

White Paper

Value-Based Reimbursement State-by-State

A 50-State Review of Value-Based Payment Innovation

Commissioned by Change Healthcare

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Executive Summary

Value-Based Payment: An Innovative and Collaborative Mosaic of Activity Across the Nation

Much attention has been paid to the federal government's role in accelerating the shift in healthcare payment from volume to value. For example, when it announced a commitment to tie 90% of Medicare payments to value by 2018, and 50% of payments to alternative payment models by 2018,¹ the Centers for Medicare & Medicaid Services (CMS) drove other healthcare stakeholders in the same direction.



Since then, the CMS has introduced numerous value-based programs, and has moved forward implementation of congressionally approved value-based payment initiatives, such as the Protecting Access to Medicare Act of 2014 (PAMA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

But CMS's role in the payment reform landscape has overshadowed the importance and momentum of other work occurring at the state level. This report seeks to shed light on this other work through an examination of state-level value-based payment initiatives underway across America.

Key findings of this 50-state review include:

1. More than 40 states have a state-initiated plan or strategy to move toward value-based payment, and almost half of those initiatives are multi-payer in scope.
2. Well-developed, value-based payment strategies have been implemented in six states for four years or longer, many with federal support; 23 states have initiatives that are two years or more in implementation; and 10 states are in the early stages of development.
3. As with the federal government, 23 states have established value-based payment targets or mandates that payers and providers agree to achieve.
4. Seventeen states have adopted or are considering adoption of ACOs or ACO-like entities to help manage costs and deliver better care, and 12 states have adopted or are considering adoption of episodes of care programs.
5. Many states have used value-based payment reform to engage with healthcare stakeholders in the redesign of the state healthcare system, identifying unique and innovative strategies that work for their state healthcare market.
6. Only seven states have little to no activity around value-based payment.

Overall, five states stand out for the breadth of their initiatives, their embrace of payment models that involve shared risk, and their willingness to test innovative strategies. These states include but are not limited to:

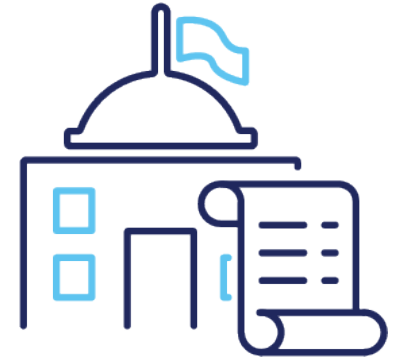
- Arkansas, which has a multi-payer EOC program in place for five years
- Colorado, which has a well-developed Medicaid ACO program, and is working with payers and large employers to implement value-based payment
- Minnesota, which was an early adopter of EOC and has now moved into ACOs
- Tennessee, which is on pace to roll out 76 episodes of care in its Medicaid and state employee programs by 2019
- Washington, which has committed to tying 80% of its state-financed health payments to value by 2021 and is seeking similar commitments from commercial payers in the state

Please see the accompanying state-by-state review matrix for details that support the above assessments.

¹ Centers for Medicare & Medicaid Services. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. January 1, 2015. Available: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>.

Introduction

It has been nearly a decade since Don Berwick and his colleagues at the Institute for Health Improvement introduced the concept of the “Triple Aim” to the healthcare policy debate.² In the article that helped launch the current payment reform movement, the authors argued that the goal of the health system should be to achieve three interdependent outcomes: improved care for individual patients, improved population health; and reduced costs of care. A central and necessary step to achieving the Triple Aim, they posit, is a shift away from the thinking that “more is better” and toward better alignment of the payment system and outcomes.



What emerged in years since is a concerted effort among commercial and public payers who, in partnership with providers, are moving away from fee-for-service to value-based payment arrangements. Among public payers, Medicare has taken a leadership role in implementing value-based payments, setting a goal in 2014 of tying 30% of Medicare payments to value by 2016 and 90% by 2018. This goal has led to the rollout of numerous value-based payment initiatives by the CMS Innovation Center, the creation of the Health Care Payment Learning, and the Health Care Payment & Learning Action Network (HCP-LAN), a public-private partnership aimed at spurring payment innovation in the healthcare system at-large, among many other initiatives. Congress also has passed major legislation (PAMA and MACRA) that require value-based payment in Medicare.

While Medicare is obviously an influential player in the healthcare system, states retain significant authority over their regional healthcare market and can play a critical role in moving healthcare toward value. Indeed, Medicaid now provides coverage for 20% of the covered lives in the U.S., behind employer-based coverage at 50% but ahead of Medicare at an estimated 14%.³ In addition, individual states have authority over both Medicaid operations and private insurance markets within their jurisdiction. With recent changes to the Medicaid and CHIP Managed Care Rule, states now have the affirmative authority to require Medicaid MCOs in their state to implement value-based payment arrangements.⁴ If they choose to exercise this authority, states have significant power to move their state health insurance markets toward value-based payment reform.

Not surprisingly, a review of state value-based payment reform initiatives demonstrates significant variation in approach, due in part to factors motivating the shift to value. State payment reform has historically been influenced by factors including state-focused CMS initiatives, state budget challenges, and state policymakers’ interest in healthcare innovation. Two CMS sponsored programs—the State Innovation Model (SIM) grants and the Delivery System Reform Incentive Program (DSRIP) for Medicaid—require states as a condition of participation to develop a payment reform strategy. SIM grants were released in two rounds beginning in 2013, and in two tracks, known as “Design” and “Test.”⁵

Design grants, which supported more than 20 states in developing a state innovation plan, were typically about a year in duration and ranged from \$1-\$3 million. Test grants support implementation of the state-designed innovation plan, and amounted to tens of millions of dollars per state over

² Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Affairs*, May 2008, 27:3. 759-769.

³ Health Insurance Coverage of the Total Population, Kaiser Family Foundation, 2015. Available: <http://www.kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed 7/13/2017.

⁴ Centers for Medicare and Medicaid Services, Medicaid and CHIP Managed Care Final Rule, April 2016. Available: <https://www.medicare.gov/medicaid/managed-care/guidance/final-rule/index.html>. Accessed 8/14/2017.

⁵ State Innovation Models Initiative: General Information. Centers for Medicare and Medicaid Innovation Center. Available: <https://innovation.cms.gov/initiatives/state-innovations/>. Accessed 7/13/2017.

a three- to four-year period. In total, 17 states benefited from Test grants, including 11 that are still actively engaged in completing the second round. The SIM program requires a multi-payer reform focus, while DSRIP focuses on Medicaid. The DSRIP has been implemented in seven states and allows for an incentive payment through Medicaid for providers that meet certain performance goals.⁶

Consistent with an annual survey conducted by researchers at the Kaiser Family Foundation,⁷ this analysis finds that value-based payment is firmly rooted in state healthcare policy, with more than 30 states investing in value-based payment strategies. Many states have focused on state-financed healthcare, including Medicaid and state employee plans, by requiring contracted plans to implement value-based payment reform as part of their agreements with the state. Still others have used their status as regulators of the health insurance market to persuade or require commercial payers to join the state in efforts to move toward value-based payment. While the vast majority of states are still in the early phases of value-based payment implementation, a handful are much further ahead and have successfully moved along the APM (Alternative Payment Model) continuum to arrangements that call for shared risk and savings.

A complete review of all 50 U.S. states' approaches to value-based payment follows.

⁶ Gates A, Rudowitz R, Guyer J. An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers. September 29, 2014. Kaiser Family Foundation. Available: <http://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>. Accessed 7/13/2017.

⁷ Gifford K, Ellis E, Edwards BC, et al. Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. Kaiser Family Foundation, October 19, 2017. Available: <https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/>.

Methodology

This report is based on an extensive analysis of publicly available information compiled from May through August 2017. The study relies on information gleaned from primary sources, including state resources, federal government resources, and contractors that participate in state-initiated VBP programs. In addition, data available from secondary sources, including research reports from healthcare industry analysts; mainstream, business, and trade media; think tanks, public policy institutes, and research institutes; and other public sources were reviewed.

The research did not include independent verification of publicly available information in the form of interviews with government officials. As a result, this report will not reflect initiatives that might be ongoing but have not been publicly acknowledged or promoted on government websites, publications, or other official channels, and might not reflect recent changes if those changes have not been published publicly.



Defining Value-Based Payment

This paper uses the term “value-based payment” to refer to the full continuum of evolving payment arrangements that payers and providers are using as they move away from fee-for-service to payments that hold providers accountable for quality, outcomes, and total cost of care.

The consensus APM Framework developed by the Health Care Payment Learning & Action Network (HCP-LAN) provides a useful starting point for understanding and communicating the taxonomy of value-based payment models. As demonstrated in the HCP-LAN diagram below, the APM Framework establishes four Categories of Payment:

1. Category 1: Fee-For-Service
2. Category 2: Fee-For-Service payments with a link to quality and value, including enhanced payments for infrastructure investment, reporting, or quality
3. Category 3: Alternative payments based on fee-for-service with either shared savings or shared savings and risk, including episode-based payments
4. Category 4: Population-based payments, which provide a risk-adjusted per-patient payment to providers that agree to manage all care for a patient or for a particular condition

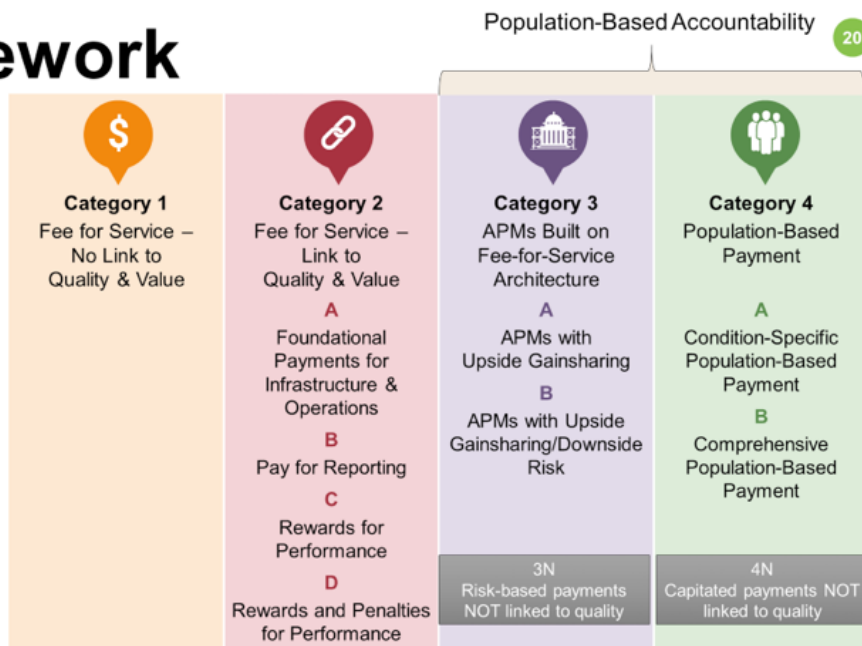
Where possible, this paper references the HCP-LAN categories of alternative payments to ensure consistent nomenclature across the analysis. For the purposes of this paper, “APM” refers to payment arrangements in Category 3 or 4 of the HCP-LAN framework, while VBP or VBR refers to the entire spectrum of payments that fall into Categories 2-4.

