



# Medicaid Managed Care Contracts as Instruments of Payment Reform

*A Compendium of Contracting Strategies*



# Contents

- Introduction ..... 3
  - Background a Brief History of Medicaid Managed Care & Payment Reform..... 3
  - Project Scope and Methodology..... 5
- Key Findings..... 6
  - A. The Landscape of Payment Reform ..... 6
  - B. Prevalence of Payment Reform by Focus Area ..... 9
  - C. Payment Reform Content Analysis by Focus Area.....11
- Key findings from Medicaid Agency Interviews ..... 14
- Conclusion.....16
- Appendices..... 17
  - General Payment Innovation Language: Contract Excerpts by State ..... 17
  - Contract Excerpts by Topic: ..... 63
    - Maternity ..... 63
    - Pharmacy..... 64
    - Behavioral Health ..... 66
    - Social Determinants of Health..... 71
    - Quality Metrics.....73
    - Provider Support..... 76
    - Care Management.....81
- GLOSSARY OF STATE ACRONYMS .....86

## Introduction

At present, 39 states plus the District of Columbia contract with managed care organizations (MCOs) to provide care for some or all of their Medicaid beneficiaries;<sup>1</sup> as of July 2017 (the most recent data available) these MCOs enrolled over 54 million Americans, or 69%<sup>2</sup> of the total eligible Medicaid population. Increasingly, states are directing these Medicaid MCOs to deepen the accountability of health care providers for their patients' outcomes through contracts that reward providers for improved quality, efficiency and cost performance. Even though Medicaid has made, on average, a less dramatic shift toward alternative payment models<sup>3</sup> than the Medicare, Medicare Advantage and commercial sectors, it can be a laboratory of innovation and reform. Medicaid agencies benefit from the freedom commercial plans enjoy to design their programs according to the unique needs of their markets, but like Medicare, they have the scale that comes with being a single purchaser, allowing them to push the envelope on experimentation and design.

Catalyst for Payment Reform (CPR) is an independent non-profit organization working to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. For the past eight years, CPR has produced model health plan contract language for purchasers in the commercial market. While some Medicaid agencies have utilized and borrowed from CPR's contract language, CPR saw an opportunity to help Medicaid agencies learn from each other – and to help commercial purchasers learn from Medicaid contracting. To that end, and with support from the [Robert Wood Johnson Foundation](#), CPR carefully scrutinized the model MCO contracts from 40 Medicaid agencies, cataloguing all language that directs MCOs to engage providers in value-oriented contracting and care delivery reform. The intent of this effort was to identify the strategies these Medicaid agencies are pursuing to accelerate growth and innovation in payment reform through mandates to their MCO contractors. CPR designed this resource to help Medicaid agencies, employers and other health care purchasers learn from each other, and to spur continued innovation and acceleration of effective payment reform.



### Background a Brief History of Medicaid Managed Care & Payment Reform

Managed care – like much of health insurance taxonomy – has different meanings depending on context. Fundamentally, “managed care organizations” are responsible for managing cost, utilization and quality for individuals in their care, and administering any other adjudicated benefits as directed by their contracts.<sup>4</sup> In the context of public insurance programs, such as Medicare and Medicaid, this describes delegation of network and

<sup>1</sup> For all intents and purposes, the term “State” is used hereafter to refer to the 39 United States + DC who contract with Medicaid MCOs.

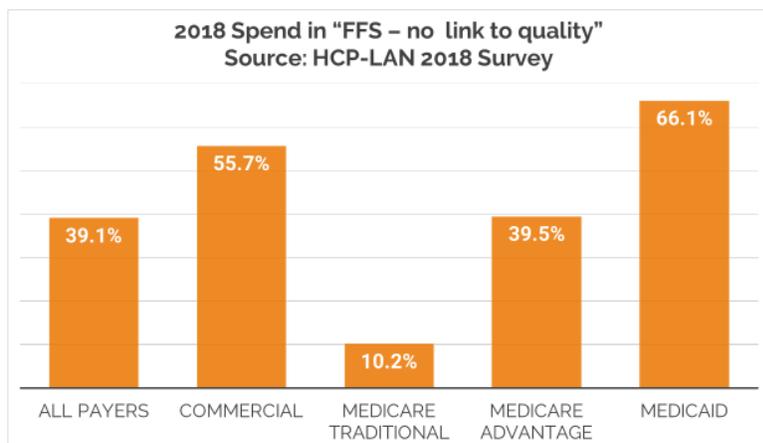
<sup>2</sup> <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

<sup>3</sup> <http://hcp-lan.org/workproducts/2018-APM-Progress-Press-Release.pdf>

