Executive summary

Many states have been experimenting with Medicaid alternative payment models (APMs) to try to control spending, improve care, and increase accountability within Medicaid and across the health care system. Have any of these models worked? How might Medicaid initiatives align with the Medicare Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA) to reinforce value-based care incentives and drive system-wide change?

The Deloitte Center for Health Solutions has reviewed research and other literature, and conducted interviews with industry experts and stakeholders to learn more about Medicaid APMs, their effectiveness, and how they might need to evolve to maximize their impact.

Key findings

- Many states are taking advantage of Medicaid program flexibility and federal financing to implement APMs in a variety of ways.
- Although many state initiatives are underway, relatively few have been evaluated for their impact on total cost of care or health outcomes. One reason may be that many initiatives are relatively new and there has not been sufficient time to observe full program effects. The cost and complexity of conducting formal evaluations also may be a limiting factor.
- Many of the initiatives with evaluation findings have focused on improving primary care through patient-centered medical homes (PCMHs) and similar programs. These findings have been mixed, with some older initiatives such as North Carolina's PCMH saving money over time and some newer initiatives such as Ohio's specialty Health Home increasing costs despite improving care in the short term.
- A smaller subset of states is pursuing episode of care (EOC) payments within their Medicaid programs. Arkansas has achieved some positive outcomes through its statewide, multi-payer bundled payment initiative.
- Several states have implemented accountable care organizations (ACOs), and more states are planning to do so. Early results from Oregon and Colorado show that ACOs can reduce unnecessary health care utilization and lower health care costs. However, their effect on quality is still largely unknown.
- The potential impact of Medicaid APMs on care delivery can depend considerably on how much of a provider's revenue comes from Medicaid. Alignment with other payers may be necessary to effectively support and incentivize providers—especially those who treat a lower volume of Medicaid patients—to participate in APMs.
- Medicaid models may need to evolve to incorporate more financial risk and increase participants’ meaningful use of electronic health records (EHRs) to qualify as advanced APMs under MACRA. This may require new or additional investment in technology and data analytics tools.
Background

Many states look to alternative payment models to help improve Medicaid program efficiency

Medicaid is the nation's single largest health insurer, covering more than 70 million low-income and disabled Americans. It is jointly financed by the federal and state governments and cost about $575 billion in 2016, making it one of the largest items in federal domestic spending and state budgets. Because of Medicaid's size, states and the federal government are often under tremendous political and economic pressure to ensure that the program is run efficiently. Many states are experimenting with APMs to help control Medicaid spending, improve care, and increase accountability across the health care system.

Approaches to implementing Medicaid APMs vary across states and, sometimes, even within states. These variations can be tied to a number of factors, including:

- Medicaid State Plan and waiver authority
- Underlying Medicaid payment systems (e.g., fee-for-service [FFS] or managed care)
- Financial resources availability
- Characteristics of the population(s) targeted provider types involved
- IT infrastructure and data availability.

States have broad discretion to design and administer their Medicaid programs

Medicaid’s federalist structure enables states to design and adapt their programs to meet the unique health care needs of their populations. Combined, the federal Medicaid statute (Title XIX of the Social Security Act) and federal regulations establish basic requirements that states must meet in order to receive federal funding, including minimum eligibility criteria and benefits. The regulations also define how and how much the federal government will pay for various activities. Generally speaking, it is up to the states to decide how they deliver and pay for covered services. Many states are looking to APMs as a way to help constrain Medicaid program costs without having to restrict eligibility or cut benefits.

The two primary ways that states pay Medicaid providers are via FFS and managed care. Most states use a mix of both to deliver services to their various Medicaid populations. Many states are implementing APMs on top of their existing FFS framework, within their managed care programs or, in some cases, both. (See sidebar on Medicaid managed care on the following page.)

Legal authorities used by many states to implement Medicaid APMs are almost as diverse as the models themselves. Whether a state must seek waiver approval—or submit a State Plan Amendment (SPA) to implement an APM—depends on the characteristics of the model being implemented, as well as the unique terms of the Medicaid State Plan and any existing program waivers.

In general, APMs implemented under State Plan authority must be available statewide and cannot limit the number or type of beneficiaries and included providers. States looking to test models in specific geographic areas, target services for specific populations, or selectively contract with certain providers likely will need a waiver. (See sidebar on Medicaid waivers below.) One exception is Medicaid Health Homes, a new State Plan option available under Section 2703 of the Affordable Care Act.

<table>
<thead>
<tr>
<th>States are using Medicaid waivers to make targeted program changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title XIX of the Social Security Act gives the Secretary of Health and Human Services (HHS) the authority to waive certain federal requirements for states that want to test new or existing methods of delivering services to beneficiaries. Waiver proposals must be “consistent with the purpose of the Medicaid program” (a determination left to the Secretary, who evaluates the request and interprets the statute). All waivers are time-limited and generally cannot increase costs for the Medicaid program.</td>
</tr>
<tr>
<td>There are multiple types of Medicaid waivers that address different parts of the program and each has unique objectives and requirements stipulated in statute. The most common types of Medicaid waivers are:</td>
</tr>
<tr>
<td>• 1915(b) managed care waivers</td>
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<tr>
<td>• 1915(c) home and community-based services (HCBS) waivers</td>
</tr>
<tr>
<td>• 1115 demonstration waivers</td>
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<tr>
<td>States may concurrently operate multiple waivers—including, in some instances, several of the same waiver type. Every state has at least one Medicaid waiver in place.</td>
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States are using Medicaid waivers to make targeted program changes
Medicaid managed care plays an important role in promoting value-based care

