ISSUE BRIEF
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Medicaid Payment and Delivery System Reform: Early Insights from 10 Medicaid Expansion States

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ABSTRACT

ISSUE: Expanded Medicaid enrollment under the Affordable Care Act has heightened the importance of states' roles as principal purchasers of health care for low-income and medically vulnerable populations. Concurrently, the federal government has augmented states' purchasing tools.

GOAL: To examine the evolution of payment and delivery system reform in 10 ACA Medicaid expansion states.

METHODS: Analysis of state managed care policies, including a detailed review of purchasing documents as well as interviews with senior agency officials in 10 states.

FINDINGS AND CONCLUSIONS: States have made health system reform a core element of their Medicaid expansions, with the aim of improving access, quality, efficiency, and population health. States have sought to incorporate evidence-based practice and payment strategies, with an emphasis on populations likely to benefit from improved care management and on better integration of treatment for physical and behavioral health problems. Seven of 10 are directly engaged in provider payment and delivery system reform. Agencies noted the importance of experienced provider networks in addressing complex health and social needs, along with managed care's role in quality improvement and payment reform. States embrace their roles as payers and health care innovators, identifying stability of both coverage and the underlying federal policy environment as key factors.

KEY TAKEAWAYS

- The 10 study states, which use managed care to administer their Medicaid programs, view their role as health care purchaser as a way to focus on improving health outcomes and increasing health care value.
- These states focus on populations that can benefit from better-managed care, including adults with chronic physical and mental health conditions, people with addiction and substance use disorders, and children.
- Most of the states use targeted performance improvement measures, like linking payment incentives to the fulfillment of specific quality improvement goals.

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BACKGROUND

With nearly 75 million beneficiaries, Medicaid is the nation's largest public insurer, as well as its most important source of health care financing. Both roles were elevated under the Affordable Care Act's (ACA) Medicaid expansion, which added approximately 12 million adult beneficiaries, a significant proportion of whom are older, in poor health, or both.[1]

Managed care has been a core feature of Medicaid for nearly 25 years. Major enrollment growth has increased the need for organized health care delivery arrangements that can promote access to care while controlling costs. Indeed, many of the features of marketplace plans, like narrow networks and close oversight of specialty care, have long been features of Medicaid managed care.[2]

States have various options when structuring their Medicaid managed care plans. They can contract with managed care organizations (MCOs) to furnish a comprehensive range of services on a shared financial risk basis. Thirty-nine state Medicaid programs use this option, which is especially prevalent in states with large Medicaid populations; in 28 states, managed care organizations enroll least 75 percent of all Medicaid beneficiaries.[3] States also can create more limited primary care management arrangements or contract with entities that specialize in a certain type of health care, such as behavioral or oral health. States also can — similar to self-insuring employers — retain overall operational and financial responsibility while using administrative service organizations to perform functions like member enrollment, oversight of provider networks, utilization management, and claims payment.

Regardless of the model chosen, Medicaid managed care is subject to extensive federal and state regulation, including standards for actuarial soundness and medical loss ratios (i.e., the percentage of premium dollars spent on health care and quality improvement vs. profit), consumer safeguards, and quality improvement. In addition to issuing regulations, states supplement and clarify these federal standards through the large purchasing contracts that support Medicaid managed care. Federal law also permits states to incorporate alternative payment methods into managed care. These include partial capitation or bundled payments that potentially can improve quality and efficiency. States also can opt to allow their plans to offer certain types of services "in lieu of" services normally covered, such as paying for home visits for new mothers and infants instead of office visits alone.

Because of its size and prevalence, Medicaid plays a major role as a health care payer, especially in expansion states. As such, the program has the potential to influence considerably the availability and quality of health care. This is particularly true in cases where Medicaid is the dominant payer, like maternity and pediatric care, behavioral health, and health care for patients with physical and behavioral health conditions. Furthermore, the purchasing strategies used by a payer representing a significant portion of the insured population carry broad implications for the health care system overall. There is extensive policy interest in the decisions Medicaid programs make in their roles as health care purchasers.

We sought greater understanding of how managed care purchasing is evolving in Medicaid expansion states, which face the challenge of adapting the modern tools of managed care purchasing to fit a beneficiary population that has grown sizably.

THE STUDY

This study, which took place in summer 2017, examines Medicaid managed care for beneficiaries eligible for coverage based on low family income alone, as opposed to those who meet both financial and age or disability requirements. We conducted an extensive review of state rules, policies, and contracting documents, supplemented by interviews with senior Medicaid officials in all study states.

