APPENDIX K: VALUE BASED PURCHASING

On September 15, 2020, CMS issued guidance encouraging state Medicaid programs to adopt value-based care strategies and align provider incentives across their programs. The guidance promotes value-based healthcare as a mechanism to allow state Medicaid program to provide efficient, high-quality care while improving health outcomes, addressing Medicaid members social determinants of health, and decreasing disparities across the healthcare system. CMS did not announce any new payment models or funding opportunities but did highlight alternative payment methodologies including payment models built on fee-for-service systems, payments for episodes of care, and payment models for total cost of care accountability.

Under fee-for-service payment models the state pays providers on a fee-for-for service basis with shared saving payments (with upside and downside risk) where providers are required to meet quality and performance targets. Under episodes of care payment models the state pays providers under a bundled payment model for a set of services related to a single healthcare event during a defined period. Finally, under the total cost of care accountability model providers are held financially responsible for meeting quality and performance measures.[1]

Medicaid trends in value-based payments are moving towards the integration of physical and behavioral health to reduce costs. By integrating physical and behavioral health services, Medicaid programs can reduce unnecessary utilization of emergency department services and hospitalizations, improve medication adherence and chronic disease management, and better address the complex needs of individuals with co-occurring physical and behavioral health conditions. This, in turn, can lead to cost savings for both Medicaid programs and beneficiaries. This trend is supported by evidence showing that integrated care can improve health outcomes and reduce costs. Strategies for promoting the integration of physical and behavioral health care include payment and delivery system reforms with a focus on developing comprehensive approaches to care coordination, providing financial incentives for evidence-based practices, and using health information technology to facilitate communication and coordination between providers. [2]

Below are highlights of each comparison state's value-based care strategies.

- **Wyoming:** Wyoming Medicaid does not have a wide value-based care strategy across its services. In 2015, Wyoming Medicaid implemented a Patient Centered Medical Home (PCMH) that requires providers to commit to implement quality improvement metrics and a patient-centered approach to care. In 2023, approximately 114 providers participated in the PCMH model. [3]

[1] CMS, *"Value Based Care Opportunities in Medicaid,"* Available online: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf
[2] Medicaid, "Promoting Physical and Behavioral Health Integration in Medicaid Through Section 1115 Demonstrations," Available online: https://www.medicaid.gov/medicaid/downloads/promoting-pbhi.pdf
[3] Wyoming Department of Health, "Patient Centered Medical Home," Available online: https://health.wyo.gov/healthcarefin/medicaid/pcmh/

- **Colorado:** In 2011, Colorado Medicaid implemented an Accountable Care Collaborative (ACC) program that uses accountable care principals to connect Medicaid members to primary care. The program was expanded in 2018, with the creation seven Regional Accountable Entities (REAs) regions. The REAs implemented value-based payment and quality metrics to integrate behavioral health services and primacy care.
    - Colorado's most recent program, the Prescriber Tool APM, is an upside-risk-only pharmacy program that was launched October 2, 2023. The goal of this APM is to improve accessibility of prescription therapies for all Coloradans and reduce the cost burden of pharmaceutical spending on residents and payers. The APM will incentivize increased and consistent use of the Prescriber Tool, specifically the Real-Time Benefits Inquiry (RTBI) module, and prescription of preferred medications where clinically appropriate. While 100% of savings from the program will be shared with eligible providers for the first program year (concludes June 30, 2024), the amount distributed will be determined by provider preferred drug list compliance rate.[4]
    - Medicaid members are required to access most care through their REA. In each region, the RAEs' are responsible for ensuring Medicaid members have access to primary care and behavioral health services, coordinating members' care and meeting quality metrics.
    - REAs also manage payments for behavioral health services and pay primary care providers bonus payments to encourage value-based care.
    - Colorado seeks to have "fifty percent (50%) of Medicaid payments tied to value-based payment methodologies that move away from fee-for-service payment and towards Alternative Payment Models (APMs) that tie financial rewards to performance measures that achieve shared goals, like improving health, closing disparities, and/or improving health care affordability." Colorado's first APM (APM1) was implemented in 2016, for primary care providers who serve Medicaid Members. Primary care providers were given the opportunity to receive enhanced payment rates if specific quality metrics were met. APM2 went live on July 1, 2021. In APM2, primary care doctors are given the option to receive a percentage of their revenue as a fixed Per Member Per Month payment. This provides stability in revenue and allows for increased investments in improving care. Providers also have the opportunity to share in the savings that result from improved chronic care management by meeting quality thresholds.
    - On November 1, 2020, Colorado's Medicaid program implemented the Maternity Bundled Payment program. Bundled payments involve a "single, comprehensive payment that covers all the services within an episode of

[4] HCPF, "Prescriber Tool Alternative Payment Model", Available online: https://hcpf.colorado.gov/prescriber-tool-alternative-payment-model

care," from prenatal, care, to labor and delivery, and postpartum care. They seek to reduce costs, incentivize doctors with potential savings, and improve maternal outcomes. [5]

