Managed Care Contracting to Drive Health Information Technology Adoption and Improve Population Health Outcomes

Over the last decade there has been a proliferation of the use of managed care in the Medicaid environment, driven primarily by the need for states to have more predictable costs as well as a need to improve health outcomes through more effective case management and appropriate utilization. At the same time managed care was expanding to be the delivery system of choice for most states, technological advances, health IT, data, and advanced analytics have opened up new possibilities for better coordination of care, medical decision-making, quality improvement, care management, program management, and in some cases, reductions in cost. These technological advances have been facilitated through enhanced funding opportunities made available through HITECH, Medicaid Information Technology Architecture (MITA), and even the Affordable Care Act (ACA).

As states look to improve quality and implement value based purchasing (VBP), alternative payment models (APMs), and other quality improvement strategies, and with the heavy reliance on managed care entities[[1]](#footnote-1) (MCEs) as partners, careful consideration should be given on the requirements needed or imposed on MCEs, such that states can work towards accomplishing their overall health care objectives.

MCE contracting is evolving to require improvements in health outcomes, often linked to value based contracting strategies. A key component to improving health outcomes includes having timely, accurate, and complete information available at the point of care. This information includes traditional health information but increasingly includes information related to social determinants of health which stand to greatly impact overall health.

MCEs, even without direct intervention from states, may also find it beneficial to leverage health information technology (health IT) and/or partner with health information exchanges (HIEs) so they can better satisfy contract requirements, improve the care of their populations, reduce cost, and increase market share. While MCE effectiveness can be improved through the use of health IT, MCEs can also drive the availability and adoption of health IT by providers. This can be done through provider contracting and even payment incentive strategies. Ultimately, MCEs and providers alike will be more successful, and patients will benefit from the increased availability of health information at the point of care.

So, how can we leverage managed care contracting strategies to drive this alignment and improvement? This paper focuses on strategies for the managed care environment that may require or leverage the meaningful use of health IT, VBP strategies, and social determinants of health data to drive population health outcomes.

**Background on VBP Programs**

The traditional Medicaid health system is based on volume driven reimbursement where providers have a financial incentive to provide more services. This environment contributes to increased Medicaid costs, but not necessarily improved beneficiary health outcomes. In recent years, the Centers for Medicare & Medicaid Services (CMS) and numerous state Medicaid programs have advanced reimbursement models that emphasize value over volume by introducing accountability that links payment to improved health care quality or outcomes. In fact, CMS’ goal is to move Medicare, Medicaid, and even commercial markets to a system where payment is predominantly tied to quality and value.

The National Association of Medicaid Directors (NAMD) identifies the overall goal of the VBP model as being to improve the value of the health delivery system, meaning to improve the quality of the care provided while at the same time controlling costs.[[2]](#endnote-1) NAMD broadly defines “value based payments” as “any activity a state Medicaid program undertakes to hold a provider or contracted managed care organization (MCO) accountable for the costs and quality of care they provide to Medicaid beneficiaries.”[[3]](#endnote-2)

States have implemented VBP models either directly with providers or by requiring MCEs to implement them within their provider networks based on contractual quality and cost requirements. States use a variety of approaches that range significantly in terms of the extent of risk placed on the MCE and/or providers[[4]](#footnote-2). These models can be relatively simple to quite complex and often have a ramp up period with more complex approaches or requirements phased in over time. Further, states design their VBP models “in a manner that makes sense for their local marketplace, their culture and their environment, so there is variability in the type of model used and how it is implemented”[[5]](#endnote-3) .

Value based purchasing may not be right for every Medicaid program or managed care delivery system. In the right situation, though, the implementation of a VBP initiative can be an effective way to further promote the delivery of better care, improved beneficiary health outcomes, and a reduced trend in program costs.

