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Evaluating Medicaid value-based care models

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Introduction

The Medicaid Program is the United States' largest health insurance program—covering one in five Americans.[1] Medicaid operates as a federal and state partnership, with each state permitted to develop its own Medicaid program and seek waivers within a larger federal framework. As a result, the Medicaid program varies by jurisdiction. Policymakers at both the federal and state levels have sought to incorporate value-based purchasing and system delivery initiatives that have been implemented in other health care contexts into the Medicaid program.[2]

The Medicaid program has undergone important changes in recent years. During the COVID-19 pandemic, the federal government offered enhanced funding to keep beneficiaries enrolled in Medicaid, which led to a large increase in the size of the national Medicaid programs. This "continuous enrollment" provision ended in 2023. In response, state Medicaid programs disenrolled millions of beneficiaries. In addition, Medicaid enrollment has historically been subject to "churn" as patients gain or lose Medicaid eligibility due to factors like changes in income. Shifts in Medicaid enrollment have important implications for value-based care models in terms of ongoing patient engagement and coordination, attribution, calculation of baseline spend and expenses, and accountability for outcomes.

During the same period, the Centers for Medicare & Medicaid Services (CMS) has become increasingly focused on the importance of health equity. As the primary governmental health financing program available to low-income Americans, Medicaid is an important tool to address health disparities and promote health equity. CMS has produced a significant amount of guidance to integrate health equity considerations into Medicaid payment and to help Medicaid programs and providers use Medicaid funds to address social determinants of health. These additional interventions can impact value-based models in several ways, including by impacting cost and quality calculations and by giving providers new tools to advance the triple aim. CMS also announced a formal Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model to help align Medicare and Medicaid value-based payment strategies.

Finally, there has been increasing focus on the significant role of the Medicaid program in covering certain health conditions. For example, Medicaid is the nation's largest payer for behavioral health care.[3] Medicaid also plays a critical role in maternal and infant health and pediatric care.[4] As a result, states have developed targeted value-based models that may create unique opportunities to care for these populations.

This document is intended to (1) provide an overview of some of the value-based care programs currently operating in state Medicaid programs, (2) offer practical guidance regarding the evaluation of and participation in these programs, and (3) allow physicians to identify key elements of these programs that will impact clinical practice. Given the ongoing disruption and innovation occurring in federal and state Medicaid policy, it is especially important for practices that serve Medicaid beneficiaries to understand their value-based care options.

1. Henry J. Kaiser Family Foundation, *10 Things to Know about Medicaid: Setting the Facts Straight* (Apr. 12, 2018) https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/
2. Value-based payment mechanisms may be implemented in a variety of payment contexts, including fee-for-service and managed care. Value-based care programs established in managed care settings are subject to the additional requirements discussed below.
3. Medicaid and CHIP Payment and Access Commission, Behavioral Health in the Medicaid Program—People, Use, and Expenditures (June 2015), https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/
4. Medicaid and CHIP Payment and Access Commission, Medicaid's Role in Financing Maternity Care (January 2020), https://www.macpac.gov/publication/medicaids-role-in-financing-maternity-care/

New or modified value-based programs can create challenges for Medicaid providers. Medicaid reimbursement is already low, often not covering the full cost of care for beneficiaries. Value-based models often require additional, sometimes costly, administrative activities related to data reporting, care coordination, and interventions for social determinants.

Medicaid programs tend to use a combination of mechanisms to reward value, incorporating both payment and system delivery reforms. Delivery system reforms include patient-centered medical homes, health homes and accountable care organizations (ACOs), including models targeting total cost of care or certain specific conditions. On the payment side, Delivery System Reform Incentive Payments (DSRIP), pay-for-performance (sometimes called "P4P") measures, and shared savings programs are frequently combined with delivery system reforms. Less commonly, Medicaid programs may pay physicians on a capitated or partially capitated basis, requiring providers to take on risk.

Delivery system reforms

The first category of Medicaid value-based reforms relates to structural changes to the care delivery model itself. Although structural changes are often paired with one or more of the methods of payment reform described below, structural changes alone can impact how physicians interact with beneficiaries, refer patients to other providers, and coordinate care across the continuum. Examples of structural reforms include incentives to promote evidence-based care, facilitating care coordination, targeting social determinants of health. These goals may fall into a broad range of formal and informal payment models, including P4P, patient-centered medical homes (PCMH), bundled payments, Health Homes, shared savings models (including ACOs) and population-based payment models.