APM Framework

At-a-Glance

The *Framework* is a critical first step toward the goal of better care, smarter spending, and healthier people.

- Serves as the foundation for generating evidence about what works and lessons learned
- Provides a road map for payment reform capable of supporting the delivery of person-centered care
- Acts as a “gauge” for measuring progress toward adoption of alternative payment models
- Establishes a common nomenclature and a set of conventions that will facilitate discussions within and across stakeholder communities



The framework situates existing and potential APMs into a series of categories.

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

■ = example payment models will not count toward APM goal.



Credit: Health Care Payment Learning & Action Network. *Alternative Payment Models (APM) Framework*. July 11, 2017. Reprinted with permission from the Mitre Corporation.

How Change Healthcare Can Help

As one of the largest, independent healthcare technology companies in the United States, Change Healthcare’s mission is to inspire a better healthcare system. We are a key catalyst of value-based healthcare, working alongside our customers and partners to help accelerate the journey toward improved lives and healthier communities.

Our solutions are designed to enable improved efficiencies and insights for major stakeholders across healthcare, including commercial and governmental payers, employers, hospitals, physicians, and other providers, laboratories, and consumers.

We champion improvement before, after, and in-between care episodes, striving to provide a visible measure of quality and value. Our solutions add value across three distinct areas—Software and Analytics, Network, and Technology Enabled Services—by helping payers, providers, and consumers improve the full spectrum of healthcare.

Change Healthcare solutions are designed to promote the following:

For Payers	For Providers	For Consumers
Payment accuracy	Revenue and financial risk management	Access to personal health information
Member Engagement, and Provider, Cost, and Quality Transparency	Patient access	Engagement with providers
Network management	Support for clinically appropriate care	Electronic payments
Transition to value-based payment	Claims payment management	Tools to help evaluate healthcare choices based on quality, cost, and convenience
Claims payment management	Optimize diagnostic and clinical data	
Support for clinically appropriate care	Imaging, workflow, and extended care	

Change Healthcare’s Industry Profile At a Glance

5,500
Hospitals

800,000
Physicians

2,100
Payer Connections

\$2.0 Trillion
Healthcare Claims

130,000
Dentists

600
Laboratories

1 in 5
U.S. Patient Records

12 Billion
Healthcare Transactions

Commonly Used Acronyms in this White Paper

ACO: Accountable Care Organization

APM: Alternative Payment Model

CMMI: Centers for Medicare & Medicaid Services Innovation Center

CMS: Centers for Medicare & Medicaid Services

DSRIP: Delivery System Reform Incentive Payments

EOC: Episodes of Care

FFS: Fee-For-Service

FQHC: Federally-Qualified Health Center

HIE: Health Information Exchange

LTSS: Long-Term Services and Supports

MCO: Managed Care Organization

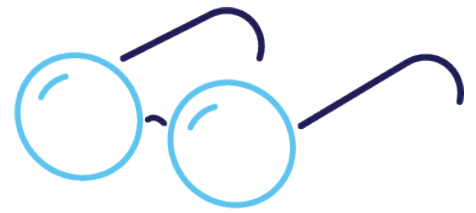
PCMH: Patient-Centered Medical Homes

PMPM: Per Member, Per Month

P4P: Pay-for-Performance

SIM: State Innovation Models

VBR/VBP: Value-Based Reimbursement, Value-Based Payment



State-By-State Summaries

A review of the 50 states' payment reform initiatives (plus Puerto Rico and the District of Columbia) reveals a range of approaches and significant variation in levels of sophistication, leadership commitment, and resources devoted to the transition from fee-for-service to value-based reimbursement. More than ten states, many with federal support, have well-developed, value-based payment strategies that have been in implementation for two years or longer, and 20 more states have initiatives that are in development or in the early stages of implementation. Only a handful (seven) have little to no activity on value-based payment. Below are short summaries of their collective value-based payment reform initiatives.



Alabama

In response to legislation passed in 2013, Alabama adopted a Regional Care Organization (RCO) model for the state Medicaid program through a 1115 Demonstration Waiver with CMS.⁸ The program was slated to begin full implementation on October 1, 2017. However, in summer 2017, the state announced that it would abandon implementation of the RCO model due to “major changes in federal regulations, funding considerations, and the potential for new opportunities for state flexibility regarding Medicaid spending and services under the Trump Administration.”⁹ The state has yet to propose an alternative plan to adopt value-based payment in the state Medicaid program.

⁸ Alabama Medicaid’s Regional Care Organizations Fact Sheet, State of Alabama Medicaid Office, 2016. Available: http://www.medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_RCOs/5.1.1_RCO_Basics/5.1.1_RCO_Fact_Sheet_2-9-16.pdf. Accessed 5/18/2017.

⁹ News: Alabama Medicaid to Pursue an Alternative to Regional Care Organizations. Alabama Medicaid Office News Release, July 27, 2017. Available: https://medicaid.alabama.gov/news_detail.aspx?ID=12363. Accessed 10/23/2017.

Alaska

Alaska passed legislation in 2016 to facilitate comprehensive reform of the state's Medicaid program, Healthy Alaska.¹⁰ There are 16 separate initiatives that make up the reform effort. Of these, three are delivery system reforms: a Health Home Initiative, a Coordinated Care Demonstration Project (ACO model), and Behavioral Health Reform. An RFP for the Coordinated Care Demonstration Project was released in December 2016.¹¹ The RFP solicits proposals from licensed insurers, care management entities, and provider-sponsored organizations to form ACO-like structures and receive a PMPM capitated rate for patient care. The timeline for ACO implementation is calendar year 2017.

¹⁰ State Medicaid Redesign Webpage includes information and updates about the redesign. http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Redesign_news.aspx. Accessed 5/20/2017.

¹¹ Request for Proposals, State of Alaska. Medicaid Coordinated Care Demonstration Project, RFP 170007291, issued December 30, 2016. Available: <http://dhss.alaska.gov/HealthyAlaska/Documents/RFP%20170007291%20Medicaid%20CCDP%20FINAL.pdf>. Accessed 6/3/2017.

Arizona

Arizona's state Medicaid program is operated by the Arizona Health Care Cost Containment System (AHCCCS: pronounced "access") and provides coverage for 25% of the state's population, or approximately 1.6 million people.¹² Arizona Medicaid has a large percentage of patients in managed care, with roughly 85% of the Medicaid population participating in managed care plans.¹³ AHCCCS has had a "Payment Modernization Plan" in place since 2014, which requires the 17 state-contracted MCOs to adopt value-based purchasing strategies.¹⁴ By 2019, MCOs in Arizona will be required to have 50% of all payments to providers subject to VBP.¹⁵ According to the state, MCOs have implemented P4P, PCMH, shared savings, and bundled payment programs as a result of this flexible VBP requirement.

¹² Arizona State Health Care Innovation Plan, Arizona Health Care Cost Containment System, Submitted July 5, 2016. Available: <https://www.azahcccs.gov/AHCCCS/Downloads/StateInnovation/SIMArizonaStateHealthCareInnovationPlan.pdf>. Accessed 8/10/2017.

¹³ State Health Facts, Total Medicaid Managed Care Enrollment, 2014. Kaiser Family Foundation. Available: <https://www.kff.org/medicaid/state-indicator/total-medicare-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed 10/12/2017.

¹⁴ AHCCCS Payment Modernization – Value-Based Purchasing. Arizona state website. Available: <https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/>.

¹⁵ Arizona State Health Care Innovation Plan, Arizona Health Care Cost Containment System, Submitted July 5, 2016. Available: <https://www.azahcccs.gov/AHCCCS/Downloads/StateInnovation/SIMArizonaStateHealthCareInnovationPlan.pdf>.

Arkansas

Arkansas received a \$42 million SIM Model Test grant from the Centers for Medicare and Medicaid Services Innovation Center (CMMI) to engage in Medicaid payment innovation.¹⁶ A State Innovation Plan was submitted to CMS in 2012, which lays out the state's plan to implement delivery system reform.¹⁷ The state's reform initiative is called the Arkansas Health Care Payment Improvement Initiative and is centered on two strategies: (1) Medical/Health Home Implementation and (2) Episode-Based Care Delivery. Both reform strategies are multi-payer in nature, involving Medicaid as well as the largest private health plans—Arkansas Blue Cross Blue Shield and QualChoice of Arkansas—in the design and implementation of the state payment reform initiative.¹⁸ The goal for the Episode-Based Care strategy is to manage several acute and chronic conditions by designating a Principal Accountable Provider for each episode of care. So far, the state has implemented six surgical bundles, four medical bundles and two behavioral health bundles. Four additional bundles are currently proposed for adoption in 2018.¹⁹ Arkansas is now looking at opportunities to improve outcomes and save costs on care provided to the LTSS patient population, possibly through the use of Coordinated Care Organizations.²⁰

¹⁶ State Innovation Models Initiative: Model Test Awards Round One. Centers for Medicare and Medicaid Services. [Innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html](https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html).

¹⁷ Arkansas Health System Transformation, State Innovation Plan, September 21, 2012. Available: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=82>. Accessed 8/1/2017.

¹⁸ Arkansas Health Care Payment Improvement Initiative. Why Payment Improvement? Available: <http://www.paymentinitiative.org/why-payment-improvement2>. Accessed 10/12/2017.

¹⁹ Arkansas Episode of Care website. Available: <http://www.paymentinitiative.org/episodes-of-care>. Accessed 8/1/2017.

²⁰ Arkansas Health Reform Legislative Task Force Final Report to the Arkansas Legislature. December 15, 2016. Available: <http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/836/I14805/Final%20Approved%20Report%20from%20TSG%202012-15-16.pdf>.

California

In partnership with health plans and physician groups, the Integrated Healthcare Association (IHA) launched a P4P program for commercial plans in 2001. In 2017, the program involved 10 health plans, more than 200 provider organizations and nine million patients.²¹ Provider participants in the P4P program must meet cost savings, quality, and HIT thresholds to qualify for participation in the shared savings incentive part of the program. Though widespread, the initiative does not encompass the state's Medicaid program, Medi-Cal, which provides coverage to 13.5 million individuals or about a third of the state's population.²² In 2013, California was the recipient of a SIM Design grant,²³ used to develop a Health Care Innovation Plan, which the state finalized in March 2014.²⁴ The state received a second SIM Design grant from CMMI in 2015.²⁵ At the end of 2015, California received approval from CMS for its 1115 DSRIP waiver, and commenced implementation in 2016.²⁶ The waiver, known as Medi-Cal 2020, is comprised of four initiatives, including the Public Hospital Redesign and Incentives in Medi-Cal (PRIME), which aims to incorporate value-based principles into the hospital payment system. In addition to achieving clinical quality goals, PRIME aims to have 60% of public hospital payments subject to an alternative payment model (APM) by 2020.²⁷ The state is also in the process of conducting an APM pilot program for federally qualified health centers (FQHC) that serve Medicaid patients. Under the terms of the voluntary pilot, which was slated to begin in October 2017, MCOs pay a risk-adjusted PMPM rate to FQHCs for care of the Medicaid population.²⁸

²¹ Value Based Pay for Performance in California, Fact Sheet, Integrated Health Association, 2016. Available: <http://www.ihha.org/sites/default/files/resources/vbp4p-fact-sheet-final-2016.pdf>. Accessed 6/8/2017.