The table below presents general examples of VBP approaches by relative degree of risk on the MCE and/or providers.

| Summary of VBP Approaches by Degree of Risk for MCEs / Providers | | | |
| --- | --- | --- | --- |
| **Activity** | | **Definition** |  |
| **Less Risk**  **More Risk** | **Pay for Coordination** | The MCE pays primary care practices or a group of practices to accept responsibility for managing the health of and the delivery of specific services to a defined population in exchange for a fee and with the goal of meeting specified health care outcomes. May require use of electronic health records. Primary care medical homes are an example of this model. | |
| **Pay for Performance** | Rewards MCEs and / or providers for achieving or exceeding contractually specified health care outcomes. Payments are determined by evaluating the MCE and/or provider performance against established benchmarks. | |
| **Episode-based / Global / Bundled Payments** | A single fee is paid to MCEs and / or providers for all services related to a specific condition or procedure. The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular course of treatment, as well as costs associated with preventable complications. | |
| **Shared Savings (Gain Sharing)** | MCEs and / or providers that succeed in keeping costs for a defined population below a total cost of care benchmark and achieve quality of care results at or above a benchmark keep a percentage of the savings. | |
| **Shared Risk (Risk Sharing)** | If actual costs for a defined population exceed a benchmark, then the MCE and / or provider is accountable for a portion of the excess costs and must repay the Medicaid agency. Shared risk is often paired with shared savings arrangements after some degree of program experience has been established. | |
| **Population-based Payments** | MCE or provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set amount of funding. If the MCE or provider effectively manages cost and performs well on health care targets, then the MCE or provider may keep a portion of the savings generated. If the MCE or provider fails to generate savings and meet targets, it is held responsible for some of the additional costs incurred. Population-based payment is the underlying payment model used in Accountable Care Organizations. | |

**State Medicaid VBP Program Experiences**

In a March 2016 survey, the National Association of Medicaid Directors (NAMD), in collaboration with the Commonwealth Fund, reported that of the 34 states that participated in the survey, 28 had developed or were in the process of developing a VBP approach.[[6]](#endnote-4)

The NAMD survey showed that at least 12 states were implementing VBP models which pay for coordination by providing payments to Patient-Centered Medicaid Homes (PCMHs) or Medicaid Health Homes. In some states a shared savings component was included. The survey reported that seven states have implemented or were in the process of implementing episode-based payments for such conditions as asthma, childbirth, or congestive heart failure. Finally, nine states reported implementing population-based payment models.

The NAMD study also cited the following survey findings based on states’ experience in developing VBP models:

* Stakeholder engagement throughout the entire process (planning, implementation and operations) is vital to the success of the VBP model.
* Reliable and timely data on cost, quality, and utilization must be available to the state, providers and MCEs.
* While states are interested in implementing VBP models, some have been challenged to find the appropriate internal skills and resources necessary or available to administer the model.
* Lack of coordination between state and federal efforts may impede the successful implementation of Medicaid VBP models. Alignment of at least state and federal models across payer types helps to alleviate provider level administrative burden.
* CMS offers a number of tools and supports that are helpful to states in the VBP model design and implementation process.

**State Medicaid Priorities**

Results from the recently completed 50-State Medicaid Budget Survey from the Kaiser Family Foundation indicates that State Medicaid directors reported five areas of priority for 2019.[[7]](#footnote-3) More than two-thirds of states reported a focus on developing and implementing initiatives to improve quality of care and health outcomes while containing costs. Avenues to achieve this include expanding, improving, and reforming managed care; reforming delivery systems; implementing value-based purchasing initiatives; and expanding the availability of Substance Use Disorder (SUD) treatment. Many states hoped to implement or pursue new Section 1115 demonstration waivers in 2019. The most frequently reported waiver concepts addressed behavioral health and/or the Institution for Mental Disease (IMD) exclusion and work and community engagement requirements.