Medical homes

One common technique to promote value-based care in Medicaid is the "medical home" model. Many states have adopted patient-centered medical home (PCMH) models in which a physician practice (typically a primary care practice) takes responsibility for a patient's overall care, either by providing care directly or arranging a "virtual team" of specialists, acute care providers, and supportive care providers. State Medicaid programs often provide PCMHs that receive recognition by the National Committee on Quality Assurance (NCQA) with opportunities for additional funding to supplement traditional fee-for-service payment.

The Affordable Care Act (ACA) also authorized Health Homes, which involve a similar suite of coordinated services for patients with certain chronic health conditions (including certain mental health and substance use disorders, asthma, diabetes, heart disease and obesity) or have certain risks of developing such conditions. States that implement a Health Home program receive certain matching federal funding for the first eight quarters of their implementation.

Health Homes may be implemented alongside PCMH models. In most cases, both models offer additional compensation to providers in the form of capitated (per-member per-month) payments. However, some states also pay enhanced fee-for-service rates for activities like care coordination for the Health Home population. Both Health Homes and PCMH models may focus on specific health conditions (for example, behavioral health) or types of patients (for example, pediatrics) and may vary eligibility and payment rates BASED on factors like severity, geography and co-morbidities.

Examples

In recent years, anywhere from 25–30 states have operated PCMH models.[5] For example, New York has enacted a comprehensive PCMH model that builds on its prior experiments in this area. Primary care practices that participate in the program are required to pursue recognition from the NCQA and are eligible for "transformation" assistance and potential enhanced reimbursement.[6] Similarly, Wyoming participates in an NCQA-driven PCMH program, where practices can earn additional payments if specific "core medical home" services are furnished.[7] Colorado, Ohio, New Mexico, Pennsylvania, Wisconsin, Oregon and many other states have implemented similar models.[8]

Key issues

Determine available medical home models and eligibility. If you're a primary care provider in a state that has adopted a medical home model, determine whether you're eligible to participate. If so, pay particular attention to the covered conditions, quality, care management and other standards your practice will need to satisfy to qualify for a medical home model in your state. The NCQA recognition standards are a good place to start (and may be a prerequisite to payment).[9]

Evaluate financial impact. Though many medical home models offer additional compensation to practices that are NCQA-certified PCMHs, this recognition and reimbursement requires meeting a number of specific care coordination, quality and other requirements. Practices may be required to make additional investments to qualify, so they must consider whether the financial benefits of PCMH status will outweigh the extra resources needed to meet these requirements. In part this means evaluating whether your practice will need to grow or maintain a significant Medicaid population to support the investment.

For specialists. Determine how Health Home implementation will impact referral patterns and coordination obligations. As CMS and states are increasingly focused on ways to engage specialists in value-based care, there may be opportunities to partner with primary care PCMH or Health Home programs.

Structure matters. Physicians who desire to participate in medical home models need to understand if this complex patient population can be appropriately served, and whether quality, efficiency and other targets can be met with existing resources.

Quality and reporting is key. Medical home models require significant data collection and reporting to retain CMS, state and NCQA approval. Practice patterns and operations should be aligned with reporting requirements for medical home success.

5. See Henry J. Kaiser Family Foundation, *States that Reported Patient Centered Medical Homes In Place* (accessed June 2024), https://www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place/.
6. A number of provider reference guides and toolkits are available; see N.Y. DEP'T OF HEALTH, New York State Patient Centered Medical Home (NYS PCMH) (last accessed June 30, 2024) https://www.health.ny.gov/technology!innovation_plan_initiative/pcmh.
7. Detailed information regarding the Wyoming Medicaid PCMH Program is available at https://health.wyo.gov/healthcarefin/medicaid/pcmh/.
8. Primary Care Collaborative, *Primary Care Innovations and PCMH Map*, https://thepcc.org/initiatives. See also Henry J. Kaiser Family Foundation, *Mapping Medicaid Managed Care Models & Delivery System and Payment Reform* (March 6, 2023), https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/.
9. See National Committee For Quality Assurance, Patient-Centered Medical Home (PCMH) (last visited June 30, 2024) https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/. Your state may also have specific resources available to encourage PCMH transitions.

