
Colorado ²	✓	✓					✓		
Connecticut ³	✓		✓		✓	✓	✓	✓	✓
Maryland ⁴	✓	✓				✓	✓	✓	✓
Massachusetts ⁵	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan ⁶	✓					✓	✓	✓	✓
Minnesota ⁷	✓	✓	✓	✓	✓	✓			
New York ⁸	✓	✓	✓	✓	✓	✓	✓		
Ohio ⁹						✓	✓		
Washington ¹⁰	✓				✓			✓	✓
Total	9/10	6/10	4/10	3/10	6/10	7/10	8/10	6/10	6/10

Note: BMI = body mass index.

¹ Medi-Cal uses an External Accountability Set consisting of HEDIS-related measures. Measures vary to reflect the diverse population in managed care (seniors, people with disabilities, rural populations, etc.). The state also employs pay-for-performance and autoassignment incentives. See http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/EAS_Measure_List_RY_2018%20_F1.pdf.

² Uses key performance Indicator (KPI) incentive payments and others for activities that drive greater value and are tied to program priority areas (emergency room visits, postpartum visits, and well-child checks ages 3 to 9), paid depending on the level of improvement achieved. Each KPI is calculated based on the utilization of services by the population enrolled in the ACC, and the payments are based on the performance of the enrollee's Regional Care Collaborative Organization (RCCO). Primary Care Medical Providers (PCMPs) whose members are enrolled in multiple RCCOs can receive varying incentive payments because payments are based upon RCCO performance.

³ Uses both administrative HEDIS and hybrid-HEDIS measures as well as "homegrown" measures (developed by the state to drive change or capture whole-population performance) to set annual performance withholds for ASO. See https://www.cga.ct.gov/med/council/2017/0210/20170210ATTACH_Health%20Quality%20Measures%20and%20Performance%20Results%20Presentation.pdf.

⁴ Plans must report on 13 HEDIS measures which form the basis for their performance incentives/disincentives in exchange for incentive payment.

⁵ New ACO option will allow ACOs to achieve shared savings for meeting performance goals. Massachusetts will include performance measures in future MCO contracts based upon its determination of specific focused areas in need for improvement incentives.

⁶ During each contract year, Michigan withholds 1.00% of the approved capitation payment from each contractor to be used performance bonus awards. Awards are made to contractors based on a group of HEDIS measures focusing on quality of care, access to care, enrollee satisfaction, and administrative functions.

⁷ Managed care organizations (MCOs) submit annual quality program updates to demonstrate how their quality improvement programs identify, monitor and work to improve service and clinical quality issues relevant to enrollees. Minnesota uses HEDIS measures that include prevention and screening, access and availability, use of service, medication management, and behavioral health medication management, among others. See <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp> and <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6646C-eng>.

⁸ Bundles maternity care through which contractors can realize shared savings. Its Quality Improvement Program has a methodology to determine the percentage of financial incentive that a plan receives, based on results from four components: quality of care, consumer satisfaction, prevention quality indicators (PQIs), and compliance.

⁹ Performance is measured according to HEDIS measures. Ohio Medicaid is converting its bonus incentive system to a quality withhold formula to ensure that better performance reaps greater payment and poorer performance leads to financial disincentives.

¹⁰ Contractors are required to ensure that at least 30% of provider payments are tied to value-based payments. Performance is measured according to Washington's Common Measure Set, focusing on access, prevention, acute care and chronic care claims and encounter data; results for other measures as provided by partner organizations; and results of surveyed patient experience. See <https://www.hca.wa.gov/assets/measures-fact-sheet.pdf>.

Data: State-provided standard Medicaid managed care contract agreements or personal communications with state officials.

Appendix 4. Payment Reform Innovation Strategies

	Bundled payments/ Episodes of care	Subcapitation/ Per member per month	Global payments	Shared savings	Alternative payments for FQHCs	Overall strategies tied to specific measures	“In-lieu-of” and “Value-added” payments
California				✓ ¹⁴	✓ ¹⁸	✓ ²²	✓ ²⁸
Colorado		✓ ⁵			✓ ¹⁹	✓ ²³	✓ ²⁹
Connecticut	✓ ¹	✓ ⁶	✓ ¹¹		✓ ²⁰	✓ ²⁴	
Maryland							✓ ³⁰
Massachusetts			✓ ¹²	✓ ¹⁵		✓ ²⁵	✓ ³¹
Michigan		✓ ⁷					
Minnesota				✓ ¹⁶			✓ ³²
New York	✓ ²	✓ ⁸	✓ ¹³	✓ ¹⁷		✓ ²⁶	✓ ³³
Ohio	✓ ³	✓ ⁹					✓ ³⁴
Washington	✓ ⁴	✓ ¹⁰			✓ ²¹	✓ ²⁷	
Total	4/10	6/10	3/10	4/10	4/10	6/10	7/10

Note: FQHCs = federally qualified health centers.