As in years past, a significant number of states reported information technology systems projects currently underway or planned. Most are related to Medicaid Management Information Systems procurements and eligibility system upgrades and replacements. States commented on redesigning their systems to meet federal “modularity” requirements, and the need for system improvements to support delivery system reform and VBP, quality improvement, provider and MCE monitoring, data analytics, and cost control strategies. vii

**The Role of Health Information Technology**

Reliance on health IT is ever-changing but one thing is clear, it is a necessity. Health IT is required to deliver timely access to reliable data at the point of care for appropriate medical decision-making. Program managers need health IT to deliver reliable data to make informed-decisions regarding utilization, access, quality improvement, and financial management. Finally, program executives and other stakeholders need health IT to deliver reliable data to establish overall objectives and inform policy decisions on population health, enrollment, coverage options, program development, budgets and forecasts, and other key decisions.

Health IT is most often viewed as a singular stand-alone thing. Indeed it is unique in many ways but today’s health IT is a highly integrated, extremely complex, web of systems and data. Having access to a system or certain dataset is one thing, but its real power is unleashed when it is combined with other systems and datasets. It all needs to effectively communicate for health IT to be truly effective.

Stakeholders, both internal and external often view health IT initiatives as a necessary, stand-alone entity, with its own goals and objectives. Health IT should not be viewed as the end goal, it is the means to accomplishing them. This connection is often misunderstood. Therefore, any health IT initiative should include a robust communication strategy to demonstrate the linkage to the success of high-level health care objectives. Stakeholder engagement is a critical component to any health IT initiative.

**General Approaches for Implementing VBP in Medicaid Managed Care**

States may implement VBP models either directly with providers, or by requiring MCEs to implement them within their provider networks. VBP models may be implemented with a link to quality or financial requirements. While VBP approaches vary by state, they all generally work as an accountability tool that ties performance targets to contractually-specified goals. At the MCE level, if the performance targets are met, the MCE receives either a portion of withheld capitation payments, shared savings, incentive payment or other options such as auto-assignment of new members enrolling in the MCE program. If the MCE does not meet the target, they are typically ineligible for payment and the state retains the funds or may impose remedies available under the MCE contract. It is important to note that the recently updated federal managed care rule places restrictions on incentive and withhold arrangements with MCEs. This approach is permissible if the payments align with performance outcomes targeted in the state’s Quality Plan but must be approved annually by CMS.

Drawing from a Center for Health Care Strategies (CHCS) analysis and Myers and Stauffer’s industry experience, presented below are high-level contracting approaches to VBP models in Medicaid managed care:[[8]](#endnote-5)

* *Require MCEs to meet contractual performance targets tied to financial incentives.*

MCEs must meet annual contractual performance targets. The MCE has the flexibility to design its own approach to ensure the performance targets are met (e.g., the contract does not require the MCE to incorporate VBP requirements in its provider contracts, but the MCE may elect to do so). For example, the FY 2017 Georgia Families 360 contract included a value based payment provision in which the state withheld five percent of MCE capitation payments to be paid to MCEs if they met specified annual performance targets. This contract did not specify how the MCEs should go about meeting these targets. The FY 2018 contracts for Georgia Families and Georgia Families 360 includes a new approach in which 50 percent of the withhold amount must be passed through to MCE providers as an incentive payment. Georgia has delayed implementation of this provision pending guidance from CMS regarding MCE federal rule requirements. Georgia also awards member auto-assignment to the best performing plan based on their performance on 19 quality measures which is evaluated every six months. Details are available at <https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/Georgia%20Families%20360%20contract.pdf> and <https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/Georgia%20Families%20Contract%20with%20RFP.pdf>.

* *Require MCEs to design and implement their own VBP models subject to state approval.*

The MCE would submit a VBP proposal to the state that aligns with the State’s quality and outcome goals and objectives. This proposal would include specified performance targets that are established or agreed to by the state. The MCE proposals would be reviewed and approved by the state. The state would then work closely with the MCE to establish an implementation timeline, quality measures, and monitoring and evaluation processes. For example, New Mexico adopted this approach as part of its Centennial Care MCE program. Each of the state’s MCEs submitted proposals based on state defined performance targets. The state then reviewed and approved proposals. The state is monitoring and evaluating the projects to determine effectiveness and scalability. Details are available at <http://www.hsd.state.nm.us/uploads/files/Value-Based%20Purchasing%20Issue%20Brief%20-%20Jan%2013%202017.pdf>