We examined the experiences of 10 states — California, Colorado, Connecticut, Maryland, Massachusetts, Michigan, Minnesota, New York, Ohio, and Washington — that are diverse in size, location, urban/rural mix, and population demographics. (Connecticut, which is included in this study because of its unique approach

to large-scale managed care, directly oversees its own managed care system, using private contractors for day-to-day administration only. The state does not enter into MCO risk contracts, but its strategies parallel those used by states that do.) Together these state populations account for 43 percent of the total Medicaid population,[4] 63 percent of the Medicaid expansion population,[5] and 42 percent of all risk-based managed care enrollment.[6]

RESULTS

Active engagement in delivery system reform. The study states all define their role as active health care purchasers focused on improved health outcomes and greater health care value. States' strategies for improving health care quality and efficiency are reflected in their purchasing documents. These documents focus attention on improving plan performance of member outreach and health improvement, care delivery, care management, network design, quality, and greater alignment of services through formal relationships between plan operations and other programs such as school health, special education, child welfare, community food and housing programs, and community employment services. Four states — California, Massachusetts, New York, and Washington — link their managed care strategies to Medicaid's Section 1115 Delivery System Reform Incentive Payment (DSRIP) initiatives that are aimed at improving the quality and efficiency of health care.[7]

Special populations. States place special emphasis on populations likely to benefit from better-managed care (Exhibit 1). Not surprisingly, given the increased numbers of working-age adults enrolled in Medicaid as a result of the ACA expansion — many of whom are older, affected by serious health problems, or both — adults with chronic physical and mental health conditions emerge as one of the most common emphases. Addressing addiction and substance use disorders emerges as a priority in nine of 10 states. Children are a major focus, especially those in foster care and out-of-home placements, who are often at risk for serious health conditions. Improving care for people experiencing a period of homelessness is a priority in several states.

Exhibit 1. Targeted Initiatives for Special Populations

	Children	Pregnant women	Adults with chronic conditions	Substance use disorders	Foster children	Homelessness/ Supportive housing
California	✓		✓	✓		✓
Colorado	✓		✓		✓	
Connecticut	✓	✓	✓	✓		✓
Maryland	✓	✓	✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓
Michigan	✓	✓		✓	✓	
Minnesota	✓		✓	✓	✓	
New York	✓		✓	✓	✓	✓
Ohio		✓	✓	✓	✓	
Washington			✓	✓	✓	✓
Total	**8/10**	**5/10**	**9/10**	**9/10**	**8/10**	**6/10**

Data: State-provided standard Medicaid managed care contract agreements or personal communications with state officials. See Appendix 1 for details.

States focus on these areas of interest in various ways. For instance, some states are working to improve integration of physical and behavioral health care, while others focus on ensuring that networks include needed providers in strategic locations, like school-based health centers, child and adolescent health centers, and behavioral health homes for children and adults with serious and chronic mental conditions. Other states emphasize specific network competencies such as care management for women with high-risk pregnancies or for people experiencing homelessness.

Service delivery integration. While all states have focused on better integration of physical, behavioral, and social services, seven (Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New York, and Washington) have taken the additional step of working to reform the health care delivery system using models that can provide comprehensive care, care management for patients with multiple conditions, and links to health and social services through organized provider networks in accountable care organizations (ACOs), coordinated care organizations (CCOs), or other similar systems. Regardless of whether the focus is at the managed care level or on the underlying structure of health care delivery through special initiatives such as accountable health care, states are placing a greater focus on the overall reach and quality of health care itself, using health information to advance evidence-based care and systematic strategies for improving quality and efficiency.

Some states have identified specific populations for special attention. New York, Washington, Maryland, and Ohio, for example, concentrate on homeless people, high-risk pregnant women, and residents of communities with healthy food shortages. For a long time, Colorado and Minnesota have focused on models of clinical and social integration designed to reach high-need populations. Washington, Massachusetts, and New York are also moving in this direction. California is testing a "whole-person" approach to care to integrate health and social services through defined relationships between provider systems, community organizations, and social services programs. Connecticut's day-to-day plan administrator oversees the state's strategy related to health and social services integration.

State integration models tend to couple strengthened primary care management for people with mild-to-moderate conditions with more intensive care for the highest-need patients. Some states use health plans that furnish or arrange for a full array of physical and behavioral health care. Other states, such as Connecticut, use contractors with specialized expertise in caring for the highest-need populations — those experiencing severe behavioral health conditions.

Special network capabilities. All states have established basic expectations regarding the capability of provider networks to deliver covered services using standards for scheduled and unscheduled (e.g., urgent and emergency) care, waiting times, and travel distance (Exhibit 2).[8] Several states have identified certain types of providers whose inclusion in networks is an explicit managed care contract requirement. Four states expressly identify safety-net providers as required network providers; six states require networks that have special capabilities such as the ability to care for people with special health care needs, foster care children, people whose first language is not English, people with HIV/AIDS, and incarcerated populations. Three states identify pediatric centers of excellence as a required type of provider.