- Decision to bundle obstetrics based on Medicaid’s role as significant payer of maternity services and the state’s efforts to lower primary and subsequent cesarean sections; Connecticut will be implementing episodes of care payments for obstetrics.
- To maximize shared savings in its Integrated Primary Care with Chronic Bundle, professional-led practices are encouraged to collaborate with hospitals and other providers on activities such as outreach, care management, and postdischarge care.
- Episode-based payments for specific medical events with associated clinical measures to ensure quality care.
- Collecting data to form bundled arrangements in the future.
- Operates a payment reform initiative within the ACC called Prime that operates in six counties’ ACC, the program is a full risk, capitated model with an enhanced focus on integration of physical and behavioral health services.
- Enhanced fee-for-service (FFS) reimbursement and annual improvement payments for PCMH initiative.
- Michigan’s contract is a unit price-per member per month (PMPM) capitated rate and the state is in the early stages of gathering alternative payment model (APM) data from its health plans; will be collecting three-year APM strategic plans to increase the use of APMs from Medicaid health plans. Currently, Michigan operates Patient-Centered Medical Homes as a part of its State Innovation Model (SIM) grant.
- Uses a value-based payment arrangement with the PPS (or with “hubs” within the PPS) which considers total PMPM expenditure for the attributed population (global capitation) and overall outcomes of care.
- Uses a comprehensive primary care model in which Medicaid population is attributed to a practitioner who is eligible to receive a PMPM in exchange for activity in clinical quality requirements, analogous to a traditional Patient-Centered Medical Home.
- As a part of its data quality improvement, the state measures encounters PMPM by the providers in high-level service categories, and uses these data in its calculation of capitation rates.
- State Innovation Model grant provided funding for development of the PCMH+ initiative, whose aim is to build on the current Medicaid PCMH program by enabling enhanced care coordination capacity, community linkages and further improved health and satisfaction outcomes for Medicaid members served by Federally Qualified Health Centers (FQHCs) and “advanced networks.” Will make shared savings payments to all Participating Entities (both FQHCs and “advanced networks”) that exceed benchmarks on a core set of measures of quality and care experience, within each entity’s savings for the performance year, if any, when evaluated against the comparison group (the individual pool). See [https://www.ct.gov/med/committees/MQ/\(PCMH%20Plus%20Overview%20and%20Update%20for%20MAPOC;%20March%202017,%202017\).pdf](https://www.ct.gov/med/committees/MQ/(PCMH%20Plus%20Overview%20and%20Update%20for%20MAPOC;%20March%202017,%202017).pdf).
- New ACO option will exclusively partner ACO with MCO and coordinate care under global payment. Also utilizes total cost of care for behavioral health and long-term services and supports.
- Integrated primary care includes the MCO using Patient-Centered Medical Homes (PCMH) or Advance Primary Care (APC) arrangements with the PPS or the PCMHs/APCs in the PPS to reimburse these PCMH/APCs based on the savings and quality outcomes achieved; savings are based primarily on “downstream” costs.
- Shared savings calculation between the state and the MCO, based on projected total cost of care. If plan is able to demonstrate costs below total cost of care and meet mutually determined outcome and quality targets, it would be eligible to receive shared savings incentive payments.
- New ACO option will allow provider-led ACOs to take financial accountability for a defined population of enrolled members through retrospective shared savings and risk. Additionally, MCO-administered ACOs will take financial accountability for enrollees through retrospective shared savings.
- Under a SIM grant, Minnesota developed an ACO model “Integrated Health Partnerships (IHPs)” with a shared savings/risk payment methodology similar to the Medicare Shared Savings Program. Minnesota requires its MCOs to participate in the shared savings/risk payment model with IHPs participating in the program. See https://www.chcs.org/media/VBP-Brief_022216_FINAL.pdf and http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=dhs16_161441#.
- Shared savings is a main component of VBP Level 1 (upside-only risk) arrangements between providers and MCOs, and is also a component of the VBP Level 2 (upside and downside risk) arrangements. See https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2017/docs/2016-06_vbp_roadmap_final.pdf.
- Operating a FQHC pilot program that replaces PPS payment and wraparound payments by an upfront, clinic-specific capitation rate. FQHCs receive a comprehensive payment from health plans on a monthly basis rather than waiting until the end of the year for a supplemental payment. Allows FQHCs to use flexible resources to deliver care in innovative ways that expand primary and specialty care access (e.g. integrated primary and behavioral health visits on the same day; group visits; email and phone “visits”; community health worker contacts; case management; and care coordination across systems).
- Implementing several primary care payment reforms for FQHCs (under APM agreements) and other primary care providers. While there are several different models, the primary care reforms are designed to contain costs while paying for improved performance, and are specifically designed for Primary Care Medical Providers (PCMPs) in the ACC. The reforms leverage partial to full capitation arrangements as well as enhanced reimbursement for quality performance for providers not participating in capitation arrangements. See <https://www.colorado.gov/pacific/hcpf/primary-care-payment-reform-3>.
- State Innovation Model grant provided funding for development of the PCMH+ initiative, whose aim is to build on the current Medicaid PCMH program by enabling enhanced care coordination capacity, community linkages and further improved health and satisfaction outcomes for Medicaid members served by Federally Qualified Health Centers (FQHCs) and “advanced networks.” Will make shared savings payments to all Participating Entities (both FQHCs and “advanced networks”) that exceed benchmarks on a core set of measures of quality and care experience, within each entity’s savings for the performance year, if any, when evaluated against the comparison group (the individual pool). See [https://www.ct.gov/med/committees/MQ/\(PCMH%20Plus%20Overview%20and%20Update%20for%20MAPOC;%20March%202017,%202017\).pdf](https://www.ct.gov/med/committees/MQ/(PCMH%20Plus%20Overview%20and%20Update%20for%20MAPOC;%20March%202017,%202017).pdf).
- The state has introduced a value-based alternative payment methodology (PMPM) in Medicaid for FQHCs and RHCs and is pursuing flexibility in delivery and financial incentives for participating Critical Access Hospitals. The model will test how increased financial flexibility can support promising models that expand care delivery. See <https://www.hca.wa.gov/assets/program/APM4-fact-sheet.pdf>.
- The value of a shared savings incentive is calculated as the difference between projected expected costs, determined prior to the measurement period, and actual costs. This approach requires development of total cost of care measurement for Medi-Cal managed health care, including adjustment for geography and risk. Quality performance is based on a combination of attainment and improvement.