Medicaid managed care has become increasingly dominant in recent years, with roughly three-quarters of beneficiaries now receiving some services through managed care, and more than half enrolled in risk-based, comprehensive managed care organizations (MCOs). In 2016, all but three states contracted with managed care companies to deliver services to at least some of their Medicaid beneficiaries (Figure 1). While the number and type of beneficiaries enrolled in managed care vary by state, the overall percentage of Medicaid beneficiaries enrolled in managed care continues to grow. Some states are transitioning from FFS to MCOs, while others are expanding MCO enrollment to more clinically complex populations (such as the elderly and disabled) and wider geographic areas. Several states operate primary care case management (PCCM) programs, a type of managed care arrangement in which the state contracts with primary care managers to coordinate services for assigned FFS Medicaid beneficiaries.

Many states recognize the extensive reach of managed care, and are becoming more proactive and assertive in their approaches to partnering with MCOs to drive the transition to value-based care. Almost all states with MCOs say they are including quality initiatives—such as pay-for-performance and quality reporting—in their contracts; a growing number are requiring their Medicaid MCOs to participate in APMs (Figure 1). For example, Minnesota and Tennessee both require their MCOs to participate in state-led APM initiatives. Other states do not dictate participation in specific models but require MCOs to make a certain percentage of their payments through APMs. South Carolina and Arizona have taken this approach and enforce it by withholding a portion of MCO capitation payments.

**Figure 1. Most states have some form of Medicaid managed care; many are leveraging their contracts to promote APMs**

<table>
<thead>
<tr>
<th>States with Medicaid managed care, FY 2016</th>
<th>States with APM requirements in their MCO contracts, FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCOs</td>
<td>MCOs and PCMM</td>
</tr>
<tr>
<td>32</td>
<td>15</td>
</tr>
<tr>
<td>Require MCOs to meet specific APM targets</td>
<td>Require/encourage MCOs to adopt APMs</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>None</td>
<td>Require/encourage MCOs to adopt APMs</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>
| Sources: KFF 50-state Medicaid Budget Survey for FY16 and FY17

In the 2016 Medicaid Managed Care Final Rule, the US Centers for Medicare and Medicaid Services (CMS) clarified the ways that states can partner with MCOs to implement value-based care initiatives. These strategies include:

- Incorporating quality and performance incentives/penalties in their managed care contracts, including withholding a portion of capitation payments
- Directing plans to implement value-based purchasing models or participate in multi-payer delivery system reform initiatives
- Allowing plans to provide “value-add” services beyond what is covered under the Medicaid State Plan or plan contract.
What does the Medicaid APM landscape look like?

Many state Medicaid agencies are using an array of value-based arrangements with their providers and payers. These arrangements may range from narrowly targeted APMs for specific patient populations to statewide, multi-payer initiatives. Four of the most commonly used model types are patient-centered medical homes (PCMHs), Medicaid Health Homes, Accountable Care Organizations (ACOs), and Episode of Care (EOC) payments.

Many state efforts to transform Medicaid from a FFS payment system to one that pays for value are consistent with trends in Medicare and the commercial markets. In some cases, Medicaid APMs were modeled on Medicare APMs. This is typically true with newer, more complex APMs like ACOs and EOC payments. In the case of older APMs, such as PCMHs, states have been the pioneers and Medicare and commercial payers have followed suit.

**Patient-centered medical home:**
PCMH is a model of organizing primary care so that patients receive care that is coordinated by a primary care physician, supported by information technologies for self-care management, delivered by a multi-disciplinary team of allied health professionals, and adherent to evidence-based practice guidelines. According to the Joint Principles established by the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association, PCMHs should have the following characteristics: a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access, and adequate payment. Some states require that providers participating in PCMH initiatives be certified by the National Committee for Quality Assurance or another certifying body.

**Medicaid Health Home:** The Health Home model builds on PCMH but goes further by requiring integration of physical and behavioral health services. It also extends care coordination beyond medical services to include social and community supports. The ACA includes incentives for states to adopt Health Homes by creating a new Medicaid state plan option, and provides 90 percent federal matching funds for the first eight quarters of program implementation. The Health Home model is also aimed at specific high-risk populations (e.g., patients with multiple chronic conditions and/or severe and persistent mental illness). Unlike other Medicaid benefits, states can limit Health Home benefits to geographic areas, and can vary the scope of benefits offered to different types of Medicaid beneficiaries without requiring a waiver.

There are three major Health Home organizational structures:

- Medical home-like programs that are variations or extensions of the PCMH model
- Specialty-provider-based programs (e.g., mental health providers)
- Care management networks.

**Episode of Care Payments:** EOC payments, also called bundled payments, provide a lump-sum payment for all health care services delivered to a patient for a particular illness, procedure, or condition (episode). In theory, EOCs can improve predictability, reduce cost variation, and provide financial incentives to improve care coordination among providers and across health care settings.

**Accountable Care Organizations:** An ACO is a network of providers who are collectively responsible for managing the full continuum of care for a defined patient population. ACOs are held responsible for the quality of care provided as well as the overall cost.
Medical home models—including PCMH and Health Homes—are the most prevalent type of Medicaid APM, with ACOs and EOC payments less common (Figure 2).