Quality improvement and payment incentives. States use targeted performance improvement measures (Exhibit 3). The vast majority of study states either tie designated quality improvement goals to payment incentives, or plan to do so. This includes additional bonuses above a base payment or repayment of amounts withheld from initial payment amounts, based on positive performance. (This latter payment incentive model is termed return of payment withholds). These target goals tend to be based on established and proven performance measurement systems, such as HEDIS. Colorado calculates payments — and Ohio plans to soon — based on the amount of improvement achieved. Michigan uses withholds for performance bonus awards and Washington requires that 30 percent of each contractor's payments be value-based.

Exhibit 2. Provider Networks — Special Considerations

	Requires provider expertise for special populations	Night and weekend availability	Safety-net providers	Centers of excellence
California		✓	✓	✓
Colorado	✓	✓	✓	
Connecticut*				
Maryland	✓	✓		
Massachusetts	✓	✓	✓	
Michigan	✓	✓		✓
Minnesota	✓	✓		
New York	✓	✓		✓
Ohio		✓	✓	
Washington		✓		
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.

Data: State-provided standard Medicaid managed care contract agreements or personal communications with state officials. See Appendix 2 for details.

Exhibit 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	Immuni-zations
California	✓	✓			✓		✓	✓	✓
Colorado	✓	✓					✓		
Connecticut	✓		✓		✓	✓	✓	✓	✓
Maryland	✓	✓				✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓					✓	✓	✓	✓
Minnesota	✓	✓	✓	✓	✓	✓			
New York	✓	✓	✓	✓	✓	✓	✓		
Ohio						✓	✓		
Washington	✓				✓			✓	✓
Total	9/10	6/10	4/10	3/10	6/10	7/10	8/10	6/10	6/10

Note: BMI = body mass index.

Data: State-provided standard Medicaid managed care contract agreements or personal communications with state officials. See Appendix 3 for details.

Among various quality improvement measures, nine states tie well-child visits to financial incentives; eight tie infant and maternity care visits to financial incentives. More than half of the study states link financial incentives to clinical process-of-care measures for adult body mass index (BMI) levels, prevention or screening measures like immunization rates or adolescent well-care visits, or service measures like hospital readmission rates and emergency department/ambulatory care utilization rates. The move to using outcomes measures appears to be occurring more slowly; states indicated that this approach is something they hope to achieve.

Testing new payment approaches. States are beginning to test innovative payment approaches, such as bundled payments or payment for episodes of care (i.e., paying for an entire care cycle rather than for individual procedures) or partial capitation payments (i.e., payment of a monthly, all-inclusive amount for a defined bundle of services). These models are designed to transition away from a payment system based on volume and toward outcome-based performance (Exhibit 4). Six states go beyond the threshold question of alternative payment models and are beginning to link financial incentives to these newer payment approaches. Six states use subcapitation (i.e., paying network providers a fixed amount per member per month for a defined set of services) to promote the assumption of a certain amount of financial risk by participating providers for specific covered services. Four states are already using or plan to use bundled payments for specific episodes of care. Connecticut, for example, has decided to bundle obstetric care into a single global payment for both medical and hospital care partly to reduce the number of cesarean sections; Ohio incorporates bundled payments for specific acute needs as part of its patient-centered medical home model. A few states are using global payment strategies (i.e., a single payment for all clinical and hospital services) in connection with prenatal, delivery, and postpartum care. Some are moving toward shared-shavings approaches;

Exhibit 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				✓	✓	✓	✓
Colorado		✓			✓	✓	✓
Connecticut	✓	✓	✓		✓	✓	
Maryland							✓
Massachusetts			✓	✓		✓	✓
Michigan		✓					
Minnesota				✓			✓
New York	✓	✓	✓	✓		✓	✓
Ohio	✓	✓					✓
Washington	✓	✓			✓	✓	
Total	**4/10**	**6/10**	**3/10**	**4/10**	**4/10**	**6/10**	**7/10**

Note: FQHCs = federally qualified health centers.

Data: State-provided boilerplate Medicaid managed care contract agreements or personal communications with state officials. See Appendix 4 for details.

these involve permitting network providers to share in the savings achieved from more efficiently furnished care that lowers health costs and to absorb a certain amount of the financial loss if there are avoidable expenditures. Four states have begun to test specific alternative payment models for federally qualified health center services. Historically these health centers have been paid for each separate encounter, similar to the way physicians are paid for office visits. The alternative models attempt to reduce the overall volume of individual visits to hold down costs while using strategies like group care, when appropriate, and of lower-cost alternatives to clinician encounters.