* *Require MCEs to adopt a contractually specified VBP model.*

MCEs must implement a VBP model that includes state required approaches. This model offers a high level of standardization in terms of provider payment, administrative requirements, and quality measures. In addition, standardization across MCEs decreases the provider burden to participate since it promotes consistency across the different MCE payers. Another benefit is that it assists the state to develop a model that can align with Medicare and other commercial payers, further reducing provider burden. For example, Tennessee’s MCEs are required to implement Patient Centered Medical Homes (PCMHs) and episode based payments. Detail is available at <http://www.qsource.org/wp-content/uploads/2017/06/2017_TennCare_June_Presentation_Population_Health_Medicaid_Value-Based_Care.pdf>.

* *Require MCEs to participate in a multi-payer VBP alignment initiative.*

In this advanced model, the state could facilitate a multi-payer initiative, including Medicaid, Medicare and commercial payers, for the purpose of ensuring consistency, reducing administrative burden, and aligning incentives across the health plan VBP efforts in the provider community. The state would require alignment with multi-payer models for areas such as performance metrics, provider eligibility criteria, consistent timing and phasing of model approaches, training, and resources to support providers. For example, CMS has implemented Comprehensive Primary Care Plus (CPC+) which is a “national advanced primary care medical home model designed to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.”[[9]](#endnote-6) CPC+ uses health care delivery requirements and associated payment options to improve the access to and quality of primary care services. This model is a long range goal for states and is attained over time. Detail is available at <https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus>.

In support of the development of VBP models, technical assistance is available at:

* CMS Medicaid Innovation Accelerator Program at <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html>
* CMS Health Care Payment and Action Network at <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>

**Other VBP Arrangement Examples**

Arizona MCE VBP

* Arizona Long Term Care System to have minimum of 50 percent of total payments be value-based by 2019.
* Can receive up to one percent of the per member per month payment if they meet certain quality measures.
* MCEs have implemented pay for performance (P4P), PCMH, shared savings, and bundled payment programs in response to the VBP requirement.

<https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html>

Pennsylvania MCE VBP

* MCEs are eligible for bonus payments based on performance compared to 11 HEDIS® and one non- HEDIS® measure.
* Can receive up to 1.5 percent of the per member per month payment.
* One percent of the incentive pool is for the MCEs’ performance in comparison to national benchmarks, and the remaining 0.5 percent is for the MCE’s year-to-year improvement on each measure.
* A penalty was incorporated for MCO performance below 50 percent of a national Medicaid benchmark.

<http://www.healthchoices.pa.gov/providers/resources/valuebasedpurchasing/index.htm>

Kansas MCE VBP Program

* Withhold five percent of payments for incentive payments.
* Pays MCEs part or all of withheld payments, depending on how many performance measures the MCE meets.
* Use national standards such as HEDIS® benchmarks and Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Outcome Measures (NOMs).

<https://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-renewal/kancare-2-0-waiver-renewal-application---for-public-comment.pdf>

Oregon Coordinated Care Organization (CCO) P4P Program

* Annual Incentive Payments.
* Uses 18 Quality Benchmarks - 10 Healthcare Effectiveness Data and Information Set (HEDIS®) measures and eight other types.
* CCO can qualify for incentive payments by meeting the absolute goal or achieving the improvement goal.
* Absolute goal method**:** Relies on national standard, such as those set by HEDIS® measures, to set the benchmarks.
* Improvement goal method sets benchmarks for performance against an improvement target. Oregon requires at least a 10 percent reduction in the gap between a CCO’s prior year’s performance and the current goal.

<https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx>

Maryland Global Budget Payment

* Under a global budget payment system MD Hospitals receive a fixed for a fixed period for a specific patient population.
* Hospitals receive the payment regardless of case volume or intensity of services delivered.
* The all-payer global budget model reduced Medicare hospital costs by $429 million, exceeding the expectation that the model would save $330 million over five years.
* Maryland hospitals reduced potentially preventable complications by 48 percent and improved the all-cause readmission rate by 57 percent.