Medicaid ACOs

ACOs are a hybrid of system and payment reforms that organize care delivery and reimbursement through established entities responsible for coordinating provider efforts. Individual providers, payers or other entities that allow providers to collaborate with one another across the continuum of care may sponsor ACO entities. In the Medicaid context, the term "ACO" is used as a general term for organizations that are responsible for such care management, and their structure or methods may not reflect other ACO models, such as an entity participating in the Medicare Shared Savings Program.[10]

Examples

Most states that utilize ACOs for Medicaid rely on a provider-led system, though other states utilize regional accountable care entities (e.g., Colorado) or other structures.[11] Most have also moved toward a shared savings payment model and may encourage providers to take on risk, though most states continue to allow "upside-only" shared savings opportunities without risk.[12] Quality measures are also important in nearly all models.[13]

Key issues

Affiliation strategies. ACO structures often require significant time, energy and resources to develop. Independent physicians may need to seek out appropriate partnerships to participate fully in ACO models.

Medicaid payment reforms

The second broad category of policy reforms centers on changes to Medicaid payment models. Examples of these reforms include Delivery System Reform Incentive Payments (DSRIP), P4P programs and shared savings programs, all of which are discussed in more detail below. For physicians, success in these programs may require strategic planning to achieve specific and identifiable quality or efficiency metrics. Achieving results may also require rethinking old practiceS and/or referral and treatment patterns, as well as internal practice operations.

10. For example, states like Colorado and Washington have implemented regional accountable care entities (called RCCOs in Colorado and Accountable Communities of Health in Washington) that are not necessarily tied to specific providers.
11. Henry J. Kaiser Family Foundation, Mapping Medicaid Managed Care Models & Delivery System and Payment Reform (March 6, 2023), https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/; Colorado Dep't Of *Health Care Policy & Financing, Accountable Care Collaborative*, (last visited June 30, 2024) https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative. Note that Colorado has announced "Phase III" of its ACC initiative, to take effect in 2025.
12. CMS Medicaid Innovation Accelerator Program, Considerations for Implementing Downside Risk in Medicaid: Accountable Care Organizations (March 2021), https://www.medicaid.gov/resources-for-states/downloads/iap-vbp-consi-impl-downside-risk-medi-acc.pdf
13. Center For Health Care Strategies, Inc., *Medicaid Accountable Care Organization Programs: State Profiles*, 4 (Oct. 2015), available at http://www.chcs.org/media/Medicaid-Accountable-Care-Organization-Programs-State-Profiles.pdf.

Delivery system reform incentive payments

Under the federal-state Medicaid framework, states may design a Medicaid program tailored to their state's particular needs. States must request certain waivers of federal requirements in order to implement new reforms. As part of these waiver programs, states are able to structure DSRIP programs that target state-specific quality or other issues. Like ACOs, DSRIP programs combine care delivery models with targeted payment initiatives to encourage systemic change in the way Medicaid beneficiaries receive care. Given their outsized impact on Medicaid beneficiary costs, DSRIP programs tend to target larger institutional providers.

Examples

Kansas' DSRIP program is an example of how states use these initiatives to improve care for their Medicaid beneficiaries. Kansas' program is targeted at two major providers within the state, each of which has developed specific initiatives to improve care. One facility focuses on specific clinical initiatives (e.g., improving sepsis outcomes), while the other is implementing structural change—expanded use of a unique PCMH model.[14] The Arizona DSRIP program targets specific patient populations, including Indian Health Service beneficiaries, individuals transitioning from incarceration, and adults and children with behavioral health needs.[15] Washington's recently renewed Medicaid demonstration waiver contains multiple DSRIP components, including payments to its regional ACO entities and to the state's managed care organizations.[16] New York's DSRIP program, begun in 2014, aims to reduce avoidable hospital use by 25% as well as fundamentally restructure the health care delivery system.[17] Over the past four years, several billion dollars have been allocated to this program, with payouts based upon achieving predefined results in system transformation, clinical management, and population health.[18]

Key issues

Impact to affiliations. If your practice is already affiliated with a large health care provider, you may already be (knowingly or not) participating in a DSRIP program. For independent practices, DSRIP programs may impact how your practice interacts with these providers, as there are specific quality and other performance improvement goals that must be satisfied.