Figure 2. More states have implemented medical home initiatives than ACOs or EOC payments

<table>
<thead>
<tr>
<th>Initiative Type</th>
<th>Number of States</th>
</tr>
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<tbody>
<tr>
<td>PCMHs</td>
<td>29</td>
</tr>
<tr>
<td>Medicaid Health Home</td>
<td>22</td>
</tr>
<tr>
<td>ACOs</td>
<td>10</td>
</tr>
<tr>
<td>EOC payments</td>
<td>3</td>
</tr>
</tbody>
</table>

Sources: KFF 50-state Medicaid Budget Survey for FY16 and FY17; CMS list of approved Medicaid Health Home SPAs (May 2017); CHCS Medicaid ACO Fact Sheet (June 2017)
Federal funding opportunities have augmented Medicaid value-based care initiatives

Many states that have implemented Medicaid APM initiatives have received federal funding to support their transformation efforts. Two mechanisms that many states have leveraged are the Center for Medicare and Medicaid Innovation (CMMI)’s State Innovation Models initiative and Medicaid Delivery System Reform Incentive Payment (DSRIP) programs.

DSRIP programs can help states access federal matching funds, which can be used to support providers as they transition to providing value-based care. DSRIP is not a federal grant program; it is a component of Medicaid Section 1115 demonstration waivers, and is subject to budget neutrality requirements. California was the first state to implement a DSRIP program in 2010. Since then, nine other states have implemented DSRIPs and four others have pursued similar, “DSRIP-like” waiver arrangements with CMS (Figure 3). Many states are using DSRIP and DSRIP-like waivers in a number of ways, and the design and scope of DSRIP projects vary considerably. For example, New York’s DSRIP waiver authorizes $6.42 billion over five years to implement a series of projects designed to reduce avoidable hospital use by increasing providers’ capacity to participate in APMs and expand the scope of current APMs. Massachusetts’ DSRIP waiver authorizes $1.8 billion over five years to support its Medicaid ACOs and further the integration of behavioral health and social services. Oregon received $1.9 billion funding though a “DSRIP-like” 1115 waiver, which the state used to establish Coordinated Care Organizations (community-based MCOs that operate similarly to ACOs).

Figure 3. Map of states with DSRIP and DSRIP-like waivers

Sources: CHCS DSRIP Activity Tracker; CHCS Medicaid ACO Fact Sheet (June 2017); KFF 50-state Medicaid Budget Survey for FY16 and FY17; CMS List of Approved Medicaid Health Home SPAs (December 2016)
Alternative payment models in Medicaid: Could MACRA be a catalyst for states’ value-based care efforts?

Through the State Innovation Models initiative (SIM), CMS is providing financial and technical support for developing and testing state-led, multi-payer health care payment and service delivery models. These models are designed to help improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries. Since 2013, CMS has awarded more than $900 million to 34 states, three territories, and Washington, D.C. through two rounds of SIM cooperative agreements (Figure 4). Some states including Minnesota and Michigan have used SIM funding to significantly expand preexisting Medicaid APM initiatives. Other states, including New York, Massachusetts, and Oregon, have combined SIM with Medicaid 1115 waivers and are using SIM to accelerate demonstration activities.

CMS has not said whether it plans to make additional rounds of funding available. In 2016, CMS issued a request for information on the evolution of the SIM initiative that solicited public input on the following:

- Ways to facilitate alignment between state and federal delivery system reform efforts, including partnering with states to develop and implement models that qualify as advanced APMs under the Medicare Quality Payment Program
- Ways to implement financial accountability for health outcomes for an entire state population
- Ways to assess the impact of specific interventions across multiple states
- Ways to facilitate alignment between state and federal delivery system reform efforts.

Figure 4. Map of SIM awardees

Sources: CMS SIM Round 1 and Round 2 Press Releases; CHCS Medicaid ACO Fact Sheet (June 2017); KFF 50-state Medicaid Budget Survey for FY16 and FY17; CMS List of Approved Medicaid Health Home SPAs (December 2016)
Qualitative evaluations of early SIM award recipients and DSRIP/DSRIP-like waivers indicate that the resources made available through these programs have been integral in facilitating provider participation in state APMs. States that have yet to implement APMs or that are looking to expand their efforts will likely need to consider financing availability. The new administration has voiced a commitment to fostering state innovation but has said little about whether or how it will provide financial support for state efforts.

Have Medicaid payment initiatives been effective?

The Deloitte Center for Health Solutions reviewed research and other literature (see sidebar on the following page), and conducted interviews with industry experts and stakeholders to better understand the structure and impact of Medicaid APMs.

Our research determined that evidence on Medicaid APMs is scarce. What is available is limited primarily to measuring operational success, rather than quantifying savings; identifying medical home models—including PCMH and Medicaid Health Homes—as the most commonly used types; and determining that Medicaid APMs layer pay-for-performance incentives on top of regular FFS payments and do not require providers to take financial risk.

Evidence on Medicaid APMs is scarce and findings are often limited

Our literature review found that information about Medicaid value-based care initiatives—especially Medicaid managed care initiatives—is fairly limited. There have been relatively few evaluations of Medicaid value-based care initiatives when compared to Medicare and commercial payer initiatives. A recently launched effort to inventory APM evaluations (including Medicare, Medicaid, commercial, and other state or local initiatives) found that less than five percent of publically-available APM evaluations are related to state-run Medicaid initiatives. Furthermore, evidence for managed care APMs is largely limited typically to case studies. Some states have reported the aggregate impact of value-based purchasing or quality improvement programs implemented with their Medicaid MCOs but the details of individual plans’ initiatives are rarely made public.