<https://hscrc.state.md.us/Pages/budgets.aspx>

New Hampshire DSRIP Waiver

* Seven Integrated Delivery Networks (IDNs) that are responsible for building regional provider networks.
* Moving from process metrics (i.e. how many patients served) to 100 percent performance metrics (i.e. outcomes) by 2019.
* Up to 65 percent of Year 1 funding will be available for capacity building and planning.
* In Years 2-5, IDNs must earn payments by meeting metrics defined by DHHS and approved by CMS to secure full funding.

<https://www.dhhs.nh.gov/section-1115-waiver/index.htm>

**Next Steps for a Medicaid Program Considering VPB in a Managed Care Environment**

***Perspectives: Health Information Technology***

If you are considering a VBP program, it is important to evaluate your ability to effectively manage, monitor, and evaluate the initiative. Health IT systems that access and aggregate data from multiple sources, some of which may be outside of the typical domain, is a prerequisite for any program.

* Start with an updated and visionary State Medicaid Health Information Technology Plan (SMHP).
  + - Understand the HIE landscape and vision to ensure alignment.
    - Align required improvements in population health with the state’s current health priorities and the state’s Quality Strategy Plan.
    - Determine what is reasonable regarding improvements given the current HIE environment. Determine the anticipated changes during the contracting period.
* Require the MCE to encourage/require network provider participation. Require a written plan that is subject to the state’s approval. The plan may include incentives or penalties.
* Require MCEs to contract with the HIE to share health data. Include data from subcontractors who are providing access to covered services.
* Require MCEs to receive and act upon event notification (e.g. Admit, Discharge and Transfers [ADTs]) in a specific way or timeframe. Examples may include number of days to initiate a utilization management (UM) case.
* Sustainability and financing.
  + - Consider requiring MCE connection fees to support long term HIE sustainability.
    - Leverage 90/10 funding for provider onboarding.
* Leverage the HIE to create patient empowerment tools that are adaptive to the current and future needs and/or conditions of the MCE enrollee.
* Leverage the HIE to validate population health outcomes and conduct program integrity activities without the need for chart abstraction.
* Advance MITA 3.0 for care management by establishing interoperable connections to replace highly manual paper-driven processes with standardized and automated business rules to improve access to case and population health management.

***Perspectives: Planning and Implementation Practices***

If a program considers moving forward to implement a VBP model, there are key planning and implementation practices that will support the process:

* Conduct an “as is” assessment of the MCE performance results, including quality measures, to identify opportunities for improvement.
* Develop and convene an internal workgroup comprised of the medical director and key operational areas such as policy, finance, quality, contracts, and information technology, and decision support services.
* Engage CMS for early discussions and vetting of potential VBP model design and financial impact.
* Conduct research and develop key program design considerations for discussion with the internal workgroup and leadership levels.
* Complete detailed analysis of VBP models implemented by other states to identify best practices and lesson learned.
* Evaluate the commercial payer and Medicare payment for existing VBP models.
* Survey Medicaid managed care providers on their current managed care and Medicare contracts and associated VBP models.
* Conduct internal data analyses to support program design and cost savings projections.
* Develop options analyses to identify potential models specific to the program, including targeted members and health outcomes.
* Review the MCE contract and identify opportunities to add language for new VBP model(s), including provider network contracting requirements (e.g., Electronic Health Records [EHR] reporting requirements, etc.).
* Conduct stakeholder engagement meetings and surveys with providers, provider associations, MCEs, and other payers on proposed VBP models, rationale, projections, and long term goals.
* Modify VBP options based on stakeholder input, as needed.
* Establish a roadmap for the initial VBP model in consideration of its long term goals and objectives.
* Develop a detailed communication plan for internal and external stakeholders.
* Collaborate with the state’s actuarial vendor on rate-setting and risk analysis implications.