Pay-for-performance

Formal P4P plans offer financial incentives or penalties based on a provider's performance under quality metrics or their improvement in performance over time.[19] If you are employed by a large health system, are involved in a co-management relationship, or participate in an ACO, you're likely already familiar with how these programs work. At a high level, P4P programs seek to incentivize the achievement of various quality or efficiency measures and pay for that achievement either by offering funds from a pool of bonus money or by withholding a portion

14. See KANCARE, Delivery System Reform Incentive Payment (last visited June 30, 20)24 available at https://www.kancare.ks.gov/home/showpublisheddocument/1996/638476545201500000.
15. Arizona Health Care Cost Containment System, *Delivery System Reform Incentive Payment* (last visited June 30, 2024) https://www.azahcccs.gov/AHCCCS/Initiatives/DSRIP/.
16. Washington State Health Care Authority, Medicaid Transformation Project (MTP) (last visited July 1, 2024), https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp
17. New York Department Of Health, *DSRIP Frequently Asked Questions* (last visited June 30, 2024). https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/dsrip_faq/index.htm.
18. *Id.*
19. Urban Institute, *Payment Methods and Benefit Designs: How They Work and How they Work Together to Improve Health Care*, (Apr. 2016) available at https://www.urban.org/sites/default/files/publication/80301/2000776-Payment-Methods-How-They-Work.pdf.

of the provider's pay until the provider achieves certain requirements. See the American Medical Association's "Evaluating Pay-for-Performance Contracts" resource for additional information about P4P programs and opportunities.

Examples

States that make use of P4P models typically do so in addition to other primary payment models. Wisconsin, for example, applies P4P programs to acute care, children's and rehabilitation hospitals and offers a distinct P4P incentive for hitting Health Information Exchange goals.[20] Florida has introduced a P4P plan, the Florida Medicaid Medical Assistance Physician Incentive Program (MPIP), for physicians, including pediatricians and OB/GYNs, through their Patient-Centered Medical Home.[21] Several other states created P4P programs based on factors including patient satisfaction, implementation of best practices, participation in state data collection activities and achieving quality goals.[22]

Key issues

Balancing performance and patient care. P4P programs may unintentionally emphasize certain metrics that are not necessarily tied to optimal health outcomes, for example, certain metrics of patient satisfaction.[23] Watch for metrics that are not meaningful to your practice and engage (when possible) with payers or other stakeholders to avoid or mitigate potential issues.

Meeting expectations. P4P measures are the most common mechanism used in value-based payment programs, not just for Medicaid but across all types of payers. As a result, physicians are often subject to more than one set of performance measures that may or may not conflict with one another.

Shared savings

Under shared saving programs, providers are offered the opportunity (through a formal structure like an ACO or independently) to earn a portion of the savings realized by the Medicaid program as a result of high-quality and cost-efficient care. Consider two general categories: (1) comprehensive shared savings arrangements where providers are held accountable for financial performance and (2) episodic or bundled payments.

Shared savings: Provider accountability

Some shared savings programs take a broad look at the cost of furnishing services to Medicaid beneficiaries across the full continuum of care. These initiatives may include only the possibility for upside benefits or may require providers to assume some risk themselves—meaning the provider incurs penalties if the cost of care exceeds certain thresholds.[24] Given the broad scope of these programs, it may be difficult for small institutions or independent providers to

20. ForwardHealth of Wisconsin, *Wisconsin Medicaid Hospital Quality Pay-for-Performance (P4P) Program*, https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/hospital/resources_01.htm.spage.
21. Florida Agency For Health Care Administration, *MMA Physician Incentive Program (MPIP)* available at https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/mma-physician-incentive-program-mpip.
22. Commonwealth Fund, *Medicaid Pay-for-Performance: Ongoing Challenges, New Opportunities*, https://www.commonwealthfund.org/publications/newsletter-article/medicaid-pay-performance-ongoing-challenges-new-opportunities
23. See, e.g., Alexandra Robbins, The Atlantic, *The Problem with Satisfied Patients* (Apr. 17, 2015) available at https://www.theatlantic.com/health/archive/2015/04/the-problem-with-satisfied-patients/390684/.
24. Rachel Matulis, Center For Health Care Strategies, Inc., *The Evolution of Shared Savings Payment Methodologies for Medicaid Accountable Care Organizations* (July 28, 2017) https://www.chcs.org/evolution-shared-savings-payment-methodologies-medicaid-accountable-care-organizations/.

effectively participate unless they affiliate with a larger organization (e.g., a regional accountable care program).