Even when information on Medicaid APM performance was available, it was often narrow in scope and mostly focused on operational metrics rather than total cost of care:

• **Evaluations are often limited to measuring operational success.** Many Medicaid program evaluations describe states’ and/or providers’ success in achieving implementation milestones (e.g., the percentage of providers using EHR technology, the number of community health workers hired and trained, the number of quality metrics reported). Information on program outcomes is typically limited and more likely to be self-reported or anecdotal. Further, details about provider impact are often reported at the aggregate level with little or no assessment of performance variation across different APM entities or among individual providers.

• **It can be difficult to quantify savings.** Few APM evaluations examine total cost of care. In some cases, this is due to data limitations (e.g., lack of access to complete claims/encounter data, or reporting time lag). Additionally, many savings estimates are the product of the state’s internal analyses, which typically cannot be externally validated.

There have been relatively few evaluations of Medicaid value-based care initiatives when compared to Medicare and commercial payer initiatives.
Stakeholders offered several explanations for the limited evidence on the overall impact of Medicaid initiatives:

- Robust evaluations can be expensive and time-consuming, and many states lack dedicated funding or resources. Many of the state initiatives where data was available were implemented as part of a federal initiative (such as a SIM grant or 1115 demonstration waiver) that required monitoring and reporting on operational metrics as a condition of participation.

- Several health plans have cited legal barriers, market competition, and evaluation costs as reasons for limited information-sharing.

- While some early Medicaid APMs have demonstrated promising results on certain utilization measures, models may require more time before they can be expected to show meaningful impacts on cost and health outcomes. Additionally, many of the more innovative—and potentially more impactful—models are still being implemented or are in the early stages of operation and have not been evaluated.

- Furthermore, concurrent initiatives can complicate evaluation design. As the US health care system transitions from paying for volume to paying for value, the number, types, and prevalence of APMs continue to increase. With many models being implemented concurrently, it can be difficult for evaluators to attribute outcomes to a specific model or identify drivers of success (or failure).

Many of the more innovative—and potentially more impactful—models are still being implemented or are in the early stages of operation and have not been evaluated.
What we know about the four main types of Medicaid APM initiatives

Patient-centered medical home

Prevalence: The PCMH model is the most commonly reported type of Medicaid APM initiative. In 2016, 29 states served at least some beneficiaries through a PCMH, and 13 states intend to establish new PCMH programs or expand existing ones in 2017.31

Results: There are many reports documenting how state and federal initiatives have helped primary care practices meet process milestones associated with the transformation to a PCMH (i.e., hiring/training care managers and implementing risk-stratified care-management).32, 33 However, it is not yet clear whether PCMH initiatives’ operational success will translate into improved health outcomes and reduced costs for patients. Most quantitative evaluations of PCMH models have found limited measurable impact on claims-based measures of quality, utilization, and cost of care for Medicaid beneficiaries. The Community Care of North Carolina program and Vermont’s Blueprint for Health program—two of the oldest, longest-running PCMH initiatives—are exceptions.

- An impact study of Vermont’s Blueprint for Health found that the program saved roughly $482 per participant per year (participants included Medicaid, Medicare, and commercial patients), primarily as a result of reductions in hospital inpatient utilization and expenditures.34 The study found no statistically significant differences in quality between program participants and a comparison group, with the exception of one specific diabetes measure.35

- A state audit of Community Care of North Carolina found that the program achieved annualized savings of $312 per Medicaid beneficiary per year, net of program administration costs.36 The audit also found that the program significantly reduced readmissions but did not have a significant impact on emergency department (ED) use. An independent study published in the Journal of Population Health Management found statistically significant program savings for non-elderly, disabled Medicaid patients and reductions in hospital admissions in every year after the first program year.37

- The federal evaluation of the first three years of the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration, CMS’s first multi-payer PCMH initiative, found limited and inconsistent evidence that MAPCP impacted Medicaid outcomes.38

  - None of the eight participating states saw significantly slower growth rates for total Medicaid expenditures or acute-care services.
  - Pennsylvania reduced all-cause readmissions and ED visits for adult beneficiaries.
  - Michigan reduced all-cause readmissions but increased the rate of specialist visits for child beneficiaries.
  - North Carolina reduced ED visits for child beneficiaries.
  - Only New York and Minnesota experienced an increase in primary care visits for Medicaid beneficiaries.

State PCMH initiatives can vary tremendously in their design and implementation. Many evaluations focus on individual states and their initiatives, and do not compare different state initiatives. CMS has commissioned national evaluations of its medical home initiatives, including the Comprehensive Primary Care (CPC) program and the MAPCP demonstration. However CMS’ cross-state analysis is largely limited to implications for Medicare, not Medicaid.39, 40 As a result, it can be difficult to identify which unique PCMH feature or combination of features is most effective for specific Medicaid populations.

It is not yet clear whether PCMH initiatives’ operational success will translate into improved health outcomes and reduced costs for patients.
Alternative payment models in Medicaid: Could MACRA be a catalyst for states’ value-based care efforts?