Seven states are testing coverage of alternative services — such as home visits in lieu of services furnished in clinical care setting, or the substitution of previously uncovered services, such as additional day clinic treatment services in lieu of the amount of residential treatment that may ordinarily be covered under a state Medicaid plan. States also are beginning to test the concept of "value-added" services through payment arrangements with integrated provider systems that reward investments in health improvement.[9] Examples being tested include the provision of bike helmets, gym membership discounts, and enhanced transportation benefits.

CONCLUSION

For 25 years, managed care has played a central role in federal and state Medicaid policy. In an era of expanded coverage, with Medicaid now paying for health care for one of five Americans, states have moved to incorporate modern delivery and payment reform strategies into the managed care model. State programs are focusing on a diverse range of ideas, purchasing principles, and health priorities. But they share a common vision of a health care system that performs well for patients while integrating clinical care with health and social services. Medicaid has emerged as not only a major source of health care financing but as a key tool for improving patient and population health. With its dominant presence in low-income communities, Medicaid delivery and payment reform strategies have the potential to achieve a sufficient level of diffusion to achieve population-level results over time.

States also share common challenges: perennially tight budgets; a surge in enrollment that places heightened demands on the system; enrollment growth among older, working-age adults in poor health; the challenge of moving from process to outcome measures for care; designing health care that works well in poor communities with elevated health risks; cost pressures brought about by new technologies and major health crises like the opioid epidemic; ensuring access to necessary specialty care; limited evidence regarding the effectiveness of payment and delivery system reform tools, along with the complexity of their implementation for payers and providers alike; and the time needed to change health care delivery on a mass scale.

In the face of these challenges, states also identified factors that help promote positive results. These include: stable beneficiary enrollment over time, a federal regulatory environment that promotes testing and measuring new approaches, and incorporating a wide range of stakeholders, including managed care organizations; health care professionals and integrated delivery systems; and health, educational, and social service programs dedicated to improving health at a community and population level. In addition, states have brought energy and commitment to the challenge facing 21st century American health care: improving the health of people while slowing the growth of health care costs.

NOTES

[1] S. L. Decker, D. Kostova, G. M. Kenney et al., "Health Status, Risk Factors, and Medical Conditions Among Persons Enrolled in Medicaid vs. Uninsured Low-Income Adults Potentially Eligible for Medicaid Under the Affordable Care Act," *Journal of the American Medical Association,* June 26, 2013 309(24):2579–86.

[2] J. Giovannelli, K. Lucia, and S. Corlette, *Regulation of Health Plan Provider Networks*, Health Policy Brief #160 (*Health Affairs,* July 28, 2016).

[3] J. Paradise, *Data Note: Medicaid Managed Care Growth and Implications of the Medicaid Expansion* (Henry J. Kaiser Family Foundation, April 2017).

[4] Kaiser State Health Facts, *Total Monthly Medicaid and CHIP Enrollment, Timeframe: July 2017* (Henry J. Kaiser Family Foundation, n.d.).

[5] Kaiser State Health Facts, *Medicaid Expansion Enrollment, Timeframe: FY 2016* (Henry J. Kaiser Family Foundation, n.d.).

[6] Kaiser State Health Facts, *Total Medicaid Managed Care Enrollment, Timeframe: 2014* (Henry J. Kaiser Family Foundation, n.d.).

[7] Medicaid and CHIP Payment and Access Commission, *Delivery System Reform Incentive Payment (DSRIP) Programs* (MACPAC, March 2015); and K. Heflin, *Driving Health Care Innovation Through DSRIP: State of the States* (Center for Health Care Strategies, Oct. 20, 2016).

[8] Connecticut treats all participating Medicaid providers as part of its managed care strategy.

[9] 42 CFR Part 438.3(e)(2) (Electronic Code of Federal Regulations, n.d.).

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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	Immuni-zations
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/lfserver/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.

[1] 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.

[2] 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.

[3] Episode-based payments for specific medical events with associated clinical measures to ensure quality care.

[4] Collecting data to form bundled arrangements in the future.

[5] 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.

[6] Enhanced fee-for-service (FFS) reimbursement and annual improvement payments for PCMH initiative.

[7] 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.

[8] 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.

[9] 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.

[10] 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.

[11] 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.cga.ct.gov/med/committees/MQ/(PCMH%20Plus%20Overview%20and%20Update%20for%20MAPOC;%20March%2017,%202017).pdf.

[12] 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.

[13] 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.

[14] 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.

[15] 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.

[16] 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&dDocName=dhs16_161441#.

[17] 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/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf.

[18] 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).

[19] 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.

[20] 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.cga.ct.gov/med/committees/MQ/(PCMH%20Plus%20Overview%20and%20Update%20for%20MAPOC;%20March%2017,%202017).pdf.

[21] 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.

[22] 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/dsrip/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.

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