Examples

Maine's Accountable Communities Program allows provider-led ACOs to choose between two shared savings models, one with downside risk and one without.[25] Massachusetts also provides for two shared savings models, which both carry downside risk and include quality measures.[26]

Key issues

Know your neighbors. In broad-based shared savings programs, physician performance is not only impacted by your own practice performance, but by the performance of participants upstream and downstream to you who are furnishing other types of care. Be selective in whom you partner with to ensure your patients receive care from providers that have similar incentives and capabilities to your own to produce high-quality (and efficient) care.

Help out. Broad-based shared savings programs are an excellent opportunity for physician involvement and leadership in reducing the cost of care. Partnering with your health system affiliates (through P4P arrangements, co-management relationships or other structures) can improve care for patients and the performance of all parties involved.

Episode of care and population-specific models

Episode of care payment models focus on improving quality and efficiency within a defined service or care episode. For example, a Medicaid program might develop a bundled payment for a specific surgical procedure (like a joint replacement) or prenatal health services. Providers receive a flat bundled payment for a comprehensive episode of care related to that specific service. If the provider manages the patient's care well and is able to perform the full service for less than the bundled rate, the provider realizes the upside of any savings. If the cost of care exceeds the bundled rate, no additional reimbursement from the Medicaid program is available. Episode of care models offer an opportunity for increased margin, but only if the necessary processes and structures are in place to deliver efficient, high-quality care.

In addition, Medicaid coverage is uniquely prominent in some clinical areas. For example, Medicaid covers a large amount of care related to behavioral health, pregnancy and childbirth, and pediatric care. States have developed various innovative models to target improved and more efficient care for these populations and conditions.

Examples

Several state Medicaid programs utilize episode of care payments.[27] Arkansas and Tennessee have implemented programs with defined episodes for prenatal care, asthma episodes and joint

25. Maine Dep't of Health & Human Svcs., Accountable Communities , https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities
26. Massachusetts Dep't Of Health & Human Svcs., *MassHealth Partners with 18 Health Care Organizations to Improve Health Care Outcomes for Members*, (June 8, 2017) http://www. mass.gov/eohhs/gov/newsroom/press-releases/eo-hhs/masshealth-partners-with-18-health-care-organizations.html.
27. Henry J. Kaiser Family Foundation, Mapping Medicaid Managed Care Models & Delivery System and Payment Reform (March 6, 2023), https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/.

replacement.[28] In both states, a "Principal Account Provider" is the "quarterback," responsible for the quality and cost of the patient's care throughout the episode.[29] The Principal Account Provider ensures all providers tied to the patient's episode meet set quality metrics—some of these metrics are required as a basic level of care, and some are tied to gain-share incentives.[30] A number of states already offer or are planning to offer episodes of care as an option for managed care organizations (MCOs) to utilize.[31] Minnesota has developed "baskets" of care, which are similar to episodes.[32]

States have also developed condition-specific value-based payment models. Louisiana developed a model in which a percentage of MCO reimbursement was withheld, conditioned on meeting certain quality goals related to reducing preterm births.[33] Arkansas developed a combination of P4P incentives, episode of care payments for delivery and postpartum care, and infant and pediatric medical homes.[34] Texas developed a set of dental management organizations that were eligible to receive special Medicaid pay-for-performance bonuses for implementing timeline pediatric dental interventions.[35]

Key issues

Identify appropriate structures. Managing patient care for defined episodes requires careful coordination between many types of providers.

Pay attention to quality. Cost is not the only consideration in managing episodes of care. These programs also require providers to hit specific quality thresholds to ensure patient care doesn't suffer in the name of efficiency.