**Medicaid Health Homes**

**Prevalence:** As of May 2017, 21 states and Washington D.C. were operating 32 CMS-approved Health Home models.\(^{41}\)

**Results:** As of the most recent HHS evaluation, quantitative analyses on patient and cost outcomes were not yet available, but qualitative analysis found that the Medicaid Health Home model has led to improved care for enrolled members.\(^{42}\)

- Participating providers and health systems reported that Health Homes have improved care coordination, behavioral and physical health integration, and member engagement.
- Participating providers agreed that the Health Home model was both appropriate and feasible to provide targeted care for high-need populations.

Several states conducted their own Health Home program evaluations and reported positive impacts on cost and quality.

- Both of Missouri’s Health Home programs (primary care and integrated mental/behavioral health) reduced both utilization and cost:
  - Per 1,000 enrollees, the primary care Health Home program decreased hospital admissions by 5.9 percent and ED use by 9.7 percent (representing an estimated cost savings of $5.7 million for the state Medicaid program).\(^{43}\)
  - Per 1,000 enrollees, the specialty mental health program decreased hospital admissions by 12.8 percent and ED use by 8.2 percent (representing an estimated cost savings of $2.9 million for the state Medicaid program). The program also showed significant improvement in clinical outcome measures for enrolled members (e.g., diabetes control, cholesterol control, and hypertension control).\(^{44}\)
- Ohio’s specialty Health Home program for persons with serious mental illness (SMI) was associated with a $561 per-member-per-month (PMPM) overall increase for Medicaid program costs; however, providers reported improvements in care coordination and satisfaction. The majority of cost increases was associated with Health Home service delivery and increased pharmacy costs.\(^{45}\)

It remains unclear whether and how states will continue their Medicaid Health Home programs when the enhanced federal funding ends after two years. Oregon absorbed its Health Home program into its broader PCMH initiative, a strategy other states such as Idaho and Ohio are considering.\(^{46}\) As a result, longer-term trends, as well as the outcomes specific to the Medicaid Health Home program (as distinct from the PCMH model), may be difficult to identify.

**Episode of Care Payments**

**Prevalence:** In 2016 only three states (Arkansas, Ohio, and Tennessee) had implemented EOC payments. Four others (Connecticut, New York, Oklahoma, and South Carolina) were considering implementing bundled payments.\(^{47}\)

**Results:** At the time of publication, the Arkansas Payment Improvement Initiative (APII) was the only Medicaid bundled payment initiative with published results:

- Perinatal EOC payments did not significantly affect screening rates for pregnant Medicaid beneficiaries. However, the rate of cesarean sections and length of inpatient stays for C-section births decreased slightly.\(^{48}\)
- Attention-deficit/hyperactivity (ADHD) disorder EOC payments increased the average number of behavioral health visits and decreased the costs of treating ADHD patients by 15 percent.\(^{49}\)
- Knee/hip replacement EOCs improved the 30-day wound infection rate for Medicaid patients; however, post-operation complication rates worsened.\(^{50}\)

Much of the bundled payments evidence comes from initiatives targeting conditions and procedures that are high-cost drivers for the Medicare population (e.g., joint replacements). However, there may be insufficient volume in the Medicaid population to achieve savings through those bundles. Some states are exploring bundles for conditions that are prevalent in the Medicaid population (e.g., asthma and maternity/perinatal bundles) but limited evidence and lack of consensus can make it difficult to define EOCs and set appropriate payment rates.
Alternative payment models in Medicaid: Could MACRA be a catalyst for states’ value-based care efforts?

Prevalence: As of June 2017, Medicaid ACOs were in place or in progress in 10 states, and at least 13 other states plan to pursue Medicaid ACO initiatives.  

Results: Because of the relative newness of the ACO model and its limited uptake in Medicaid, most program evaluations have focused on measuring the progress towards implementation. Overall findings suggest that Medicaid ACO models are maturing more slowly than anticipated. Oregon and Colorado’s ACO initiatives are among the oldest and have been more widely studied:

- According to a report by the Colorado Department of Health, the Accountable Care Collaborative program reduced Medicaid costs by an average of $60 PMPM for adults, and $20 PMPM for children. The savings, however, varied greatly by geographic area. The program did not show a significant impact on key performance, quality, or access measures.  

- Oregon credits its Coordinated Care Organizations (CCOs)—community-based MCOs with ACO-like attributes—for reducing overall Medicaid spending growth below the 3.4 percent per year target established as a condition of its 1115 Medicaid demonstration waiver.  

- Despite their differences in model design and upfront implementation costs, an independent study comparing Colorado’s and Oregon’s Medicaid ACO initiatives found no statistically significant difference between the two models’ impact on performance measures (adjusted for demographics and health risk) or Medicaid program spending (measured by standardized PMPM expenditures).
Medicaid APMs base payment on quality but few require participants to bear financial risk

The Health Care Payment Learning and Action Network (HCP-LAN) developed a framework for classifying APMs for the purpose of tracking the progress of value-based payment transformation. The HCP-LAN APM framework divides models into four categories based on their underlying payment arrangements (Figure 5). This framework can be useful for conceptualizing where different Medicaid initiatives fall along the risk spectrum. For example, a PCMH or ACO model could be deemed a category two, three, or four depending on how participants are paid (see Figure 7 on page 15).

Figure 5. HCP-LAN APM framework

Source: Deloitte Center for Health Solutions analysis of 2016 HCP-LAN APM framework
According to a survey conducted by the National Association of Medicaid Directors (NAMD), most of the Medicaid APMs implemented to date layer pay-for-performance incentives on top of regular FFS payments and do not require providers to take financial risk. However, more states are planning and implementing models that hold providers accountable for some or all of the cost of care (Figure 6). States such as Michigan and New York have developed strategies to explicitly encourage participation in category 3 and category 4 APMs and align Medicaid initiatives with Medicare and commercial APMs.  