- ²³ The PRIME initiative has the following measures tied to its medical loss ratio: A1c control, BMI assessment, member activation, and depression screening. See <https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-payment-reform-initiative-hb12-1281>. APM payment model is a point-based system. Practices will choose which measures to focus on, and each measure is assigned a point value. The model offers practices a choice of both structural measures, meaning characteristics of a practice, and performance measures, meaning improvements in clinical processes or outcomes.
- ²⁴ In addition to enabling shared savings arrangements with all participating entities, PCMH+ is making supplemental payments to participating FQHCs in support of enhanced care coordination activities focused on: behavioral health integration; cultural competency, including use of CLAS standards; children and youth with special health care needs; and disability competency.
- ²⁵ Massachusetts' evaluation of performance management for PCP value-based payments takes into account each PCP's performance on costs of care and quality measures. Upon identifying PCPs demonstrating unsatisfactory performance, Massachusetts may take actions such as providing improvement opportunities or adjusting performance financial incentives.
- ²⁶ Weighted baseline (historical data, risk adjustment, growth trend) + target baseline performance adjustments (efficiency and quality adjustments) plus stimulus adjustment equals target budget for selected VBP arrangements. See https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/vbp_roadmap_final.pdf.
- ²⁷ Over the 2017–2021 timeframe, Washington plans to transition 90 percent of its provider payments under state-financed health care to link to quality and value. Ultimately, the state plans for APMs to be population-based and include models such as population-based payments for condition-specific care; population-based payments for comprehensive pediatric or geriatric care; episode-based, population payments for clinical conditions; partial population-based payments for primary care; and full or percent of premium population-based payments. See https://www.hca.wa.gov/assets/program/vbp_roadmap.pdf.
- ²⁸ State is in discussions to implement in future.
- ²⁹ Applies to BHOs. See <https://www.colorado.gov/pacific/hcpf/behavioral-health-organizations>.
- ³⁰ Optional for plans; they have to get state approval; most use VBP for physician services and create incentive payments to move towards VBP goals.
- ³¹ Value Added: Plans can choose, but frequently supply items like bike helmets, gym membership discounts, and more extensive transportation benefits. As a part of its DSRIP waiver, Massachusetts is developing flexible services through which it can reimburse ACOs for nonmedical services that address social determinants of health.
- ³² MCOs required to cover "in-lieu-of" services or settings covered under the state plan if medically appropriate and cost-effective substitute, use is voluntary for the enrollee, and utilization and actual cost of "in-lieu-of" services is taken into account in developing the component of the capitation rates that represents the covered state plan services.
- ³³ Value-based payment is being implemented in New York; working with plans to create a process where plans can propose "in-lieu-of" services to be approved by the state in compliance with federal rules.
- ³⁴ Optional for plans. The MCP may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Additional benefits offered include, enhanced transportation, dental, vision.

Data: State-provided boilerplate Medicaid managed care contract agreements or personal communications with state officials.