Understand opportunity. Medicaid may offer opportunities to engage in value-based efforts that are not always prioritized in Medicare or commercial markets. Physicians should be aware that there may be unique models that may give them additional contracting opportunities. Medicaid programs may also be putting new quality-based pressure on MCOs to improve certain outcomes, which may put physicians and other clinicians with relevant skills at an advantage.

28. Arkansas Health Care Payment Improvement Initiative, *Episodes of Care Provider Manual* (last visited June 15, 2018) available at https://www.google.com/search?q=Arkansas+Health+Care+Payment+Improvement+Initiative%2C+Episodes+of+Care+Provider+Manua&rlz=1C1GCEB_enUS921US921&oq=Arkansas+Health+Care+Payment+Improvement+Initiative%2C+Episodes+of+Care+Provider+Manua&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBBzI5MWowajeoAgCwAgA&sourceid=chrome&ie=UTF-8; TennCare, Episodes by Wave (last visited June 15, 2018) https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html.
29. Tennessee Div. of Health Care Fin. & Admin., *Executive Summary*: Perinatal Episode (Jan. 12, 2017) https://www.tn.gov/content/dam/tn/tenncare/documents2/PERISumm.pdf.
30 Episodes of Care Provider Manual, *supra* note 38; Perinatal Episode, supra note 39.
31. *See* Change Healthcare, Value-Based Care in America: State-by-State (2017), https://www.changehealthcare.com/insights/value-based-reimbursement-by-state. ("Value-Based Reimbursement State-by-State"). .
32 *Id.*
33. CMS Medicaid Innovation Accelerator Program, Medicaid Value-Based Payment, Approaches for Maternal and Infant Health (November 2, 2017), https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/vbp-mihi-webinar.pdf
34. *Id.*
35. CMS Medicaid Innovation Accelerator Program, Medicaid Value-Based Payment, Approaches for Children's Oral Health (October 19, 2017), https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/vbp-oral-health-webinar.pdf

Other value-based payment issues

Value-based reimbursement for Medicaid managed care

A majority of Medicaid beneficiaries receive some or all of their care through a capitated reimbursement model furnished by a Medicaid managed care organization (MCO).[36] Nearly all Medicaid programs offer some services to beneficiaries through a MCO, but federal law generally prohibits state Medicaid programs from directing specific pass-through payments to providers.[37] A pass-through payment is any amount required by the state to be added to contracted payment rates between an MCO and a physician that is not generally for services, graduate medical education or wrap-around payments made to Federally Qualified Health Centers and Rural Health Clinics.

The prohibition against pass-through payments includes an exception for states that require MCOs to implement value-based purchasing models to pay physicians or other providers as long as they (1) are connected to utilization of services, (2) treat all providers in a class in the same fashion, (3) are expected to and measurably advance goals and objectives of the state's required quality strategy and (4) are approved by CMS in advance.[38] Approved pass-through payments, even for value-based reimbursement strategies, may not be renewed automatically.

Alternatively, some states use withholding or "non-payment" policies to encourage MCOs to adopt value-based models. For example, a state may hold back a portion of the payer's capitated funding until the payer demonstrates its network meets certain goals (including making a certain percentage of payment through value-based models or hitting certain quality goals). Alternatively, a Medicaid program may publicly state it will not pay for certain practices that are associated with lower-quality care. These techniques allow Medicaid programs to promote increased value without requiring a "pass-through" with regulatory implications.

Because advance approval and periodic renewals from CMS are required for such payments as part of the rate approval process, physicians have an opportunity to monitor and potentially participate in developing value-based reimbursement strategies prior to approval or renewal. Advance review of quality goals and metrics permits providers to work with state Medicaid programs to anticipate and overcome misplaced or ineffective measures that could cost physicians value-based reimbursement amounts and defeat the state's quality strategy.

In addition to development and oversight of pass-through payments to introduce value-based reimbursement to MCO arrangements, some states are simply directing MCO vendors to include value-based reimbursement in their payment methodologies.

CMS Innovation Center state-focused models

The Center for Medicare and Medicaid Innovation ("CMMI"), also known as the CMS Innovation Center, proposes and evaluates alternative reimbursement and service delivery models across

36. Henry J. Kaiser Family Foundation, *Medicaid Managed Care Tracker* (last visited June 14, 2018) available at https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/.
37. 42 C.F.R. § 438.6(c).
38. 42 C.F.R. § 438.6(c)(2).

government and commercial health care payers. The center previously supported state-level innovation through State Innovation Model ("SIM") grants, which have since expired. The center created the new Advancing All-Payer Health Equity and Development (AHEAD) model, which will provide support for up to eight all-payer state value-based payment initiatives from 2026–2034.