**Figure 6. State-reported APM initiatives by LAN category**

More states are planning and implementing models that hold health care providers accountable for some or all of the cost of care.
### Technology and data analytics can be fundamental to APM participation

Payers and providers need to be able to access, aggregate, and analyze different types of data (e.g., claims data, encounter data, clinical data) to target resources effectively and track quality and cost. Technological challenges, such as outdated or inadequate eligibility and claims processing systems and lack of EHR interoperability, may hinder or preclude adoption of more risk-bearing APMs in Medicaid. States that have implemented APMs with upside and downside risk have invested heavily in data-sharing technology and analytics tools, and provide reports directly to providers to support their care improvement efforts.

### Figure 7. Examples of Medicaid ACO initiatives by LAN category

<table>
<thead>
<tr>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS + link to quality and value</td>
<td>Built on FFS architecture with upside/downside risk</td>
<td>Population-based payment</td>
</tr>
</tbody>
</table>

**Colorado’s Accountable Care Collaborative**  
- **Base payment**: Regular FFS + PMPM fee from state*  
- **Incentives/penalties**: State withholds $1 of PMPM to fund quarterly incentive pools; RCCOs and primary care providers must meet quality targets to recoup full PMPM  
*CO is piloting full-risk capitation in one region

**Minnesota’s Integrated Health Partnerships (IHPs)**  
- **Base payment**: Providers receive regular FFS payment from state or MCO  
- **Financial risk**:  
  - Virtual model = shared savings only (≤ 50%)  
  - Integrated model = shared savings and increasing shared risk (eventually symmetrical)

**Oregon’s Coordinated Care Organizations (CCOs)**  
- **Base payment**: CCOs receive global capitation payments from state  
- **Financial risk**: State withholds percentage of capitation payment; CCO must meet cost/quality benchmarks to receive full payment  
- **Bonuses**: CCOs can earn additional “challenge” funds

Source: Deloitte Center for Health Solutions analysis of publically available program information
What might the future hold for Medicaid APMs?

Despite limited evidence, APMs continue to spread and federal and state policies are increasing pressure on providers and insurers to participate. Aligning Medicaid APMs’ design, reporting requirements, and financial incentives with other payers could potentially increase their impact and likelihood of success. This could be particularly true for specialists or other providers who treat a low volume of Medicaid patients.

MACRA creates incentive for Medicaid clinicians who also treat Medicare patients to participate in APMs

The Medicare Access and CHIP Reauthorization Act (MACRA), bipartisan legislation enacted in 2015, overhauls the way that Medicare pays clinicians under the Part B Physician Fee Schedule. It also has the potential to transform the health care payment landscape beyond Medicare.

MACRA established the Quality Payment Program (QPP), which offers financial incentives for Medicare Part B providers to participate in risk-bearing APM arrangements. Under MACRA, qualifying APM participants (QPs) who earn a minimum percentage of their payments through advanced APMs or see a minimum percentage of patients through advanced APMs are exempted from Merit-based Incentive Payment System (MIPS) reporting requirements and can earn a five percent Medicare payment bonus from 2019-2024. Beginning in 2026, QPs will receive a higher annual Medicare fee schedule adjustment than non-QPs. In addition, eligible clinicians who participate in certain APMs but do not meet the QP requirements still may receive more favorable scoring under MIPS.

For the first two years of the QPP, only participation in Medicare advanced APMs will count towards meeting the QP threshold. Beginning in performance year 2019, clinicians who do not meet the minimum Medicare thresholds can also count their participation in APM arrangements with other payers—including Medicaid—so long as the arrangements meet the other-payer advanced APM criteria. Other-payer advanced APMs must require participating clinicians to use certified EHRs; base payments on quality measures that are evidence-based, reliable, and valid; and bear more than nominal financial risk. (See Figure 8 and sidebar on the following page.)

Figure 8. In the first two years, QPP only counts Medicare patients and payments towards advanced APM criteria; it expands to other payers in future years

Sources: Deloitte Center for Health Solutions analysis of Public Law 114-10 (April 16, 2015); 81 Fed. Reg. 77491 (November 4, 2016)
Alternative payment models in Medicaid: Could MACRA be a catalyst for states' value-based care efforts?

Other-payer advanced APMs must meet strict criteria for clinicians’ participation to count for QPP

**Criterion 1**

Must require at least 50% of participants to use certified EHR technology (CEHRT)

**Criterion 2**

Must base payments on evidence-based, valid, and reliable quality measures comparable to those used in MIPS (e.g., Medicaid Core Measures)

**Criterion 3**

Must require participants to bear more than a nominal amount of financial risk*  
*or be a Medical Home model expanded under CMMI authority

Source: Public Law 114-10 (April 16, 2015)

Bearing financial risk means that the payer must withhold payment for services to APM entity/provider; reduce payment rates to APM entity/provider; or require direct payments by APM entity if actual expenditures exceed expected expenditures under APM arrangement. Nominal amount of risk is defined as:

- Total risk ≥ 3% of expected expenditures for which the APM entity is responsible under an APM arrangement (benchmark-based standard); or total risk ≥ 8% estimated revenue (revenue-based standard)
- APM entity is at risk ≥ 30% of losses in excess of expected expenditures (marginal risk)
- Minimum loss rate ≤ 4%.