**Key Considerations of VBP Models**

There is no one standard approach to Medicaid VBP models, instead states must consider their population health status and needs, the provider landscape, the health insurance market, administrative capacity in designing and implementing a VBP, and the impact of federal regulatory requirements. Specifically, key considerations in assessing the VBP approach that best meets the program’s needs are:

* *Population Health Status and Needs:* Analyze data to identify member health care status, needs and costs. Based on this information, determine which members and health outcomes should be targeted by the model. For example, some states have a high incidence of premature, low birth weight deliveries and so they target pregnant women with the goal of reducing premature, low birth weight deliveries and the associated hospital costs.
* *The Provider Landscape:* After identifying the targeted members and outcomes, determine which provider types and/or services should be targeted such as hospitals or primary care physicians.
* *Health Insurance Market*: It is important to identify current VBP models in the state with providers in commercial and Medicare markets possibly align with these efforts. Also, it is useful to assess if the state’s contracted MCEs have successfully implemented VBP in other states.
* *Administrative Capacity:* States need to determine how quality measures will be benchmarked, and the process and resources necessary for collecting and validating data. States will also want to consider whether to align selected measures with existing state MCE quality efforts.
* *Federal Managed Care Regulatory Requirements (42 CFR 438):* Under the rule, VBP arrangements are an exception to the provision that states cannot direct MCE payment to providers; however, the rule adds new limitations on VBP incentive or withhold arrangements for the MCE. Any proposed model must be considered in the context of these regulations.

**Benefits and Challenges of VBP Models**

The table below presents some of the major benefits and challenges associated with VBP models:

| **Value Based Payment Benefits and Challenges** | |
| --- | --- |
| **VBP Benefits** | **VBP Challenges** |
| * Shifts payment system from a volume based approach to value based approach that contractually incentivizes MCEs to improve the quality of care. | * While CMS and a majority of states have implemented VBP models, the approach is relatively new and definitive results on effectiveness are not currently available. |
| * Has the potential to reduce inappropriate care by rewarding MCEs/providers for achieving desired performance outcomes. | * The state’s return on investment, staffing, and data infrastructure needs can vary significantly and cannot be determined until the state identifies VBP model goals and approach. * MCEs and providers may be reluctant to and/or decide not to participate in the Medicaid program if they view their Medicaid reimbursements as already low and identify the VBP model as a financial risk. Providers may also consider perceived barriers to meeting health outcomes or the administrative burden of new payment models. * May be difficult to achieve outcomes in rural areas experiencing health care professional shortages. |
| * Drives improvements in quality, emphasizes prevention, and may slow the growth in health care spending. | * State/MCE/provider readiness in terms of data infrastructure. Systems must be able to process data associated with the VBP structure, clinical outcomes, and be able to generate timely reports to and from the state, MCE and/or providers. |
| * Creates an opportunity for multi-payer alignment, especially with Medicare for dual-eligibles. | * Agency/MCE/Provider readiness in terms of staff resources including size and skill set to support the VBP model. |

**HCP LAN Roadmap for Driving High Performance in Alternative Payment Models viii**

In April, 2019, the HCP-LAN published the *Roadmap for Driving High Performance in Alternative Payment Models (APM)* (Roadmap)*.* The Roadmap is designed to provide promising APM use casesthat have achieved success, defined by HCP-LAN as improving quality and lowering costs. The Roadmapis a pilot study designed from interviews with payers and providers involved in 10 different APMs. Roadmap practices are presented in three domains: APM Design, Payer-Provider Collaboration, and Person- Centered Care. The Roadmapalso includes helpful information regarding a “Path Forward” to identify prerequisites needed to support the development of APMs.

According to the HCP-LAN, the Roadmap:

* Describes the characteristics of successful APMs
* Highlights best practices
* Provides strategies for mitigating common challenges

The following is a summary of best practices by domain. viii

***APM Design:***

* Establishing different payment structures such as base payments, capital investments, and quality-based incentive payments for both population and episode-based models. Certain strategies are designed to achieve incremental adoption of APMs based on readiness or to limit financial accountability.
* Utilizing HEDIS measures that address patient outcomes in population-based models, while attempting to reduce administrative burden.
* In episode-based models, use both core measure sets and episode-specific measures.
* Implement prospective and retrospective patient attribution methodologies in population-based models.
* Establishing attribution in episodes of care based on specified criteria.
* Collaborating with stakeholders to develop multi-payer models that drive alignment with overall model design objectives.
* Accelerating multi-payer alignment through strong leadership from states and dominant stakeholders.

***Payer – Provider Collaboration:***

* Engaging stakeholders in APM design such as through advisory councils or committees.
* Assessing capabilities for population health management.
* Establishing processes for communication and learning collaboration.
* Establishing data sharing processes to identify gaps in care, cost and utilization trends, and quality performance.
* Establishing technical support strategies to assist with implementation.
* Leveraging data analytics, learning collaboration, and best practices to conduct business process reengineering and organizational assessment.

***Person – Centered Care:***

* Promoting shared decision making and requiring patients to acknowledge their important role.
* Promoting patient education, health care literacy, and directing patients toward high quality, low cost providers.
* Developing payments that recognize the added value of care management by providers.
* Addressing social determinants of health by leveraging social workers, multidisciplinary teams, and other community resources.

For more information on the HCP-LAN Roadmap, please visit <https://hcp-lan.org/apm-roadmap/>.

**Conclusion**

The implementation of a VBP model for the Medicaid managed care program offers the state an opportunity to increase program cost effectiveness by contractually and financially incentivizing MCEs to achieve desired health outcomes. Consideration of the various VBP models and benefits and challenges will help inform the state of the best potential solutions. The design, development, and implementation of a VBP model can easily align with the State’s current and long term plans for quality measures and MCE performance initiatives. Further, there is already a great deal of federal and state experience available that states can draw upon in determining if and how to move forward.

For more information, please contact:

References

1. Managed care entity, managed care organization, care management organization, and coordinated care organization are terms often used by states to describe Medicaid managed care health plans. Unless referring a specific state or model, the term managed care entity (MCE) is used in this document. [↑](#footnote-ref-1)
2. Baillit Health and the National Association of Medicaid Directors. The Role of State Medicaid Programs in Improving the Value of the Health Care System. March 22, 2016 [↑](#endnote-ref-1)
3. National Association of Medicaid Directors. Value-Based Purchasing Snapshot. January 2017. [↑](#endnote-ref-2)
4. The approaches used in VBP models are often referred to as alternative payment models (APM). These terms can sometimes be used interchangeably. This briefing document refers to all approaches as VBP models. [↑](#footnote-ref-2)
5. Baillit Health and the National Association of Medicaid Directors. The Role of State Medicaid Programs in Improving the Value of the Health Care System. March 22, 2016. [↑](#endnote-ref-3)
6. National Association of Medicaid Directors. Value-Based Purchasing in Medicare and Medicaid: Areas of Intersection and Opportunities for Future Alignment. June 2016. [↑](#endnote-ref-4)
7. Health Mgmt. Assocs. & Kaiser Family Found., States Focus on Quality and Outcomes Amid Waiver Changes 81–82 (Oct. 2018), <https://www.healthmanagement.com/wp-content/uploads/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019.pdf>. [↑](#footnote-ref-3)
8. Tricia Leddy, Tricia McGinnis, and Greg Howe, Center for Health Care Strategies. Value Based Payment in Medicaid Managed Care: An Overview of State Approaches. February 2016. [↑](#endnote-ref-5)
9. Centers for Medicare and Medicaid Services at <https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus>

   Kaiser Family Found., Proposed Changes to “Public Charge” Policies for Immigrants: Implications for Health Coverage (Sept. 2018), <https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/>.

   Health Care Payment Learning & Action Network, Roadmap for Driving High Performance in Alternative Payment Models (April 2019), <https://hcp-lan.org/apm-roadmap/>. [↑](#endnote-ref-6)