. **Idaho:** In 2016, Idaho Medicaid launched a Healthy Connections Value Based Care program which integrated their patient-centered medical home (PCMH) and primary care case management (PCCM) program into one program. In 2017, the State added value-based payments to the program. In 2020, Idaho implemented an updated value-based model which awards payments to primary care providers (PCP) and FQHCs based on cost savings and quality of care metrics. PCPs participate as either accountable primary care organizations or accountable hospital care organizations. Referred to as value care organizations (VOCs) the goal is to contain Medicaid's total cost of care while improving quality. PCPs are paid on a fee-for-for service basis plus a per member per month (PMPM) care management fee and the larger VOCs share in savings or losses generated for Medicaid. [6]

- **Montana:** In 1993, Montana Medicaid implemented a primary care case management (PCCM) program. Most Medicaid members are required to participate in the program. Members have a PCP who coordinate most acute, primary, and behavioral health services. The PCCM program which pays a PMPM participation fee and a PMPM fee to support disease management. In 2018, Montana began a 5-year CMS pilot program, Comprehensive Primary Care Plus (CPC+). An advanced primary care medical home model rewards value and quality through innovative payments that support comprehensive care. The program provides actionable patient-level cost and utilization feedback to providers to guide provider decision making.[7] Beginning January 1, 2022, CPC+ practices will also be able to participate in Primary Care First (PCF). The PCF Payment Model is a voluntary payment model introduced by the CMS in 2019 to encourage primary care practices to shift to a value-based care approach. The model offers a set of payment options designed to support and reward primary care practices for providing high-quality care to their patients.[8]
- **Nebraska:** In 2014, Nebraska Medicaid implemented a voluntary, multi-payer PCMH program. Participating managed care entities (MCE) contracted with PCMH clinics to achieve quality measures. In 2017, the state enrolled nearly all Medicaid members in

[5] HCPF, "Alternative Payment Models" Available online: https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%20Fact%20Sheet.pdf
[6]NASHP, "*Idaho Develops a Medicaid Value-Based Model for its FQHCs, Based on Cost and Quality*," Available online: https://www.nashp.org/idaho-develops-a-medicaid-value-based-payment-model-for-its-fqhcs-based-on-cost-and-quality/
[7] Montana DPHHS "*CPC+ Overview*," Available online: https://dphhs.mt.gov/montanahealthcareprograms/cpcplus
[8] CMS, "Primary Care First Model Options" Available online: https://innovation.cms.gov/innovation-models/primary-care-first-model-options

its Medicaid Managed Care program. The MCEs were required to support the PCMH initiative and enter value-based contracts with providers.[9,10]

- **South Dakota:** South Dakota does not have a wide value-based care Medicaid strategy. Since 2013, South Dakota has operated a Medicaid Health Homes model for Medicaid enrollees with complex health care needs. Eligible members have two or more chronic conditions or a severe medical illness or emotional disturbance. Health homes are paid on a Per Member Per Month (PMPM) basis for providing core services.[11]
- **Utah:** In 2011, Utah's legislature required the Medicaid agency to implement a value-based reimbursement program. In 2013, the state created four payer-led ACOs that receive monthly risk-adjusted capitated payments for Medicaid members. ACO contracts require providers to achieve a minimum quality performance level. As of 2021, 13 out of 29 counties in Utah require Medicaid members to enroll in an ACO plan, while the rest are allowed to choose between an ACO and FFS Medicaid. Initially, ACOs in Utah were only expected to maintain certain quality standards. However, in 2018, the state changed its approach and began asking ACOs to focus on improving quality by progressively achieving scores that are at or above the national average. This shift in focus has been successful, and Utah's Medicaid ACO program has been able to save the state an average of $15 million each year. [12,13]

[9] Nebraska State Legislature, *"Participation Agreement to recognize and reform payment structures to support Patient Centered Medical Home,"* Available online: http://news.legislature.ne.gov/dist35/files/2013/12/Final-agreement-on-ltrhd-12-18-2013-corrected.pdf
[10] Nebraska State Legislature, *"Legislative Resolution 22 (2015): Progress of Patient Centered Medical Homes and the PCMH Participation Agreement,"* Available online: http://news.legislature.ne.gov/dist35/files/2016/01/LR-22-report.pdf
[11] South Dakota Medicaid, *"Health Home Program,"* Available online: https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Care_Management/Health_Home_Program.pdf
[12] National Association of ACOs, "Utah," Available online: https://www.naacos.com/medicaid-acos-utah
[13] Utah HHS, *"Accountable Care Organizations,"* Available online: https://medicaid.utah.gov/accountable-care-organizations/#:~:text=Utah%20Medicaid%20contracts%20with%20health,counties%20must%20choose%20an%20ACO.