*No medical home models have been expanded under CMMI authority to date; however Medicaid Medical Home models can still qualify as other-payer advanced APMs if the APM entity meets the following criteria:

- Includes fewer than 50 eligible clinicians in the parent organization that owns/operates the APM entity (CPC+ participants are exempt from 50 clinician cap)
- Loses the right to all or part of an otherwise guaranteed payment, has payment withheld, has payment rate reduced, or is required to make direct payments to the state or MCO in the event that its actual expenditures exceed agreed-upon aggregate expenditure targets
- Is at risk for at least 3% of the APM entity’s total Medicaid revenue in performance year 2019, at least 4% in 2020, and 5% in 2021 and beyond.

MACRA establishes a specific definition for Medicaid medical homes. For QPP purposes, CMS has determined that a Medicaid Medical Home model is a payment arrangement under Title XIX that has the following features:

- Participants include primary care practices or multi-specialty practices that have primary care providers and offer primary care services
- Empanelment of each patient to a primary clinician
- Four or more of these features:
  - Patient access and continuity of care
  - Coordination of care across the “medical neighborhood”
  - Shared decision-making
  - Coordination of chronic and preventative care
  - Risk-stratified care management
  - Payment arrangements in addition to or substituting for FFS payments (e.g., pay-for-performance, gainsharing, risk-sharing, partial capitation, global payment).
Alternative payment models in Medicaid: Could MACRA be a catalyst for states’ value-based care efforts?

How do Medicaid APMs compare to Medicare advanced APMs?

CMS has released a list of CMMI models that it considers to be Medicare advanced APMs for performance year 2017 as well as Medicare models expected to qualify in future years.\(^{70}\)

Deloitte researchers compared the design elements of a sample of Medicaid APMs with select Medicare advanced APMs to assess whether/how each model meets the three advanced APM criteria (Figure 9).

**Figure 9. Medicaid APMs typically include the same components as Medicare APMs; however it is unclear whether they would satisfy the financial risk and EHR criteria to qualify as advanced APMs under QPP**

<table>
<thead>
<tr>
<th>APM</th>
<th>Criterion 1: EHR use</th>
<th>Criterion 2: Quality measures</th>
<th>Criterion 3: Financial risk</th>
<th>Model type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Shared Savings Program Track 2/3(^{71}) and Track 1(^{72})</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> Use of CEHRT is one of required quality measures.</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> All three tracks are required to meet performance targets on 31 quality measures to qualify for shared savings (ranging from 50-75%).</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> All three tracks must meet requirements for shared loss rates (ranging from 30-75%) and loss limits (ranging from 5-15%).</td>
<td>Medicare ACO</td>
</tr>
<tr>
<td>Massachusetts ACO Model B (Primary care ACO)(^{73})</td>
<td>![?] (Unsure) Requires providers to report on participants’ EHR capabilities and plans for increasing rates of EHR adoption/Health Information Exchange (HIE) usage.</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> Requires ACOs to report on 38 quality measures and to meet a minimum quality score to share in savings; also can reduce shared losses by up to 20% through strong quality performance.</td>
<td>![?] (Unsure) ACOs that achieve savings target can receive shared savings; ACOs that exceed targets are required to make shared loss payments. Payment amounts depend on ACO’s chosen risk track.</td>
<td>Medicaid ACO</td>
</tr>
<tr>
<td>MaineCare Accountable Communities Initiative Model II(^{75}), (^{76})</td>
<td>![?] (Unsure) Unknown</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> AC lead entities are evaluated on 28 quality measures. AC lead entities can share savings up to 60%, based their aggregate quality score.</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> AC lead entities are accountable for downside risk beginning in second performance year. The shared loss rate is 40-60% and the loss limit is 5% in year 2 and 10% in year 3 and beyond.</td>
<td>Medicaid ACO</td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+)(^{77}), (^{78})</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> All practices are required to adopt CEHRT.</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> Practices receive prospective performance-based incentive payments (PBIP) based half on quality and half on utilization measures; CMS retrospectively calculates the amount of PBIP a practice can keep, based on their performance.</td>
<td><img src="https://example.com/checkmark.png" alt="✓" /> Practices are “at risk” for returning up to the full amount of the prepaid PBIP to CMS if they do not meet minimum quality benchmarks.</td>
<td>Medicare PCMH</td>
</tr>
</tbody>
</table>
Alternative payment models in Medicaid: Could MACRA be a catalyst for states’ value-based care efforts?

Figure 9 cont.

<table>
<thead>
<tr>
<th>APM</th>
<th>Criterion 1: EHR use</th>
<th>Criterion 2: Quality measures</th>
<th>Criterion 3: Financial risk</th>
<th>Model type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan SIM PCMH initiative</td>
<td>Requires practices to have CEHRT, meet state 1 meaningful use requirements, and connect to HIE.</td>
<td>Requires practices to report on quality and utilization measures; must be accredited as PCMH by an approved entity (e.g., NCQA, BCBSM) in to receive PMPM payments.</td>
<td>N/A</td>
<td>Medicaid PCMH</td>
</tr>
<tr>
<td>Comprehensive Care for Joint Replacement (CJR) Model</td>
<td>Requires track 1 participants to meet CEHRT requirements.</td>
<td>Requires hospitals to meet quality requirements (and meet certain savings targets) to receive reconciliation payments.</td>
<td>Sets target spending levels prospectively and requires hospitals to share in savings or losses, which are calculated by CMS retrospectively.</td>
<td>Medicare EOC</td>
</tr>
<tr>
<td>Arkansas Payment Improvement Initiative (APII) Episodes of Care</td>
<td>No requirements in EOC model; however, APII also includes PCMH initiative which has EHR component.</td>
<td>Evaluates principal accountable providers (PAPs) based on their performance on four quality/utilization measures and requires PAPs to meet certain quality standards to be eligible to share savings with payer.</td>
<td>?</td>
<td>Medicaid EOC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