SIM grants were awarded to over 30 states and territories in two cohorts. They were designed to promote value-based reimbursement and system redesign approaches incorporating Medicare and Medicaid populations (and, eventually, other kinds of payers, including state employee insurance programs and commercial health insurance).[39]

The AHEAD model will create a new funding opportunity to achieve similar goals, with additional refinements based on CMS's experience with statewide payment reform models like those implemented in Maryland, Vermont and Pennsylvania. The model uses a combination of approaches to incentivize management of the total cost of care across all payers in a state (or a region of a state). Participating states will be eligible for additional funding from the CMS Innovation Center, but they will be required to implement hospital global budgets and coordinate with CMS to offer additional funding for primary care management. States will also be required to develop a formal health equity plan and implement certain social risk adjustments.

States must apply for the AHEAD model in 2024. However, states will develop the terms of the model during a "Pre-Implementation" period that, in some cases, extends through 2026. As a result, if a state is accepted into the AHEAD Model grant, physicians will have an opportunity to work closely with the state to develop the specific terms of their model. Because the AHEAD model mandates use of hospital global budgets and includes goals related to controlling total cost of care, it is likely to create new incentives for hospitals and state Medicaid agencies to work closely with physicians to develop new kinds of financial arrangements.

Social determinant of health interventions

In recent years, CMS has become increasingly focused on strategies to tackle social determinants of health (SDoH). Non-clinical factors like housing, education, access to food, and interaction with the criminal justice system can have important implications for health care outcomes and costs.

As the nation's primary insurer for low-income people, Medicaid serves many patients encountering social factors that negatively impact their health. However, federal law previously placed tight limits on states' use of Medicaid funding to pay for social interventions like housing or nutrition. As CMS has increasingly focused on opportunities to address social determinants, it has revised its positions to loosen restrictions on Medicaid spending to address social determinants.

CMS has especially focused on opportunities to permit MCOs to pay for other kinds of benefits. For example, CMS has issued rulemaking clarifying that MCOs can provide benefits like housing or in-home visits "in lieu of" other covered services or on a voluntary "value added" basis not directly reimbursed by federal Medicaid funds.[40] States also sometimes integrated SDoH requirements into their MCO agreements (imposing requirements like screening for specific conditions or social factors, partnering with social service referral agencies, implementing ICD "Z-codes" for SDoH, or

39. See The Henry J. Kaiser Commission, *The State Innovation Models (SIM) Program: An Overview* (Dec. 9, 2017) https://www.kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/.; See also https://www.cms.gov/priorities/innovation/innovation-models/state-innovations
40. See 89 FR 41002, 41140 (May 10, 2024). See also id. at 41133 (covering value-added services).

covering Community Health Workers).[41] CMS has helpfully created a tool summarizing the various authorities that permit spending on various health-related social needs (HRSNs).[42]

It is important for physicians to understand whether their state has permitted (or is requiring) MCOs to pay for social determinant interventions. If an MCO has a financial incentive to improve data collection or screening, it may be willing to offer support to help practices increase their appropriate screening rates. If physicians are at risk (for example, through a sub-capitation arrangement), they should understand their options to refer patients to social determinant interventions that may prove to be effective compared to hospital or specialty care. Alternatively, in more complex arrangements like ACOs, physicians may be able to work with hospitals, social service agencies, and other partners to develop formal administrative and financial models to improve access to social determinant interventions.

Conclusion

The popularity of value-based care in the Medicaid program continues to increase across the country and will only continue to grow as more states develop waiver programs to match their beneficiaries' needs. These care delivery and payment reforms offer the opportunity for improved practice management, increased collaboration with other providers, and enhanced reimbursement. Investing in data tracking and management tools and other practice operational improvements today can contribute to long-term improvements as participation in value-based programs increases.

41. Henry J. Kaiser Family Foundation, Medicaid Authorities and Options to Address Social Determinants of Health (January 29, 2024), https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/.
42. CMS, Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP), https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf .