



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 to the Medicaid program.²

This document is intended to (1) provide an overview of some of the value-based programs currently operating in state Medicaid programs, (2) offer practical guidance regarding evaluation of and participation in these programs, and (3) allow physicians to identify key elements of these programs that will impact clinical practice. Significant changes are currently occurring at many state Medicaid programs, particularly with respect to payment. Understanding these changes is especially important for practices that serve Medicaid beneficiaries.

Navigating new programs can be a challenge. Medicaid reimbursement is already low, often not covering the full cost of care for beneficiaries. Now, many states are levying new accountability, efficiency, and quality requirements. Managing these requirements effectively is key to the sustainability of practices serving Medicaid beneficiaries, particularly in states that have expanded Medicaid eligibility under the Affordable Care Act (“ACA”).

In Medicaid, the mechanisms to pay for value are typically a combination of payment and system delivery reforms. Care delivery system reforms include patient-centered medical homes, health homes and Accountable Care Organizations (“ACOs”), (loosely described). On the payment side, Delivery System Reform Incentive Payments (“DSRIP”), pay-for-performance measures, and shared savings programs are frequently combined with care delivery reforms.

- 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-setting-the-facts-straight/>.
- 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.

System Delivery 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 Medicaid patient-centered medical homes (“PCMH”), Health Homes, and ACOs.

Patient-Centered Medical Homes

The PCMH model is designed to improve the patient experience across the continuum of care by placing ongoing responsibility for patient care in the hands of a multidisciplinary team of professionals. PCMHs are intended to increase coordination of referrals for specialty services, improve access to and utilization of primary care, and encourage the effective management of beneficiaries with chronic conditions. Depending upon the state, PCMHs may receive additional reimbursement from the Medicaid program to manage these initiatives (in addition to standard fee-for-service reimbursement). Eligible providers may include physicians, advanced practice practitioners (depending on state scope of practice regulations and laws), rural health clinics, federally qualified health centers, and Indian Health Service providers.³

Examples

As many as eleven states have adopted a PCMH model, with additional states anticipating growth of these programs in the coming years.⁴ 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 National Committee for Quality Assurance (“NCQA”), and are eligible for no-cost “transformation” assistance and potential enhanced reimbursement.⁵ Similarly, Wyoming participates in an NCQA-driven

- 3 Provider eligibility may vary by state.
- 4 See Henry J. Kaiser Family Foundation, *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017* (Oct. 13, 2016) available at <https://www.kff.org/report-section/implementing-coverage-and-payment-initiatives-emerging-delivery-system-and-payment-reforms/> (the “KFF Report”).
- 5 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 14, 2018) https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/.

PCMH program, where practices can earn additional payments if specific “core medical home” services are furnished.⁶ Colorado, Ohio, New Mexico, Pennsylvania, Massachusetts, Rhode Island, and many other states have implemented similar models.⁷

Key Issues

- **Determine Eligibility for PCMH Status.** If you’re a primary care provider in a state that has adopted a PCMH model – determine whether you’re eligible to participate. If so, pay particular attention to the quality, care management, and other standards your practice will need to satisfy in order to qualify for PCMH in your state. The NCQA recognition standards are a good place to start.⁸
- **Evaluate Financial Impact.** Though many PCMH models offer additional compensation to practices that are recognized as PCMHs, this recognition and reimbursement comes at the cost of meeting a number of specific care coordination, quality, and other requirements. Consider whether the financial benefits of PCMH status will outweigh the extra resources needed to meet these requirements, and whether your practice will need to grow or maintain a significant Medicaid population if you participate.
- **For Specialists.** Determine how PCMH implementation will impact referral patterns, and coordinate closely with PCMH partners.

Health Homes

Health Homes are an expansion of the PCMH concept included in the ACA. In the states that continue using the Health Home model, participation offers physicians the opportunity for additional compensation for successful management of the most complex patients. These programs are distinguishable from PCMHs because Health Homes are specifically designed to target beneficiaries that: (1) have two or more chronic conditions, (2) have one chronic

6 Detailed information regarding the Wyoming Medicaid PCMH Program is available at <https://wymedicaid.portal.conduent.com/PCMH.html>.

7 KFF Report, Table 11; see, e.g., Ohio Dep’t of Health, *Patient Centered Medical Homes* (last visited June 14, 2018) <https://www.odh.ohio.gov/landing/medicalhomes/pcmh.aspx>.

8 See *National Committee For Quality Assurance, Patient-Centered Medical Home (PCMH) Recognition* (last visited June 14, 2018) <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>; your state may also have specific resources available to encourage PCMH transitions.

condition and are at risk for a second, or (3) have one serious and persistent mental health condition.⁹ Eligible providers include individual and group physician practices, rural health clinics, community health centers, and home health agencies.¹⁰ Health Home services include care management and coordination services, patient and family support, health promotion services, and coordination of referrals to community and social support.¹¹ Chronic diseases covered by a Health Home program may include mental health and substance use disorders, asthma, diabetes, heart disease, and obesity.¹² Health home programs require participating providers to meet specific qualification standards, and states are expected to implement processes to effectively monitor provider compliance.¹³

Examples

The popularity of Health Homes has waned over time. In FY 2015, 20 states had adopted some form of the Health Home model. By 2017, this number had dwindled to 7 states.¹⁴ Among states still participating, Health Homes are used to treat adults and children with a limited set of conditions (e.g., Tennessee, which covers severe mental illness)¹⁵ or a broader range (e.g., Washington, which covers a full list of conditions, including diabetes, cancer, heart disease, HIV/AIDS, and renal failure).¹⁶

Key Issues

- **Structure Matters.** As with PCMH models, physicians who desire to participate in a Health Home 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.

9 See *Centers For Medicare & Medicaid Services, State Medicaid Director Letter 10-024, 5* (Nov. 16, 2010) available at <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smdl10024.pdf>.

10 *Id.* at 7-8; states have additional flexibility to designate participating provider types through the State Plan Amendment process.

11 Center For Health Care Strategies, *Health Homes (Section 2703) Frequently Asked Questions* (Oct. 10, 2011) available at http://www.chcs.org/media/Health_Homes_FAQs_101211.pdf.

12 State Medicaid Director Letter 10-024, 5.

13 *Id.* at 9.

14 KFF Report at 7; Some states have taken formal health home concepts, however, and wrapped them into other Medicaid initiatives (e.g., 1115 Demonstration Projects).

15 More information on Tennessee’s program is available at <https://www.tn.gov/content/dam/tn/tennicare/documents2/HealthHome.pdf>.

16 The original CMS approval letter for Washington’s Health Home model is available at <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-08-Ltr.pdf>.

- **Quality and Reporting is Key.** Health Home models require significant data collection and reporting to retain CMS approval. Practice patterns and operations should be aligned with reporting requirements for Health Home success.

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 another entity that allows 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 align with the traditional understanding of what an ACO is – i.e., an entity that is built for participation in the Medicare Shared Savings Program.¹⁷

Examples

Most states that utilize ACOs for Medicaid rely on a provider-led system (seven of the eleven), though other states utilize regional accountable care entities (e.g., Colorado) or other structures.¹⁸ Most have also moved towards a shared savings payment model, increasingly encouraging providers to take on risk, though alternative tracks remain available in most states for entities unable or unwilling to manage the potential for downside risk.¹⁹ Quality measures are also important in nearly all models – Utah is the only one of the eleven states where quality measures do not impact payment.²⁰

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.

17 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.

18 Center For Health Care Strategies, Inc., *Medicaid ACOs: State Activity Map* (Feb. 2018) available at <https://www.chcs.org/resource/medicaid-aco-state-update/>; Colorado Dept Of Health Care Policy & Financing, *Accountable Care Collaborative*, (last visited June 14, 2018) <https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative>.

19 *Id.*

20 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>.

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), pay for performance programs and shared savings programs, each 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 practice and/or referral and treatment patterns, as well as internal practice operations.

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.²¹ 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.²² Washington’s recently approved Medicaid demonstration waiver contains multiple DSRIP components, including payments to

21 See KANCARE, *Delivery System Reform Incentive Payment* (last visited June 15, 2018) available at [http://www.kancare.ks.gov/docs/default-source/policies-and-reports/delivery-system-reform-incentive-payment-pool-\(dsrip\)/cms-approval/dsrip-approval-letter.pdf?sfvrsn=2](http://www.kancare.ks.gov/docs/default-source/policies-and-reports/delivery-system-reform-incentive-payment-pool-(dsrip)/cms-approval/dsrip-approval-letter.pdf?sfvrsn=2).

22 Arizona Health Care Cost Containment System, *Delivery System Reform Incentive Payment* (last visited June 15, 2018) <https://www.azahcccs.gov/AHCCCS/Initiatives/DSRIP/>.

its regional ACO entities and to the state's managed care organizations.²³ New York's DSRIP program, begun in 2014, aims to reduce avoidable hospital use by 25 percent as well as fundamentally restructure the health care delivery system.²⁴ 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.²⁵

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

Pay-for-performance ("P4P") plans offer financial incentives or penalties based on a provider's performance under quality metrics or their improvement in performance over time.²⁶ 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 of the provider's pay until performance can be measured. See the AMA's [Evaluating Pay-for-Performance Contracts](#) resource for additional information about P4P programs and opportunities.

23 CMS, Approval of Washington State Medicaid Transformation Project (Feb. 16, 2018) available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-medicaid-transformation-ca.pdf>.
24 New York Department Of Health, *DSRIP Frequently Asked Questions* (last visited August 16, 2018). https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/dsrip_faq/section2_faqs.htm#a.
25 *Id.*
26 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/09_pay_for_performance.pdf.

Examples

States that make use of P4P models typically do so in addition to other primary payment models. Wisconsin, for example, uses two different P4P programs for inpatient hospital services.²⁷ Florida has introduced a P4P plan, the Florida Medicaid Medical Assistance Physician Incentive Program (MPIP), for pediatricians and OB/GYNs through their Patient-Centered Medical Home.²⁸ Managed care organizations (MCOs) have also implemented pay-for-performance models under Arizona's program.²⁹

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.³⁰ 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.

27 Wisconsin Dep't Of Health Svcs., *Medicaid Reimbursement for Inpatient Hospital Services: Measurement Year 2017 Pay-for-Performance Program Updates* https://docs.legis.wisconsin.gov/code/register/2016/723A2/register/public_notices/medicaid_reimbursement_for_inpatient_hospital_services/medicaid_reimbursement_for_inpatient_hospital_services.
28 Florida Agency For Health Care Administration, *Comprehensive Quality Strategy 2017* (2017) available at https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf.
29 Change Healthcare, *Value-Based Reimbursement State-by-State* (2017) <http://mhsinfo3.mckesson.com/rs/834-UAW-463/images/Change%20Healthcare%20State-by-State%20VBR%20Study%202017%20report.pdf>.
30 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/>.

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.³¹ Given the broad scope of these programs, it may be difficult for small institutions or independent providers to 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.³² Massachusetts also provides for two shared savings models, which both carry downside risk and include quality measures.³³

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 pay-for-performance arrangements, co-management relationships, or other structures) can improve care for patients and the performance of all parties involved.

31 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/>.

32 Maine Dep’t of Health & Human Svcs., *MaineCare Accountable Communities 2016 Request for Applications*, available at <http://www.maine.gov/dhhs/oms/vbp/AC%20Documents/MaineCare%202016%20Accountable%20Communities%20Request%20for%20Applications.pdf>.

33 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/eohhs/masshealth-partners-with-18-health-care-organizations.html>.

Episode of Care Payments

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.

Examples

Several state Medicaid programs utilize episode of care payments.³⁴ Arkansas and Tennessee have implemented programs with defined episodes for prenatal care, asthma episodes, and joint replacement.³⁵ In both states, a “Principal Account Provider” is the “quarterback,” responsible for the quality and cost of the patient’s care throughout the episode.³⁶ 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.³⁷ A number of states already offer or are planning to offer episodes of care as an option for MCOs to utilize.³⁸ Minnesota has developed “baskets” of care, which are similar to episodes.³⁹

Key Issues

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

34 KFF Report, *supra* note 4.

35 Arkansas Health Care Payment Improvement Initiative, *Episodes of Care Provider Manual* (last visited June 15, 2018) available at <http://www.paymentinitiative.org/episodes-of-care>; TennCare, *Episodes by Wave* (last visited June 15, 2018) <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html>.

36 Tennessee Div. of Health Care Fin. & Admin., *Executive Summary: Perinatal Episode* (Jan. 12, 2017) <https://www.tn.gov/content/dam/tn/tenncare/documents/PerinatalSummaryVC3.0.pdf>.

37 *Episodes of Care Provider Manual*, *supra* note 33; *Perinatal Episode*, *supra* note 34.

38 See *Value-Based Reimbursement State-by-State*, *supra* note 27.

39 *Id.*

- **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.

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 ("MMCO").⁴⁰ Nearly all Medicaid programs offer some services to beneficiaries through a MMCO, but federal law generally prohibits state Medicaid programs from directing specific pass-through payments to providers.⁴¹ A pass-through payment is any amount required by the state to be added to contracted payment rates between an MMCO 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 MMCOs 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.⁴² Approved pass-through payments, even for value-based reimbursement strategies, may not be renewed automatically.

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 MMCO arrangements, some states are simply directing MMCO vendors to include value-based reimbursement in their payment methodologies.⁴³

State Innovation Model (SIM) Program

The Center for Medicare and Medicaid Innovation ("CMMI") proposes and evaluates alternative reimbursement and service delivery models across government and commercial health care payers. One such model is the State Innovation Model ("SIM"). SIM awards are awarded in phases and initially favored value-based reimbursement and system redesign approaches proposed in Medicare and Medicaid. SIM awards have expanded recently with provision of grants to states to design and/or test innovative payment and delivery systems across government and commercial health care payers including Medicare, Medicaid, state employee insurance programs and commercial health insurance.⁴⁴

The SIM model includes support for physician practice transformation to promote SIM goals. In some states practice transformation activities include direct assistance grants to physician practices to fund adoption of tools and service delivery models to promote innovation.⁴⁵ Other practice transformation activities provide assistance in gathering, storing and using patient data, support learning collaboratives among transforming practices, and direct training of physician practices.

Thirty-four states, three territories and the District of Columbia have received SIM grants. Physicians interested in system reform and transformation should engage with the administrator of the SIM grant(s) in their state. More state-specific information on SIM awards is available on the CMMI [website](#).

40 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/>.

41 42 C.F.R. § 438.6(c).

42 42 C.F.R. § 438.6(c)(2).

43 Including Arizona, Hawaii, Iowa, Maryland, Michigan, Nebraska, New Mexico, New York, Pennsylvania, Puerto Rico, South Carolina and Rhode Island. Value Based Reimbursement by State document.

44 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/>.

45 Colorado, Oregon and Vermont. CHCS, *Practice Transformation Assistance in State Innovation Models* (Apr. 2017) available at <https://www.chcs.org/resource/state-innovation-model-resources-for-states>.

Conclusion

The popularity of value-based care in the Medicaid program is surging 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.