All of the Medicaid APMs analyzed base payment on evidence-based, reliable, and valid quality measures comparable to those used in MIPS. Both of the Medicaid ACO models and Arkansas’ EOC payment model include a shared savings and shared risk component; however it is unclear whether Massachusetts’ and Arkansas’ initiatives would meet the advanced APM nominal risk criteria. Michigan’s Medicaid PCMH initiative does not require participating practices to bear financial risk; however, the state has said it plans to move towards a risk-bearing model in the future. The results of NAMD’s Medicaid APM survey similarly suggest that many of the Medicaid APM models in place today would need to evolve to meet the QPP advanced APM financial risk criteria. Most of the Medicaid initiatives analyzed encourage use of EHRs but few had explicit meaningful use requirements or thresholds as required for advanced APMs.
Stakeholder considerations

States

- State Medicaid agencies can promote VBC initiatives by entering into APM arrangements with Medicaid providers and/or promoting APMs within their managed care contracts. States will likely have to realistically assess the capacity of providers and health plans to participate in APMs as well as their own ability to administer or oversee such initiatives when designing program/contract requirements.
- State Medicaid agencies need to be able to access, aggregate, and analyze different types of data (e.g., claims data, encounter data, clinical data) to help effectively administer APMs and hold providers/plans accountable for quality and cost outcomes. States looking to implement new APMs may need to invest in upgrading their enterprise data systems and developing/acquiring new data analytics solutions.
- To the extent possible, state Medicaid agencies should seek alignment between Medicaid APMs and other payer initiatives to help maximize program impact, reduce burdens, and increase incentives for providers. State Medicaid agencies might consider participating in CMS-led multi-payer initiatives like CPC+ (or requiring their MCOs to participate) if such programs are consistent with their program goals.
- State Medicaid agencies can voluntarily submit information about Medicaid APMs to CMS to determine whether those models meet the criteria for other-payer advanced APMs under MACRA. The submission deadline for the first year of the all-payer combination option is April 2018, which means states have limited time to implement/update model requirements to align with MACRA and prepare information for CMS.
- State Medicaid agencies should consider federal requirements and whether or not they need to submit or renew a waiver to implement APM initiatives. The new administration may interpret statutory requirements differently than its predecessor, which could create new opportunities or challenges for states seeking to implement APMs or expand existing initiatives.

Health plans

- Health plans could benefit from monitoring changes to Medicaid MCO contract requirements, including those related to APM adoption. MCOs with APM experience may have a competitive advantage when bidding on state contracts; conversely, MCOs that lack the capacity to implement APMs may be at risk of losing Medicaid business.
- Health plans may be able to design their own Medicaid APMs or influence the design of state-led APM initiatives. In some cases, MCOs may be able to share Medicaid APM savings with the state.
- Medicaid managed care plans that operate APMs and want to have their models qualify as an other-payer advanced APM for MACRA purposes will likely have to work with their state Medicaid agency to receive a determination from CMS. One reason Medicaid plans may want to do this is to help their network providers potentially receive greater Medicare payments.
- Medicaid initiatives may create new business opportunities for health plans that can provide critical infrastructure and/or analytic support to administer APMs.
Alternative payment models in Medicaid: Could MACRA be a catalyst for states’ value-based care efforts?

Providers

- Many states and Medicaid health plans are eagerly pursuing value-based contracts with providers, which can present new opportunities and challenges. Health systems, hospitals, and clinicians should perform an impact assessment to understand how different models might affect their revenue, relationships with other providers, patient engagement strategy, and competitive position so they can make tactical decisions about which APM(s) to pursue.

- Provider organizations should evaluate their capacity to participate in APMs, including technology and analytic infrastructure and readiness to accept financial risk. The ability to aggregate, analyze, and share data can be essential to identify high-needs, high-risk patients, coordinate care, report on quality measures, and track spending. Organizations may need to invest in new technology, staff, or training to successfully participate in new APM arrangements.

- Health systems and large provider organizations may be able to leverage their market power to promote payer participation in multi-payer APMs and/or promote alignment among different APM models.

- Medicaid clinicians who also see Medicare patients will likely need to determine whether they are subject to MIPS reporting or qualify for MACRA’s advanced APM track. CMS plans to conduct QP determinations under the all-payer combination option at the individual clinician level; therefore, clinicians or the APM entity they are part of will need to submit information to CMS for their participation in an other-payer APM to count.86

- MACRA established the physician-focused Payment Model Technical Advisory Committee (PTAC) to review and consult on innovative payment models to be considered APMs under MACRA’s Quality Payment Program. PTAC may be a gateway to allow greater specialist participation in future APMs.

The potential impact of Medicaid APMs on care delivery can depend considerably on how much of a provider’s revenue comes from Medicaid. Alignment with other payers may be necessary to effectively support and incentivize providers to participate in APMs.
Alternative payment models in Medicaid: Could MACRA be a catalyst for states' value-based care efforts?

Endnotes


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