²² Lally, S. Aligning Performance Measures Across Medi-Cal Initiatives. Integrated Healthcare Association Issue Brief No. 23. December 2016. Available: <http://www.ihha.org/sites/default/files/resources/medi-cal-performance-measures-2016.pdf>. Accessed 10/12/2017.

²³ State Innovation Models Initiative: Model Design Awards Round One. Centers for Medicare and Medicaid Services. <https://innovation.cms.gov/initiatives/State-Innovations-Model-Design/index.html>. Accessed 11/1/2017.

²⁴ California State Health Care Innovation Plan, March 31, 2014. California Health and Human Services Agency. Available: http://www.chhs.ca.gov/InnovationPlan/CalSIM%20State%20Health%20Care%20Innovation%20Plan_Final.pdf.

²⁵ State Innovation Models Initiative: Model Design Awards Round Two. Centers for Medicare and Medicaid Services. <https://innovation.cms.gov/initiatives/State-Innovations-Model-Design-Round-Two/index.html>. Accessed 11/1/2017.

²⁶ Department of Health & Human Services, Letter to California Department of Health Care Services, dated 12/30/2015. Available: http://www.dhcs.ca.gov/provgovpart/Documents/Letter_to_State-CA.PDF. Accessed 10/23/2017.

²⁷ Pagel L and Schwartz T. The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program: Continuing California's Delivery System Transformation. Harbage Consulting, January 2017. Available: http://www.dhcs.ca.gov/provgovpart/Documents/PRIME/PRIME_Fact-Sheet_Final_1_18_17.pdf. Accessed 10/24/2017.

²⁸ Howe G, Moses K, and McGinnis, T. Advancing Payment Innovation within Federally Qualified Health Centers: Lessons from California. Center for Health Care Strategies, Inc. May 2017. Available: https://www.chcs.org/media/CHCS-CA-FQHC-APM-Brief_052517.pdf. Accessed 10/24/2017.

Colorado

In 2011, Colorado Medicaid became one of the first states in the nation to utilize ACOs to manage care for Medicaid enrollees. Regional Care Collaborative Organizations (RCCOs) receive a PMPM payment to manage care as well as FFS payments. Incentive payments are paid out annually based on performance. In 2014, Colorado received a \$65 million SIM Test grant from CMMI to implement a multifaceted health reform initiative.²⁹ The payment reform strategy builds on the work of the Multi-Payer Collaborative (MPC), which had existed prior to the grant. Ten public and private Colorado payers have joined the MPC, agreeing to use a common set of measures and to achieve a joint goal of having more than 80% of Colorado residents receive integrated behavioral and physical health care through value-based payment programs by 2019. Under the model, providers would receive a care coordination payment plus a pay-for-performance bonus. In a 2016 report,³⁰ the state indicated its intent to ask Medicare, the Veteran's Administration, and Tricare to join the initiative and to engage with the Colorado Business Group on Health (CBGH), which represents 17 self-funded groups in the state. At the same time, in 2016, CBGH initiated the Healthcare Incentives Payment Pilot (HIPP), which is a three-year episode of care intervention that is to be implemented across a number of self-insured employer plans.³¹

²⁹ State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

³⁰ Colorado SIM Operational Plan, State of Colorado SIM Model, January 6, 2016. Available: <https://drive.google.com/file/d/0BxUiTIOWSbPUY2xvRmNpX1JkMDg/view>.

³¹ Colorado Business Group on Health, Healthcare Incentives Payment Pilot (HIPP) website. Available: <http://www.cbghhealth.org/resources/reducing-costs/healthcare-incentives-payment-pilot-hipp/>.

Connecticut

Connecticut received a four-year, \$45 million SIM Test grant award from CMMI in 2014.³² The Connecticut SIM program chose to implement a value-based payment strategy that sets up a “glide path” for providers to transition from a P4P payment program to a shared savings model.³³ The ultimate goal, according to the state’s innovation plan, is to have 88% of the state’s population being treated by a clinician who is responsible for quality and cost of care.³⁴ As part of this strategy, the state will align all payers in the state to a common set of measures spanning the domains of quality, care experience, health equity, and cost. Payers and providers would be free to negotiate the terms of the performance payments and the degree to which they prefer to share in savings and risk. There is limited information about the progress of this strategy at this time, but so far, the state has established a Value Based Insurance Design Consortium, which has created information on value-based insurance design for self-insured employers.³⁵

³² State Innovation Models Initiative: Model Test Awards Round Two. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

³³ Connecticut Innovation Plan Executive Summary, State of Connecticut, 2013. Available: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/innovation_plan_executive_summary_v82.pdf. Note: State Medicaid providers will only participate in upside risk arrangements rather than shared risk based on concerns about already-low payments and challenges in risk-adjustment for Medicaid patients.

³⁴ Connecticut State Innovation Model, SIM At a Glance. Available: www.healthreform.ct.gov/ohri/lib/ohri/general_documents/sim_ataglance_20161018.pdf. Accessed 11/1/2017.

³⁵ Fendrick M and Chernew M. Freedman Healthcare, LLC. Value Based Insurance Design Employer Manual for Self-Insured Employers, Value Based Insurance Design Consortium, Connecticut SIM Office, September 26, 2016. Available: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/vbid/public_comment/fully_insured/vbid_fully_insured_manual_v2.0-09262016.pdf. Accessed 6/23/2017.

Delaware

Delaware received a \$35 million SIM Test grant in 2014 to implement several health improvement strategies.³⁶ Delaware's value-based payment model is a combined Pay for Value (P4V) and Total Cost of Care approach depending on a given provider's level of sophistication. The state offers two options for providers participating in the state Medicaid program (via MCOs run by Highmark and United): (1) a P4V program in which providers will receive incentive payments for achieving both quality and utilization targets; and (2) a choice of Total Cost of Care Programs—upside only or upside/downside risk-sharing agreements. The goal in 2017 is for all payers, including both private and public, to implement one P4V program and one Total Cost of Care program in the calendar year.³⁷ Ultimately, the state aims to have 40% of providers participate in at least one value-based payment model by the end of CY2017, and 95% of providers in at least one model by the end of 2019. In July 2017, the state Medicaid program announced that it would rebid its Medicaid and Children's Health Insurance Program Contracts to include a requirement that 80% of all payments be made through value-based payment programs within three years.³⁸ The payment reform portion of the SIM project is managed by the Payment Model Monitoring Committee within the Delaware Center for Health Innovation.³⁹

³⁶ State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

³⁷ Delaware SIM Operational Plan 3, 2017. Available: <http://dhss.delaware.gov/dhss/dhcc/files/desimopplan3.pdf>. Accessed 5/21/2017.

³⁸ Delaware Rebidding Diamond State Health Plan Contracts, Planning to Move 80% of Reimbursement to Value-Based Models, Open Minds, July 9, 2017. Available: <https://www.openminds.com/market-intelligence/news/delaware-rebidding-diamond-state-health-plan-contracts-planning-move-80-reimbursement-value-based-models/>. Accessed 7/13/2017.

³⁹ Delaware Center for Health Innovation. Available: <https://www.dehealthinnovation.org/about>. Accessed 6/30/2017.

District of Columbia

Washington, D.C., received a \$1 million SIM Design grant from CMS in 2015 to complete a State Health Innovation Plan, which was submitted to CMS in July 2016.⁴⁰ The Plan establishes five strategic goals for the D.C. health system over five years, aiming to improve quality of care and develop payment systems that tie value to payment. Noting that 40% of the District’s residents are Medicaid recipients, the District chose to focus on transforming payment and care delivery within the Medicaid system. The resulting payment reform goal commits the District to linking 85% of the Medicaid payments to quality and 50% of payments to an alternative payment model by 2021. In the short-term, DC plans to implement a P4P program within Medicaid, across the Health Home program, MCOs, and in contracts with Federally-Qualified Health Centers (FQHCs). P4P will allow providers an opportunity to get comfortable with the concepts of care coordination and population health management prior to engaging in risk-sharing. After two years of P4P implementation, the District will offer providers a “menu” of alternative payment options from which they may choose.⁴¹

⁴⁰ Government of the District of Columbia, State Health Innovation Plan, July 31, 2016. Available: <https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DC%20SHIP%207%2031%20Final%20Web%20Verison%201.pdf>. Accessed 8/14/2017.

⁴¹ Op cit, at page 45.

Florida

While there are several ongoing Medicare and commercial VBP programs in the state, Florida has a limited strategy to embrace value-based payment in the state Medicaid program. As part of the state's plan to increase payments for Medicaid providers and to tie those payments to value, the Florida Agency for Health Care Administration established a physician incentive program (P4P) for Medicaid providers, beginning with pediatricians and OB/GYNs in 2016.⁴² The state plans to include additional physician groups in future years and give the state's 16 contracted MCOs the option to create their own incentive programs that track with the state's goals.

⁴² State of Florida, Agency for Health Care Administration, Comprehensive Quality Strategy, 2017. Available: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf. Accessed 8/10/2017.

Georgia

While there are a number of Medicare and commercial VBP programs in the state, Georgia does not have a coordinated state strategy for achieving increased use of value-based payment in the state.

Hawaii

Hawaii received a SIM Design grant, which was used to complete the Hawaii State Health Innovation Plan in June 2016.⁴³ The main objectives of the Innovation Plan are greater integration of behavioral healthcare and improvement in oral health access. There is less emphasis in the plan on VBP. However, since 2013, Hawaii Med-Quest (Medicaid) has required its five contracted MCOs to incorporate value-based purchasing requirements into their provider contracts. The state MCO contracts ratchet up the percent of providers that must be covered by VBP contracts each year (by 2017, 80% must be subject to VBP). The plans have discretion about how to implement VBP, but they are required to use the same quality measures. As of 2015, provider participation in VBP ranged from 6% in some plans (Ohana) to 100% in others (Kaiser).⁴⁴

⁴³ Hawaii State Health Innovation Plan. June 2016. Available: <https://governor.hawaii.gov/wp-content/uploads/2015/06/FINAL-Hawaii-State-Health-System-Innovation-Plan-Appendices-June-2016.pdf>.

⁴⁴ Op cit at page 48.

Idaho

Idaho received a four-year, \$40 million SIM Test grant in 2014 to implement its state health innovation plan.⁴⁵ In that plan, Idaho focuses on transforming the state's primary care practices to patient-centered medical homes (PCMH). The effort to achieve a shift in payment from FFS to VBP is a goal of the state plan, and the state commits to transitioning 80% of all payments made in the state to VBP. The state is engaging commercial payers in this effort through a Multi-Payer Workgroup, and is collecting data on an annual basis.⁴⁶ To date, Idaho has completed a baseline survey of all payers, which showed that in 2015, 100% of all Medicaid payments and 21% of all commercial payments made in the state were FFS with no link to quality.⁴⁷

⁴⁵ State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

⁴⁶ Idaho Innovation Operational Plan, December 2016. Available: http://ship.idaho.gov/Portals/93/Documents/Grant%20Documents/AY3%20Ops%20Plan%20V1.1F_01032017.pdf?ver=2017-01-06-102357-023.

⁴⁷ SHIP Payer Financial and Enrollment Metrics for Goal 6: Prepared for the Statewide Healthcare Innovation Plan, January 2017. Mercer, Inc. Available: <http://ship.idaho.gov/>.

Illinois

In 2011, the Illinois legislature passed a Medicaid reform law, which requires 50% of the Medicaid population to be enrolled in coordinated, risk-based care by 2015.⁴⁸ As a result of this directive, the Department of Healthcare and Family Services launched a range of care models, including Care Coordination Entities (CCEs) for special populations, MCOs, and Accountable Care Entities (ACEs), all with similar quality metrics and escalating risk arrangements. Illinois received two rounds of SIM Design grants in 2013 and 2015 to plan for delivery system and payment reform.⁴⁹ A new governor was elected in 2015 and launched a Health & Human Services Transformation initiative, which included a focus on promoting value-based payment in the state Medicaid program. The initiative has focused on achieving efficiency through reducing the number of contracted MCOs and providers in the Medicaid system. In its most recent Medicaid RFP, the state requires respondents to describe how they will “design and execute value-based payment (VBP) and payment innovation within [the state’s] managed care program, across its populations and services.”⁵⁰

⁴⁸ Public Act 96-1501, Illinois General Assembly, January 2011. Available: <http://www.ilga.gov/legislation/publicacts/96/096-1501.htm>. Accessed 8/10/2017.

⁴⁹ Illinois Department of Public Health, State Innovation Models webpage. Available: <http://www.idph.state.il.us/ship/icc/SIM.htm>. Accessed 6/28/2017.

⁵⁰ Illinois Medicaid Managed Care Organization Request for Proposals, February 2017. Available: https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Documents/2018-24-001_Illinois_Medicaid_MCO_RFP.pdf.

Indiana

While there is some participation in commercial value-based payment programs as well as those run by CMS, including BPCI and Next Generation ACO Model, Indiana does not have a coordinated statewide strategy to move in the direction of VBP.

Iowa

In 2014, Iowa received approval for its 1115 waiver from CMS to expand Medicaid and develop an ACO-based VBP program called the Iowa Wellness Plan, to manage the expansion population.⁵¹ As part of the waiver, the Iowa Medicaid Office established a set of incentives to help providers achieve the state's goals of increasing healthy behaviors among Medicaid recipients. These incentives are pegged to quality data that is tracked by the state's Value Index Score (VIS) Dashboard (developed by 3M), which is made available to providers and payers.⁵²

Recently, Iowa abandoned the Iowa Wellness Plan in favor of a strategy geared toward full managed care, which took effect January 1, 2016. While still in flux, Iowa's Medicaid program remains committed to VBP and the VIS quality reporting system—MCO contracts require that 40% of the MCO's covered lives be within a VBP model.⁵³ These contracts must be based on both total cost of care and VIS quality measurements.

Also in 2014, Iowa received a \$43 million SIM test grant to implement its State Innovation Plan.⁵⁴ Among the goals in the Iowa SIM is to increase participation in VBP in the state by having 50% of payments made through Medicaid, Wellmark, and Medicare payments linked to VBP contracts by 2018. In addition to setting targets for the percent of payments made via VBP, the state has also set a goal of increasing the percentage of VBP arrangements that involve shared risk.⁵⁵ The state is implementing three strategies to support the transition to VBP: (1) A real-time alert system for ACOs so they know when one of their assigned members has an inpatient admission, discharge, or ER visit; (2) a statewide technical assistance program to help stakeholders transition to VBP; and (3) development of community care teams (CCTs) to identify and coordinate community resources that address the social determinants of health.⁵⁶

⁵¹ Iowa Medicaid ACO Program Outcomes, Iowa Department of Human Services, 2016. Available: https://dhs.iowa.gov/sites/default/files/ACO_Wellness_Program_Outcomes_Paper.pdf.

⁵² 3MTM Value Index Score (VIS) Domains and Measures: Action Plans for Quality Improvement. Iowa Department of Human Services. Available: https://dhs.iowa.gov/sites/default/files/VIS_Strategies.pdf. Accessed 11/1/2017.

⁵³ Value-Based Payment (VBP) Models Definition and Qualifying Criteria for Determining Eligible Models. Iowa Department of Human Services. 2015. Available: https://dhs.iowa.gov/sites/default/files/VBP_Models_Definition_and_Qualifying_Criteria_for_Determining_Eligible_Models.pdf.

⁵⁴ State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

⁵⁵ Iowa Department of Human Services. Primary Driver Diagram: Payment Reform. Align Payers in VBP. Available: <https://dhs.iowa.gov/sites/default/files/SIMPaymentReformDiagram.pdf>. Accessed 8/11/2017.

⁵⁶ Medicaid Modernization Transition Fact Sheet: Iowa's Medicaid Managed Care Transition for ACOs. Iowa Department of Human Services. Available: https://dhs.iowa.gov/sites/default/files/IowaMedicaidTransition_for_ACOs.pdf.

Kansas

While there are a number of commercial and Medicare VBP initiatives underway in Kansas, the state does not have a coordinated, statewide strategy to implement VBP reform. The state has done some limited work to implement patient-centered medical homes (PCMH) in primary care practices and has also implemented a voluntary P4P strategy for nursing homes in the Medicaid program.⁵⁷

⁵⁷ Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK). Kansas Department for Aging and Disability Services. Available: <http://www.kdads.ks.gov/commissions/scc/peak>.

Kentucky

While there are several private and federal initiatives occurring in Kentucky, the state does not have a coordinated, statewide strategy to implement payment reform. Kentucky received a SIM Model Design grant from CMMI, which the state used to complete a State Health System Innovation Plan (SHSIP), submitted to CMS in December 2015.⁵⁸ The SHSIP lays out a four-pronged strategy: (1) expanding the state's patient-centered medical home (PCMH) initiative to improve primary care; (2) implementing a multi-payer ACO strategy; (3) Launching Episodes of Care (EOC); and (4) developing a Community Innovation Consortium to share best practices. The plan has not been implemented, possibly because a new governor took office shortly after the SIM plan was submitted to CMS.

⁵⁸ State Health System Innovation Plan (SHSIP), State Innovation Model (SIM) Model Design Grant, Commonwealth of Kentucky, December 2015. Available: http://chfs.ky.gov/NR/rdonlyres/B1913E4E-1793-4B27-9789-F56A57262EBC/0/KYSIMSHSIP_12042015_Website.pdf.

Louisiana

Louisiana has no statewide coordinated strategy to transition to a value-based reimbursement model. However, in March 2016, the legislature passed a law (HCR 77) asking the LA Department of Health to report on the feasibility of using ACOs in the Healthy Louisiana (Medicaid) program. In response to this request, the state issued an RFI to solicit feedback regarding the possibility of moving toward a system whereby the state would contract directly with ACOs at a per-member, per-month rate to provide care to Medicaid patients. Per the RFI, this would be done as part of a planned re-procurement of Medicaid in 2019, and ACOs would supplement rather than replace MCOs.⁵⁹

⁵⁹ Louisiana Department of Health, Request for Information, Provider-Led Accountable Care Organizations, 11/4/2016. Available: <http://dhh.louisiana.gov/assets/medicaid/RFIDocs/HCR77ACOREportRS2016.pdf>.

Maine

Maine launched a statewide value-based purchasing strategy in 2011 within the state Medicaid program, known as MaineCare.⁶⁰ As part of this strategy, Maine has invested in three VBP models: (1) Health Homes; (2) Behavioral Health Homes; and (3) Accountable Communities, a form of ACO. The Accountable Communities Initiative offers shared savings for MaineCare provider organizations. In the third year of the program, which concluded in July 2017, four regional ACOs participated, serving 55,000 MaineCare beneficiaries.⁶¹ In 2013, Maine was awarded a \$33 million SIM Model Test grant from CMMI to implement its State Innovation Plan.⁶² The payment reform goals in the SIM include support for quality improvement in behavioral health, a statewide quality dashboard, and a multi-stakeholder payment reform workgroup to help transition the state to VBP. Maine's payment reform work is managed by the Maine Health Management Coalition, which is working to engage stakeholders in the process to move the Maine healthcare system to one that is value-based.

⁶⁰ Office of MaineCare Services, Maine Department of Health and Human Services, Value Based Purchasing Strategy, Available: <http://www.maine.gov/dhhs/oms/vbp/VBP%20Intro.html>.

⁶¹ Maine Department of Health and Human Services, Accountable Communities Providers and Number of Members, 2017. Available: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Accountable-Communities-Providers-and-Number-of-Members.pdf. Accessed 10/12/2017.

⁶² State Innovation Models Initiative: Test Awards Round One. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html>. Accessed 11/1/2017.

Maryland

For decades, Maryland has had a unique all-payer model for hospital payments, made possible through a waiver with CMS, which allows the state to set all-payer rates for hospital payments. Under this agreement, Medicare, Medicaid, and all third-party payers agree to pay the same rates as established by the Maryland Health Services Cost Review Commission.⁶³ In 2009, Maryland agreed to incorporate quality measures into the payment system and to make other adjustments to the payment system. Currently, all hospitals in the state are on global budgets, but by 2018 they will also be moving to a scaled adjustment based on total cost of care. In 2016, the state began working with hospitals to improve care coordination for “high utilizers”—those patients with complex, chronic conditions. In 2018-2019, the state plans to focus on dual eligible patients, medical home expansion and post-acute care models.⁶⁴ In addition to the all-payer model, Maryland has a Value-Based Purchasing strategy within its Medicaid program that sets performance targets (based on encounter-based and HEDIS measures) for contracted MCOs. At the end of a program year, each MCO either receives an incentive payment, a disincentive assessment, or no change in payment depending on performance.⁶⁵

⁶³ Maryland All-Payer Model, Centers for Medicare and Medicaid Services Innovation Center. Available: <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>.

⁶⁴ Maryland All-Payer Model Background, Progression and Vision Elements. February 2016 Advisory Council Meeting. Health Services Cost Review Commission. Available: <http://www.hsrcr.state.md.us/documents/md-maphs/ac/2016-02-03/2-3-16-Evolving-Vision-and-Strategy-in-Maryland-Deck-Web.pdf>.

⁶⁵ Medicaid and You: Measuring Medicaid Impact. Maryland Department of Health and Mental Hygiene, 2016. Available: https://mmcp.dhmh.maryland.gov/docs/Medicaid_and_You_2016_e.pdf.

Massachusetts

In 2014, the Massachusetts legislature passed a massive health system overhaul, known as Chapter 224, to contain health care costs in the state. The law requires the state to adopt alternative payment models across state programs, establishes an all-payer claims database, and empowers the state's Health Policy Commission to set a global cap on the state's health costs. As part of this reform effort (and with support from a \$44 million federal SIM Test grant), Massachusetts expanded its use of Patient Centered Medical Homes (PCMH) with shared savings across multiple payers; and Primary Care Payment Reform (PCPR) in Medicaid with three payment methodologies: a risk-adjusted PMPM payment, a quality-incentive payment, and a shared savings/risk payment.⁶⁶ Massachusetts applied for a 1115 Demonstration waiver from CMS and received approval in November 2016 to implement an ACO-based reform initiative.⁶⁷ In December 2016, Massachusetts launched its Medicaid ACO initiative, with a one-year pilot program.⁶⁸ After the year-long pilot, the state will contract with 18 ACOs across the state to provide care for 900,000 Medicaid beneficiaries.⁶⁹ According to the state waiver, ACOs will be expected to provide integrated behavioral health, LTSS and social supports, as well as traditional medical care for a capitated, PMPM payment. Some ACOs will partner with MCOs (e.g., Tufts Health Plan, Fallon Health), while others will contract directly with the State Office of Medicaid.

⁶⁶ Commonwealth of Massachusetts, Executive Office of Health & Human Services, State Innovation Model Operational Plan, August 1, 2013. Available: <http://www.mass.gov/eohhs/docs/eohhs/state-innovation/ma-sim-operational-plan.pdf>. Accessed 8/14/2017.

⁶⁷ Press Release, Office of Governor Charlie Baker, Baker-Polito Administration, Centers for Medicare and Medicaid Services Announce Five Year, \$54 billion Deal for MassHealth Restructuring. November 4, 2016. Available: <http://www.mass.gov/governor/press-office/press-releases/fy2017/five-year-deal-for-mashealth-restructuring-announced.html>. Accessed 8/14/2017.

⁶⁸ Massachusetts Office of Medicaid, MassHealth Partners with Six Health Care Organizations to Improve Member Care. 11/29/2017. Available: <http://www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/mashealth-partners-with-six-health-care-organizations.html>.

⁶⁹ Massachusetts Insurance Market Reform, Affordability and MassHealth Sustainability. Executive Office of Health and Human Services, January 26, 2017. Available: <http://www.mass.gov/eohhs/docs/eohhs/insurance-market-reform-proposals.pdf>.

Michigan

Michigan received a SIM Model Test grant from CMMI in February 2015 totaling \$70 million to implement the state's innovation plan. In that plan, Michigan proposes to roll out state-led multi-payer delivery and payment reforms that support patient-centered care. The components of the SIM program include: (1) PCMH, launched January 2017 and covering 350,000 beneficiaries; (2) build-out of the state's HIE; and (3) Community Health Innovation Regions, an effort to create links between clinical and community resources, and working more collaboratively on regional population health.⁷⁰ In the coming years, the state will be setting measurable VBP goals for MCOs to achieve as part of the state's new managed care contracts beginning in October 2017.⁷¹ The state is also working on a "multi-payer payment and service delivery model, including a formal partnership with CMS for Medicare alignment."⁷²

⁷⁰ Michigan Department of Health and Human Services, Policy Planning and Legislative Affairs Administration Report, FY2018. Available: http://www.michigan.gov/documents/mdhhs/Policy_Budget_Presentation_FY18_FINAL_553728_7.PDF.

⁷¹ State Innovation Model Newsletter, Michigan Department of Health and Human Services, June 2017. Available: http://www.michigan.gov/documents/mdhhs/SIM_Newsletter_June_2017_577279_7.pdf. Accessed 6/30/2017.

⁷² State Innovation Model Initiative Summary, Michigan Department of Health and Human Services, April 2017. Available: http://www.michigan.gov/documents/mdhhs/SIM_Summary_April_2017_577278_7.pdf. Accessed 6/30/2017.

Minnesota

Minnesota was among the first states in the country to consider payment reform as part of an overall approach to reforming the state health system. As part of a 2008 Health Reform Law, the legislature directed the Minnesota Health Department to develop a “basket of care” initiative, which, similar to episode of care payments, would define a “basket” of services related to a particular disease state.⁷³ In response, the state developed seven baskets of care, including those for both chronic conditions as well as surgical procedures. Another law, in 2010, directed the state to implement delivery system reform and led to the creation of the Integrated Health Partnership (IHP) demonstration, a shared-risk ACO program for the Medicaid population.⁷⁴ Minnesota received a SIM Model Test Grant of \$45 million in February 2013 to implement its State Innovation Plan. The grant period is expected to end in December 2017. Minnesota’s innovation model builds on the state’s IHP demonstration, which currently includes 21 providers and serves 465,000 Medicaid recipients.⁷⁵ The SIM plan will expand this model to include other payers in the state. Using SIM resources, the state will invest in its information-sharing platform (HIE), data analytics tools for providers, and technical assistance in value-based payment arrangements.⁷⁶ In addition, Minnesota aims to use about 15% of its funds to establish up to 15 Accountable Communities for Health (ACH) across the state that will work collaboratively to improve outcomes by increasing coordination, connecting community/clinical organizations, and focusing on the social determinants of health.

⁷³ Health Reform Minnesota website, Minnesota Department of Health. Available: <http://www.health.state.mn.us/healthreform/baskets/index.html>. Accessed 10/12/17.

⁷⁴ Integrated Health Partnerships (IHP) Overview. Minnesota Department of Health. Available: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441#. Accessed 10/12/17.

⁷⁵ Op Cit.

⁷⁶ SIM Project Details in MN. Department of Health, State of Minnesota. Available: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_198762.

Mississippi

While there are various VBP programs occurring in Mississippi through Medicare or commercial payers, Mississippi does not have a coordinated statewide strategy to implement value-based payment programs in its healthcare system.

Missouri

Missouri has a limited strategy to better manage its state Medicaid program through VBP strategies. Prior to 2017, about half of the state's Medicaid population was covered through at-risk contracts with MCOs, while the remaining members were covered through a state-run FFS program.⁷⁷ Effective May 1, 2017, the state completed a significant expansion of the MCO program, which now includes coverage of the entire state and excludes only the elderly and disabled population. The new MCO program will provide coverage for more than 700,000 individuals.

⁷⁷ Missouri Medicaid Basics. Missouri Foundation For Health, Spring 2017. Available: <https://mffh.org/wordpress/wp-content/uploads/2017/03/MedicaidBasics2017.pdf>.

Montana

Montana has implemented a Patient-Centered Medical Home (PCMH) program across multiple payers in the state. The program pays a PMPM participation fee as well as a PMPM fee to support disease management. Some payers also offer a shared savings bonus to providers.⁷⁸ In 2015, Montana won a SIM planning grant from CMMI to complete a State Health Care Innovation Plan. The resulting plan, completed and submitted to CMS in 2016, includes value-based payment reform as a key strategy in the effort to transform Montana's healthcare system.⁷⁹ The plan refers to a strategy wherein the state will gradually move along the continuum to value-based payment, but does not necessarily recommend a starting point or concrete next steps. At the same time as the state was working on its State Innovation Plan, it was selected by CMS to participate as one of 14 states in the Comprehensive Primary Care Plus (CPC+) model, a five-year multi-payer strategy to reduce costs by enhancing primary care. CPC+ will provide PMPM care management payments, incentive payments for meeting quality/utilization goals, and the opportunity for shared savings.

⁷⁸ Montana State Innovation Model Design, Presentation to the Governor's Council, March 8, 2016. Available: <http://dphhs.mt.gov/Portals/85/Documents/SIM/160308GovernorsCouncilSlides.pdf>.

⁷⁹ Montana Healthcare Innovation Plan, Governor Steve Bullock's Council on Health Care Innovation and Reform, June 2016. Available: <http://dphhs.mt.gov/Portals/85/Documents/SIM/GovernorsCouncilonHealthcareInnovationPlan160630.pdf>.

Nebraska

In 2014, the Nebraska Legislature initiated a voluntary, multi-payer PCMH program that required participating health plans to contract with PCMH clinics and agree to use the same quality measures.⁸⁰ Payment details were left to the individual payers to determine. In 2017, Nebraska expanded Managed Medicaid to cover all Nebraska Medicaid enrollees (about 230,000 residents). Newly contracted MCOs will be required to enter into value-based contracts with providers and to continue to support the state's PCMH initiative.⁸¹

⁸⁰ Nebraska Medicaid Multi-Payer Medical Home Pilot Program, Patient-Centered Primary Care Collaborative, March 2015. Available: <https://www.pcpcc.org/initiative/nebraska-medicaid-multi-payer-medical-home-pilot-program>.

⁸¹ Nebraska Medicaid's New Integrated Managed Care Program: Heritage Health. Nebraska Department of Health and Human Services. Presentation before the Health and Human Services Committee, October 19, 2016. Available: <http://dhhs.ne.gov/Legislative%20Documents/MLTC%2010-19%20HH%20Briefing.pdf>.

Nevada

Nevada received a SIM Model Design grant in 2015 to create its State Innovation Plan, which was submitted to CMS in 2016.⁸² According to the plan, the state will base its payment and delivery system reforms on three elements: Patient-Centered Medical Homes (PCMH), Medicaid Health Homes, and a program that focuses on high utilizers. The PCMH initiative will proceed in four phases of implementation that range from incentivizing participation, to paying for reporting and outcomes, and finally to a shared-savings model. The Health Home participants will be paid a risk-adjusted PMPM payment as well as an outcomes-based incentive payment. After this initial VBR implementation phase, “consideration of bundled or episode-based payments will follow” as the state moves to more complex models with upside and then downside risk.⁸³

⁸² Nevada State Innovation Model, Nevada Department of Health and Human Services, January 29, 2016. Available: [http://dhcfnv.gov/uploadedFiles/dhcfpnv.gov/content/Resources/Rates/Nevada%20State%20Health%20System%20Innovation%20Plan\(1\).pdf](http://dhcfnv.gov/uploadedFiles/dhcfpnv.gov/content/Resources/Rates/Nevada%20State%20Health%20System%20Innovation%20Plan(1).pdf).

⁸³ Op cit.

New Hampshire

In 2013 and 2015, New Hampshire received two rounds of SIM Design grants from CMMI to create a State Innovation Plan.⁸⁴ The resulting plan laid out two tracks for reform in the state: reform of services for the Long Term Supports and Services population, and improvements in population health. The plan's focus is on adopting the Medicaid Health Home model for complex patients and a move toward a global budget for LTSS patients. As part of the LTSS reform, the state will also create a "Triple Aim Incentive Pool", which will be paid out to providers that achieve certain cost savings and quality targets. In 2015, after the state received a second SIM design grant, the New Hampshire Insurance Department contracted with a University of Massachusetts consulting firm to evaluate opportunities for the state to utilize value-based reimbursement strategies to lower health care spending in the state.⁸⁵ The UMass report echoed much of what was already in the state plan, but added the suggestion that the state provide technical assistance to private parties—i.e., a model contract and public reporting of quality data—to help ease the transition to VBP. In 2015, New Hampshire submitted a DSRIP waiver to CMS that creates a system of seven regional Integrated Delivery Networks (IDNs) and commits to move at least 50% of payments to Medicaid providers to APMs by 2020. The seven IDNs, like ACOs, will coordinate behavioral and social support services as well as provide physical health services to Medicaid beneficiaries in their regions, which account for about 13% of New Hampshire's total population. The state's APM Roadmap calls for the creation of an APM Workgroup comprised of IDN and MCO stakeholders so that all parties have clear guidance as to what constitutes an APM and how the program will intersect with other existing value-based payment initiatives.⁸⁶ The APM Workgroup members were to be named by the end of September 2017 and the Workgroup will begin its process in November 2017. As part of the initial steps, IDNs have reported to the state on their participation in existing state, federal, and commercial APM programs and MCOs were due to submit information on their APM activity by the end of September 2017.⁸⁷

⁸⁴ State Health Care Innovation Plan, New Hampshire Department of Health and Human Services, December 2013. Available: <https://www.dhhs.nh.gov/ocom/documents/nh-sim-plan.pdf>.

⁸⁵ Highland JP, et al. Health Care Payment Reform: Options and Recommendations. UMass Medical School Commonwealth Medicine. April 20, 2015. Available: https://www.nh.gov/insurance/reports/documents/compass_umass_pmt_rfm_rpt.pdf. Accessed 6/23/2017.

⁸⁶ New Hampshire's Building Capacity for Transformation Section 1115(a) Medicaid Research and Demonstration Waiver, DSRIP Alternative Payment Models Roadmap, Year 2 (CY2017) and Year 3 (CY2018). Available: <https://www.dhhs.nh.gov/section-1115-waiver/documents/dsrip-apm-roadmap.pdf>. Accessed 10/12/2017.

⁸⁷ Op cit.

New Jersey

New Jersey has implemented a PCMH pilot project to manage frail elders and an ACO demonstration project (2015 legislation) within its Medicaid program. It was also one of the first states to incorporate LTSS supports into the Medicaid managed care program. In 2015, the Rutgers Center for State Health Policy was awarded a \$3 million SIM Design grant for the state of New Jersey. The SIM project produced several reports, including an in-depth analysis of the outcomes of the state's ACO demonstration.⁸⁸ In March 2017, the New Jersey Health Quality Institute released a report titled "Medicaid 2.0: A Blueprint for the Future," which makes several recommendations to the state regarding improvements that should be made to ensure Medicaid's long-term solvency.⁸⁹ On alternative payment models, the report recommends that the state require Medicaid MCOs to test three to five episode of care models, beginning with bundles for maternity care, cardiac care, and total joint replacement. The report also recommends implementation of a statewide PCMH program.

⁸⁸ Thompson FJ and Cantor JC. The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process. Rutgers Center for State Health Policy, May 2016. Available: <http://www.cshp.rutgers.edu/Downloads/10950.pdf>. Accessed 6/30/2017.

⁸⁹ Medicaid 2.0: Blueprint for the Future. New Jersey Healthcare Quality Institute and the Nicholson Foundation. March 2017. Available: http://www.njhcai.org/wp-content/uploads/2017/03/Medicaid-2.0-Blueprint-for-the-Future_3-3-17-1.pdf.

New Mexico

In 2013, New Mexico received final approval for its 1115 waiver for Centennial Care, the state Medicaid program. In the waiver, the state promised to require MCOs by contract to implement value-based payment pilot programs. These MCO contracts require plans to (1) subject a certain percentage (16% by 2017) of provider payments to VBP arrangements and (2) “step up” the intensity of the VBP agreements from level one (withhold/incentive for quality) to level two (shared savings and bundled payments) to level three (some or full-risk capitation). In 2015, state-contracted MCOs launched 10 value-based payment pilot programs, representing a range of models, including PCMH, shared savings and episodes of care.⁹⁰ MCOs are required to have 16% of provider payments subject to VBP arrangements by 2017. The state is currently in the process of revising the original plan and proposes to increase percentage of payments that are tied to value in MCO contracts.⁹¹ The state’s goal is to submit a revised plan to CMS by November 2017, with an eventual implementation date of January 2019.

⁹⁰ Centennial Care Value-Based Purchasing Brief. NM Human Services Department, January 2017. Available: <http://www.hsd.state.nm.us/uploads/files/Value-Based%20Purchasing%20Issue%20Brief%20-%20Jan%2013%202017.pdf>.

⁹¹ Centennial Care 2.0: Section 1115 Demonstration Waiver Renewal Concept Paper, New Mexico Human Services Department, May 2017. Available: http://www.hsd.state.nm.us/uploads/files/CC%202%200%20Concept%20Paper_FINAL.pdf.

New York

New York received a \$100 million Round 2 SIM Test grant in 2015⁹² and in the same year received approval for its 1115 DSRIP waiver to CMS. The goals in both plans are similar: in the SIM application, the state committed to 80% of all payments in VBP by 2021, and in the waiver, the state committed to achieving 90% VBP in Medicaid by 2021. The state's DSRIP waiver creates 25 Performing Provider Systems (PPS) which will be responsible for providing care for five million Medicaid beneficiaries in the state. The plan is to move the PPS providers from a P4P payment model in 2017. The state's waiver update from 2016 notes that the state has "extensive experience with what [is] described as Level 0 Value Based Payments, FFS with quality bonus payments" used in the PCMH and medical home demonstrations that have taken place across the state.⁹³ In 2016, less than 25% of the state's Medicaid spending was in a Level 1 or higher VBP program.⁹⁴ For this reason, the state seeks to push MCOs and providers along the continuum to Level 1, 2, and 3 risk-sharing arrangements, or the MCOs will face penalties. While the state is prepared to provide technical assistance, a standardized quality measure set, and other guidance, it leaves the MCOs and providers to determine the details of their individual VBP contracts.⁹⁵ As of 2016, the state hoped to launch approximately 15 VBP pilots with a focus on (1) total care for the general population; (2) integrated primary care; (3) maternity care; (4) HIV/AIDS; and (5) health and recovery plans. The state does note that Prometheus is the bundling methodology of choice for the maternity and (eventually) chronic care bundles.⁹⁶ Experience with these pilots through 2019 will be used to inform the future direction of Medicaid payment reform. Implementation of the SIM plan, which is expected to extend into 2019, is following a parallel path, with a focus on moving to VBP in the commercial market in addition to Medicaid. The centerpiece of the SIM plan is the development of Advanced Primary Care (similar to PCMH) in the state with a common set of measures and payments tied to aiding this transition. The PPSs (ACOs) created by DSRIP are expected to conform with the APC program so that all payers can align payment around a common set of measures.⁹⁷ New York has contracted with the Northeast Business Group on Health to provide outreach to employers and self-insured stakeholders and engage them in the state's overall strategy to transition to VBP.⁹⁸

⁹² State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

⁹³ A Path Toward Value Based Payment: Annual Update. New York State Roadmap for Medicaid Payment Reform. NY State Department of Health Medicaid Redesign Team, June 2016. Available: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/1st_annual_update_nystate_roadmap.pdf. (p. 9).

⁹⁴ Jason Helgerson, New York State Medical Director, Presentation to the New York State Innovation Council, November 29, 2016. Available: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/2016-11-29_innov_council.pdf.

⁹⁵ A Path toward Value Based Payment: Annual Update. New York State Roadmap for Medicaid Payment Reform. New York State Department of Health Medicaid Redesign Team, June 2016. Available: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/1st_annual_update_nystate_roadmap.htm#update.

⁹⁶ List of Prioritized VBP Arrangements. NY State Department of Health. 2016. Available: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/1st_annual_update_nystate_roadmap.htm#two2b.

⁹⁷ SIM Year 2 Operational Plan, 2015. Available: https://www.healthresearch.org/wp-content/uploads/2016/06/Year_2_Operational_Plan_12-24-15_Public.pdf. Accessed 6/30/2017.

⁹⁸ Op Cit.

North Carolina

Two separate pieces of legislation (in 2015 and 2016) authorized the state Department of Health and Human Services to undertake Medicaid transformation, including payment reform. The state began a process and submitted a waiver application to CMS in June 2016.⁹⁹ The waiver, which is still under consideration at CMS, proposes to use Prepaid Health Plans, available through commercial insurers and provider-led entities, which would receive a capitated, risk-adjusted per-member payment. It also proposes to establish a North Carolina Health Transformation Center, which will facilitate stakeholder engagement in systems changes and technical assistance as payers and providers move to VBP.¹⁰⁰ In August 2017, the state's new administration released an updated vision for Medicaid Managed Care, posted for public comment, which provides more detail regarding the plan for implementation of Medicaid reform.¹⁰¹ In the area of VBP, the state notes that it will include VBP language in the RFP for Medicaid PHPs and will reward those that help to advance the state's value-based payment goals.

⁹⁹ North Carolina Medicaid and NC Health Choice Section 1115 Demonstration Waiver Application. North Carolina Department of Health and Human Services. June 1, 2016. Available: <https://ncdhhs.s3.amazonaws.com/s3fs-public/NC-Section-1115-Demonstration-App2016.pdf>. Accessed 6/10/2017.

¹⁰⁰ Id.

¹⁰¹ North Carolina's Proposed Program Design for Medicaid Managed Care, August 2017. Available: https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf. Accessed 8/10/2017.

North Dakota

While there are VBP initiatives operated by CMS and commercial payers in the state, North Dakota does not have a coordinated statewide strategy to achieve payment reform.

Ohio

In 2013, Ohio received a SIM Design grant to develop its State Innovation Plan¹⁰² and a follow-up \$75 million Test grant in 2015 to implement its plan,¹⁰³ which promises to tie 80-90% of payments in the state to VBP by 2019. To achieve this, Ohio will implement two strategies: (1) expand the PCMH model with the goal of statewide coverage by 2018; and (2) implement a multi-payer episode model.¹⁰⁴ Ohio has secured participation from its largest commercial payers as well as its Medicaid health plans, which collectively account for 90% of the state population.¹⁰⁵ Under the episode-based strategy, patients are assigned to a Principal Accountable Provider (PAP) for each episode, who is responsible for coordinating care. PAPs are assessed against the cost of an average episode and either receive shared savings or a negative incentive based on their performance. The episode-based strategy began rolling out in 2015 with six episodes. Seven more were developed in 2016 and an additional 20+ will launch in 2017.¹⁰⁶ Behavioral health bundles are contemplated for the fourth wave, slated to begin in 2018. By the end of 2018, the state hopes to have 50+ episodes defined and launched across payers.¹⁰⁷

¹⁰² State Innovation Models Initiative: Model Design Awards Round One. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Design/index.html>. Accessed 11/1/2017.

¹⁰³ State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

¹⁰⁴ Introduction to the Ohio Episode-Based Payment Model, Governor's Office of Health Transformation, December 2015. Available: <http://healthtransformation.ohio.gov/Portals/0/Episode%20Overview%2012-11-2015.pdf?ver=2015-12-16-083244-683>. Accessed 11/1/2017. .

¹⁰⁵ Ohio Governor's Office of Health Transformation. State Innovation Models Round 2 Model Test: Ohio Operational Plan, Updated December 16, 2015. Available: http://healthtransformation.ohio.gov/Portals/0/SIM%20Op%20plan_website%20FINAL.pdf?ver=2016-01-14-121412-923.

¹⁰⁶ Ohio Governor's Office of Health Transformation. Introduction to the Ohio Episode-Based Payment Model. December 2015. Available: <http://healthtransformation.ohio.gov/Portals/0/Episode%20Overview%2012-11-2015.pdf?ver=2015-12-16-083244-683>.

¹⁰⁷ Op Cit at page 6.

Oklahoma

Oklahoma's governor has a stated goal of achieving 80% of provider payments being in a VBP arrangement by 2020. In 2015, Oklahoma received a SIM model design grant to complete a State Innovation Plan. The State Health System Innovation Plan was submitted to CMS in March 2016.¹⁰⁸ The plan proposes to shift to a Regional Care Organization (RCO) model for all state-purchased care, including Medicaid and state employees. RCOs will receive a risk-adjusted capitated PMPM payment for each attributed member and will also be eligible for incentive payments based on quality measures. To participate, RCOs must agree to: (1) have 80% of their payments to providers be value-based by 2020; (2) participate in the multi-payer episodes of care program; and (3) use one additional alternative payment model.¹⁰⁹ In addition to RCOs, Oklahoma proposes to implement an episodes of care program that will focus on Medicaid and eventually be expanded to all payers. The state is proposing an initial group of episodes, but plans to expand the list once the program is up and running.

¹⁰⁸ Oklahoma State Health System Innovation Plan, State Innovation Model Design Grant. Oklahoma State Department of Health. March 31, 2016. Available: [https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20\(SHSIP\)%20Final%20Draft.pdf](https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20(SHSIP)%20Final%20Draft.pdf). Accessed 6/12/2017.

¹⁰⁹ Id.

Oregon

Oregon's health reform initiative began with the launch of Patient Centered Primary Care Homes in 2010 and Coordinated Care Organizations (CCOs) in 2012. In 2013, Oregon received a SIM Model Test grant in the amount of \$45 million to implement the state innovation plan. The grant, which concluded in September 2016, provided funding for the state's transition to global payments for CCOs and development of a "starter set" of alternative payment models.¹¹⁰ CCOs are networks of all types of health care providers that agree to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs receive a risk-adjusted PMPM payment for each attributed member and accept financial risk for providing mental, physical, and dental care to their member population. In 2016, nearly one million Oregon residents were enrolled in Medicaid and 90% of these enrollees received care through a CCO.¹¹¹

¹¹⁰ State Innovation Model Grant (SIM) website, Oregon Health Authority Transformation Center, Available: <http://www.oregon.gov/oha/HPA/CSI-TC/Pages/SIM.aspx>. Accessed 8/1/2017.

¹¹¹ Oregon's Health System Transformation: Annual Update. Oregon Health Authority, January 2016. Available: <http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/HST%20Annual%20Report%20-%202016.pdf>. Accessed 8/1/2017.

Pennsylvania

Pennsylvania received a total of about \$4.5 million in two SIM Design grants in 2013 and 2015 to develop the Health Innovation in Pennsylvania Plan, which was submitted to CMS in June 2016.¹¹² In the plan, Pennsylvania outlines three complementary strategies for achieving value-based payment reform in the state: multi-payer episode of care (EOC) payments for acute care; global payments for enhanced primary care through Patient-Centered Medical Homes; and a global budget for rural hospitals. In addition, in the most recent Medicaid MCO contracts, the state requires MCOs to shift 30% of their payments into alternative payment models by 2019, with a ramp-up beginning in 2017.¹¹³ The state intends to begin a planning process in 2017 to develop the approach to EOC payments. According to the plan, the goal of these stakeholder meetings will be to (1) adopt a common approach for performance measures; (2) identify regions and/or episodes where payers will shift payment to EOC; and (3) develop a roadmap for EOC implementation. The EOC Work Group process is expected to last from February 2017–January 2019.¹¹⁴

¹¹² Health Innovation in Pennsylvania Plan, Pennsylvania State Health Department. June 20, 2016. Available: <http://www.health.pa.gov/Your-Department-of-Health/innovation/Documents/Health%20Innovation%20in%20PA%20Plan%2020160630%20for%20CMMI.pdf>.

¹¹³ Op Cit at page 37.

¹¹⁴ Transitioning to Value-Based Payment in Pennsylvania. Implementation Plan. Available: http://www.health.pa.gov/Your-Department-of-Health/innovation/Documents/External%20Plan_VBP.pdf.

Puerto Rico

In 2015, Puerto Rico received a nearly \$2 million SIM Design grant to create a State Health Innovation Plan. The plan, which was filed with CMS in 2016, lays out a three-year roadmap for Medicaid transformation on the island.¹¹⁵ Puerto Rico's VBP plan breaks down into two phases; first, the government will establish five disease-specific bundles (prenatal care; pediatric asthma; diabetes management; chronic kidney disease; and super-utilizers), followed by implementation of at least three provider-led ACOs that would contract directly with the state to provide care for Medicaid patients. As for timeline, Puerto Rico began implementation of the plan in 2017 and will incorporate the proposed value-based payment reforms into the Medicaid program via the 2018 MCO RFP.¹¹⁶

¹¹⁵ Nichols D, Farrell K, Morrison M, Berkman N, and Gavin N. State Innovation Models (SIM) Round 2: Model Design Final Report. RTI International, August 2017. Available: <https://innovation.cms.gov/Files/reports/sim-designrd2-final.pdf>. Accessed 11/2/2017.

¹¹⁶ Op cit at page 27.

Rhode Island

Rhode Island received a \$20 million SIM Model Test grant from CMMI in 2015 to implement payment and delivery system reform in the state.¹¹⁷ In the state innovation plan, the state committed to achieving 50% of commercial and Medicaid payments subject to APM in 2018 and 80% of payments linked to value.¹¹⁸ To achieve this, the state is pursuing parallel strategies in the Medicaid and commercial markets. The Medicaid strategy focuses on PCMH and Behavioral Health initiatives. It also includes the creation of Medicaid Accountable Entities (“AEs”) that will be certified by the state to provide comprehensive care to Medicaid patients via contracts with MCOs.¹¹⁹ By 2022, the state aims to have a third of eligible Medicaid patients attributed to an AE that is receiving a total cost of care payment or other approved APM through participating MCOs.¹²⁰ On the commercial side, the state promulgated regulations in February 2015 that require commercial payers with 10,000 or more covered lives in the state to “significantly reduce the use of fee-for-service payment as a payment methodology, to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies.”¹²¹ For Calendar Year 2017, plans must demonstrate that 40% of medical payments are made through an alternative payment method and this ratchets up to 50% in CY2018. Approved APMs to meet this requirement include (1) total cost of care budget models; (2) limited scope of service budget models; (3) episode-based payments; and (4) infrastructure payments and P4P (2016-2017 only).¹²²

¹¹⁷ Rhode Island Health Department. Rhode Island State Innovation Model (SIM) Test Grant Fact Sheet. Available: <http://www.health.ri.gov/publications/summaries/StateInnovationModel.pdf>.

¹¹⁸ Rhode Island Health Department. Rhode Island State Innovation Model (SIM) Grant Operational Plan, May 9, 2017. Available: <http://www.health.ri.gov/publications/plans/StateInnovationModelTestGrantOperational.pdf>. Accessed 6/21/2017.

¹¹⁹ Medicaid Program Accountable Entity Roadmap Document, Rhode Island Executive Office of Health and Human Services (EOHHS), April 13, 2017. Available: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/MedicaidAERoadmap.pdf. Accessed 10/24/2017.

¹²⁰ Op Cit.

¹²¹ Office of the Health Insurance Commissioner. Regulation 2, Section 10(d)(2). Available: <http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf>. Accessed 6/19/2017.

¹²² Rhode Island 2017-2018 Alternative Payment Methodology Plan. Rhode Island Office of the Health Commissioner, January 27, 2017. Available: <http://www.ohic.ri.gov/documents/2017-2018-Alternative-Payment-Methodology-Plan-Final.pdf>. Accessed 11/2/2017.

South Carolina

South Carolina has moved forward with a few limited strategies to implement value-based reimbursement. First, in its Medicaid program, South Carolina provides a capitated PMPM payment to Patient Centered Medical Homes (PCMH) that provide care to 25% of the state's Medicaid population.¹²³ In its contracts with Medicaid MCOs, South Carolina requires adoption of value-based purchasing—in 2017, the state requires 20% of payments to be covered by VBP. The state provides some technical assistance, but does not prescribe which type of VBP should be used. In addition, from the results of two recent surveys—one by the Center for Healthcare Studies and one by Bailit Health—the state has indicated that it is also considering implementing episodes of care in the coming years.¹²⁴

¹²³ The Role of State Medicaid Programs in Improving the Value of the Healthcare System. Bailit Health and the National Association of Medicaid Directors. March 22, 2016. Available at: http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf.

¹²⁴ Leddy T, McGinnis T, Howe G. Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches. Center for Health Care Strategies, Inc. February 2016. Available: http://www.chcs.org/media/VBP-Brief_022216_FINAL.pdf.

South Dakota

South Dakota does not have a coordinated statewide strategy to move toward value-based care, but has moved forward with implementation of the Health Homes model within the Medicaid program, which serves patients with two or more chronic conditions.¹²⁵ Under this program the state pays providers a PMPM payment for six services.

¹²⁵ Patient Centered Primary Care Collaborative. South Dakota Health Homes. Available: <https://www.pcpcc.org/initiative/south-dakota-health-homes>.

Tennessee

Tennessee received a SIM Design grant in 2013 to develop a state innovation plan. In 2015, the state received a \$65 million SIM Test grant to begin implementation of the innovation plan.¹²⁶ Tennessee requires all contracted TennCare (Tennessee Medicaid) and employee health plans in the state to participate in the state's innovation plan. The innovation plan involves a three-pronged strategy: (1) primary care transformation with PCMH, "HealthLink" care coordination for TennCare members with significant behavioral health needs, and an online care coordination tool; (2) implementation of episodes of care, for acute and specialist driven care; and (3) value-based payments in LTSS care settings.¹²⁷ Tennessee set a goal of implementing 75 by 2019, in a phased, five-year rollout.¹²⁸ The EOC program is retrospective and based on a combination of quality and cost measurements, designed by McKinsey.¹²⁹ The TennCare EOC initiative began rollout in 2015 and the employee benefit plans transitioned to mandatory EOC in 2017.¹³⁰ After concerns were raised by Tennessee providers and provider associations, the state made the EOC a rewards-only program for the commercial market, while TennCare EOC employs both rewards and penalties. In addition to TennCare and the state employee plans, some commercial payers are working in parallel to the state to implement their own EOC programs.¹³¹

¹²⁶ State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>. Accessed 11/1/2017.

¹²⁷ Division of Health Care Finance & Administration. Introduction to Episodes of Care in Tennessee. Available: <https://www.tn.gov/assets/entities/hcfa/attachments/IntroductionEpisodes.pdf>.

¹²⁸ Episodes of Care Roadmap: Over 70 episodes of care will be designed and implemented over 5 years. Tennessee Division of Health Care Finance & Administration. Available: <https://www.tn.gov/assets/entities/hcfa/attachments/EpisodesOfCareSequence.pdf>.

¹²⁹ Episode Thresholds 2017. Tennessee Division of Health Care Finance & Administration. Available: <https://www.tn.gov/assets/entities/hcfa/attachments/EpisodesThresholds2017.pdf>.

¹³⁰ Letter to Stakeholders from the Tennessee Department of Finance and Administration, Benefits Administration. March 8, 2017. Available: <https://www.tnmed.org/Documents/State%20Memo%20re%20voluntary%2020170306%20final.pdf>.

¹³¹ Tennessee Model Test Project Narrative. State Innovation Models Grant. Available: <https://www.tn.gov/assets/entities/hcfa/attachments/ProjectNarrativeTNSIMgrant.pdf>. Accessed 11/1/2017.

Texas

In 2014, Texas implemented a statutorily-required Pay for Quality (P4Q) program in its Medicaid and CHIP programs, aimed at improving quality and inducing its contracted Medicaid MCOs to engage in value-based contracting. In contracts with MCOs, the state puts 4% of the capitation payment at risk pending reporting by the MCOs on various quality-related outcomes.¹³² The state also explicitly requires MCOs to “develop and submit to [the state] a written plan for expansion of value-based contracting with its physician and non-physician providers that encourages innovation and collaboration, and increases quality and efficiency.”¹³³ According to the most recent summary report of VBP used by the state Medicaid MCOs (plan year 2015), the plans used a combination of (1) FFS with bonus payments for achieving specific measures (most common); (2) Partial capitation with bonuses for quality and/or bundles; (3) Medical home models; and (4) Shared savings approaches (least common).¹³⁴

¹³² Quality-Based Payment and Delivery Reforms in Medicaid and the Children’s Health Insurance Program, TX Health and Human Services Commission Report. February 2016. Available: <https://hhs.texas.gov/sites/default/files//sb7-rider-46.pdf>.

¹³³ Texas Uniform Managed Care Contract. Available: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/UniformManagedCareContract.pdf>.

¹³⁴ Overview of Texas Medicaid-CHIP MCO and DMO Value-Based Contracting Initiatives in 2016. TX Department of Health and Human Services, July 13, 2016. Available: <https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/2015-MCO-DMO-VBC-summary-071316.pdf>.

Utah

The Utah state legislature passed a law in 2011 requiring the state Department of Health to move to value-based reimbursement in the Medicaid program. In 2013, the state completed implementation, which resulted in the creation of four payer-led ACOs that serve 70% of the state's Medicaid population.¹³⁵ The ACOs receive monthly risk-adjusted capitated payments for members. There are no bonus payments for achieving quality measures, but the contracts do require providers to achieve a certain level of performance on quality. Utah received almost \$3 million in two SIM Design grants,¹³⁶ which resulted in a state goal of achieving 80% of payments in a value-based purchasing plan by 2018.¹³⁷ However, there is little publicly available information on the state's progress toward achieving this goal.

¹³⁵ Lloyd J, Houston R, McGinnis T. Medicaid Accountable Care Organization Programs: State Profiles. Center for Health Care Strategies, Inc. October 2015. Available: <http://www.chcs.org/media/Medicaid-Accountable-Care-Organization-Programs-State-Profiles.pdf>.

¹³⁶ Centers for Medicare & Medicaid Services. State Innovation Models Initiative: Model Design Awards Round One. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Design/index.html>. Centers for Medicare & Medicaid Services. State Innovation Models Initiative: Model Design Awards Round Two. <https://innovation.cms.gov/initiatives/State-Innovations-Model-Design-Round-Two/index.html>. Accessed 11/1/2017.

¹³⁷ Utah Department of Health. Utah Health Innovation Plan, December 2013. Available: https://docuri.com/download/utah-health-innovation-plan_59ae46a5f581710a6200b70f_pdf. Accessed 11/1/2017.

Vermont

Vermont has been an active health reform state since before the Affordable Care Act passed. In 2011, the Green Mountain Care Board was created by the legislature to regulate the healthcare market and has been the most active healthcare entity in the state. The state has a Patient Centered Medical Home strategy called Blueprint for Health, which rewards advanced primary care practices for achieving quality and population health targets. In 2013, Vermont received a \$45 million SIM Test grant from CMMI¹³⁸ and the state used the funding to consider several APM options, including shared savings ACOs, EOC for the Medicaid population, Health Homes, and Accountable Community for Health. The state abandoned its work on EOC and ACH and instead launched Medicaid and commercial shared savings ACOs in 2014 as a three-year pilot.¹³⁹ Three ACOs (OneCare, CHAC, Healthfirst) were formed in the state and cover about 60% of the total population. The ACO program has two tracks: (1) upside only risk or (2) upside/downside risk. In 2016, the three ACOs joined together to become the Vermont Care Organization (VCO), which is a coordinating body rather than being an ACO on its own.¹⁴⁰ The consolidated organization allows providers to contract with VCO to take on varying degrees of risk. In the beginning of 2017, Vermont signed a waiver with CMS to implement an ambitious all-payer ACO model in the state. Under the proposed model, commercial and government payers would align around PMPM capitated payments to ACOs for care of attributed members.

¹³⁸ State Innovation Models Initiative: Model Test Awards Round One. Centers for Medicare and Medicaid Services. Available: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html>. Accessed 11/1/2017.

¹³⁹ Vermont Health Care Innovation Project, Payment Model Design and Implementation. Available: <http://healthcareinnovation.vermont.gov/areas/payment-model>.

¹⁴⁰ Value-Based Payment Reform and ACOs, Presentation before the House Health Care Committee, Vermont Care Organization, February 2017. Available: <http://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House%20Health%20Care/Accountable%20Care%20Organizations/W~Todd%20Moore~Value-Based%20Payment%20Reform%20and%20ACOs~2-23-2017.pdf>.

Virginia

Virginia received a SIM Design grant in December 2014 and partnered with the non-profit Virginia Center for Health Innovation to complete a state innovation plan.¹⁴¹ The work on the innovation plan fed into the Delivery System Reform Incentive Program waiver that the state submitted to CMS.¹⁴² Now approved, the DSRIP process is expected to involve changes to the Medicaid payment system in the state beginning in 2019. This payment reform strategy will focus on formation of Accountable Care Communities in five regions in the state, called Virginia Integrated Partners.¹⁴³ Virginia Integrated Partners will be responsible for working with the state's MCOs to coordinate care for Medicaid enrollees. The DSRIP plan aims to begin with the "high utilizer" population in 2018 and scale up to the full Medicaid population by 2021.¹⁴⁴ Likewise, VBP will ramp up from incentive and care coordination payments in 2018 to total cost of care payments in 2021.

¹⁴¹ Better Value for a Healthier Commonwealth: A Summary of Virginia's State Innovation Model Design. Virginia Center for Health Innovation, 2016. Available: http://www.vahealthinnovation.org/wp-content/uploads/2016/01/VCHI-SIM-Report_Final.pdf.

¹⁴² Virginia Department of Medical Assistance Services. Virginia Section 1115 Demonstration Waiver Application, January 19, 2015. Available: http://www.dmas.virginia.gov/Content_atchs/mltss/Virginia%20Section%201115%20Demonstration%20Waiver%20Application%20Jan%2019%202016.pdf. Accessed 6/25/2017.

¹⁴³ Virginia Center for Health Innovation. Regional Accountable Care Communities. Available: <http://www.vahealthinnovation.org/wp-content/uploads/2015/04/ACCMAP.jpg>. Accessed 6/23/2017.

¹⁴⁴ Virginia Department of Medical Assistance Services. Virginia Section 1115 Demonstration Waiver Application, January 19, 2015. Available: http://www.dmas.virginia.gov/Content_atchs/mltss/Virginia%20Section%201115%20Demonstration%20Waiver%20Application%20Jan%2019%202016.pdf. (p. 14).

Washington

Washington state received a SIM Model Test grant in 2014 to fund the rollout of initiatives in “The Washington Way,” the state’s innovation plan.¹⁴⁵ The innovation plan commits Washington state to assume the role as a “first mover” in the state by tying 80% of its state-financed health care payments to VBP by 2021.¹⁴⁶ This accounts for both the state Medicaid plan, Apple Health, and the state employee health plan, which together cover two million residents. The state-financed VBP strategy takes the form of two primary initiatives: (1) a primary care initiative focused on a shift to PMPM payments prospectively adjusted for quality; (2) an Accountable Care Program (ACP) with integrated care for state employees.¹⁴⁷ This year, the state employee program introduced a bundled payment program for total joint replacements. Additionally, the innovation plan calls for commercial payers to have at least 50% of their payments in VBP during the same five-year timeframe through implementation of a Public/Private Transformation Action Strategy, in which the state will ask commercial stakeholders to commit in writing to help implement the strategy.¹⁴⁸ By 2019, the state aims to have written commitments from companies that represent 60% of the current healthcare market share.¹⁴⁹

¹⁴⁵ Washington Health Care Authority. The Washington Way: Washington State Health Care Innovation Plan. January 2014. Available: https://www.hca.wa.gov/assets/program/SHCIP_InnovationPlan.pdf. Accessed 6/29/2017.

¹⁴⁶ Washington State Health Care Authority website. Accessed 6/22/2017. Available: <https://www.hca.wa.gov/about-hca/healthier-washington/paying-value>.

¹⁴⁷ Id.

¹⁴⁸ The Washington Way, *supra* at 42.

¹⁴⁹ Id at 47.

West Virginia

West Virginia received a 2014 SIM Design grant from CMMI. The funding was used to develop the West Virginia Health System Innovation Plan, which the state filed with CMS in August 2016.¹⁵⁰ The plan recommends three strategies regarding VBP: (1) set targets within the state Medicaid program requiring adoption of VBP by contracted plans; (2) encourage other payers to adopt VBP; and (3) establish regional accountable health communities.¹⁵¹ It further sets goals of 10% VBP across all payers except for Medicare in 2017 and ramps up to a goal of 80% in VBP by 2021.¹⁵² To shepherd this transformation process, the plan proposes the creation of a new non-profit organization, the West Virginia Health Transformation Accelerator (WVHTA). As of 2017, the WVHTA had not yet been formed.

¹⁵⁰ West Virginia Department of Health and Human Resources. West Virginia Health System Innovation Plan, August 5, 2016. Available: <http://www.wvhicollaborative.wv.gov/Documents/West%20Virginia%20SHSIP%20with%20Cover%20Letter%20and%20Errata.pdf>. Accessed 6/29/2017.

¹⁵¹ Op Cit at page 96.

¹⁵² Op Cit at page 317.

Wisconsin

In 2011, a group of 30 organizations, including large payers, providers, and state agencies, formed the Statewide Value Committee, a public-private partnership which focused on identifying common performance measures to be used in the move to value-based payment.¹⁵³ In 2014, the group, in partnership with the Wisconsin Department of Health Services, applied for a Round-2 SIM Design grant. This grant was awarded in late 2014 and the group developed a State Innovation Plan that it submitted to CMS in January 2016.¹⁵⁴ After an exhaustive review of value-based payment reform options, the Plan recommends that the state adopt a fee-for-service model with P4P incentives and care coordination payments. Of note, in 2009, the state Medicaid program, known as BadgerCare, began a P4P program with contracted MCOs and expanded the program in 2013 to include hospitals that were paid through the FFS program. According to the plan, this experience demonstrates that the state is able to take a leadership role in promoting VBP and helping others move along the continuum.

¹⁵³ Wisconsin Collaborative for Healthcare Quality. Statewide Value Committee (SVC). Available: <http://www.wchq.org/measures/initiatives/svc.php>. Accessed 6/29/2017.

¹⁵⁴ Wisconsin State Health Innovation Plan. Wisconsin Department of Health Services, 2016. Available: <https://www.dhs.wisconsin.gov/publications/p01688.pdf>. Accessed 6/23/2017.

Wyoming

Wyoming does not have a coordinated statewide strategy to implement value-based payment strategies. In 2015, the state Medicaid program implemented PCMH through a state plan amendment and expanded the number of practices that participate in the PCMH program in 2016 and 2017.

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