<sup>4</sup> <https://www.medicaid.gov/medicaid/managed-care/index.html>

benefits administration from the payer (i.e. the federal government and states, respectively) to organizations, predominantly through risk-based, capitated, per member per month payments.<sup>5</sup> To date, 39 states plus the District of Columbia offer Medicaid benefits to some portion of their beneficiaries through comprehensive, risk-based managed care programs.<sup>6</sup>

When it comes to implementation of alternative payment models (APMS),<sup>7</sup> Medicaid's reported spend lags behind other market segments (Medicare, Medicare Advantage and Commercial). In the most recent survey tracking the progress of payment reform implementation nationally by the Health Care Payment Learning and Action Network (HCP-LAN), over 66% of Medicaid spending still flows through legacy payments (e.g. fee-for-service payment without any link to quality). By way of comparison, only 10% of Traditional Medicare spending remains in traditional FFS.<sup>8</sup>



There are many plausible reasons why two-thirds of Medicaid spend is still in legacy FFS – and since each state's Medicaid agency operates independently, those reasons may differ by State. It's also worth mentioning that only a handful of states report Medicaid data to the LAN, making it difficult to assess the representativeness of these findings.

But structurally, Medicaid faces unique circumstances that may make it challenging to implement broad payment reform. First, because states *must* balance their budgets each year, they have little to no elasticity in their Medicaid budgets; this means that programs like pay for performance, which require the State to fund bonus pools, are difficult to finance. Moreover, ACO product models that include narrowed networks are challenging in Medicaid because of strict federal requirements around patient access to care. Finally, there are the challenges of implementing a population health management model in a population with highly acute health care needs and with a high degree of churn in and out of Medicaid. The combination of these factors requires creativity on the part of state agencies to design the right tools and incentive structures for their alternative payment programs. The good news is that a laboratory of 40 independent Medicaid agencies, each striving to improve quality and care efficiency, provides an ideal environment for innovation and learning.

<sup>5</sup> <https://www.macpac.gov/subtopic/managed-care-overview/>

<sup>6</sup> <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

<sup>7</sup> Refers to a range of health care payment models/methods that use payment to promote or leverage greater value for patients, purchasers, payers, and providers (<http://catalyze.org/new-york-state-payment-reform-definitions/>); however, states may also use terms such as "alternative payment models," "value-based payment," and "value-based contracting" with the same intent and meaning.

<sup>8</sup> <https://hcp-lan.org/workproducts/apm-infographic-2019.pdf>

## Project Scope and Methodology

The vast majority of Medicaid MCO contracts are paid through full-risk capitation, and – through federal regulations. These contracts also require MCOs to meet specified quality assessment and improvement targets. However, the focus of this project is *not* on how the state pays the MCO, but rather on if and how the state instructs the MCO to pay *providers*.

The intent of this report is to offer a catalogue of the directions Medicaid agencies have conferred to MCOs that dictate how the MCOs shall pay and incentivize providers for improving the quality, efficiency and cost of care. Therefore, the report deliberately focuses on contracting language that meets the following criteria:

- Provides instruction to the MCO on how to contract with providers – excluding provisions that describe how the Medicaid agency will reward the MCO for cost or quality outcomes.
- Is focused on payment reform, which CPR defines as a range of payment models or methods that, at a minimum, provide financial incentives to health care providers to improve the quality of care. Payment reform may also create incentives to improve the efficiency and cost-effectiveness and affordability of care.
- Is codified in the state's Medicaid MCO model contract – several states have value-based payment roadmaps or specifications documented outside of their MCO contracts. In such cases, the key findings section may pull from supplemental materials, and links are provided in the appendix. But this project is focused on the wording of provisions in the contracts themselves; we therefore do not excerpt language from supplemental materials.

CPR collected the Medicaid Acute Care MCO contracts directly from state Medicaid agency websites – or from the agencies themselves when the most current materials were unavailable online. If a Medicaid agency was in the midst of the procurement process, we substituted their request for proposal (RFP) for their model contract to capture each state's most current approach to MCO contracting. CPR assembled an ad hoc advisory committee of Medicaid experts to develop frameworks and categorization systems to describe the landscape of Medicaid payment reform. This included a framework to describe the spectrum of approaches Medicaid agencies have followed to activate and accelerate provider payment reform, and payment reform focus areas that programs are designed to address.



## Frameworks Describing Medicaid Payment Reform Landscape

Approaches to Payment Reform in Medicaid MCO Contracts	Payment Reform Focus Areas
<ul style="list-style-type: none"><li>a) No mention of payment reform</li><li>b) State encourages payment reform but without targets, incentives or penalties</li><li>c) State establishes payment reform % spend targets but does not specify implementation requirements or care delivery transformation support</li><li>d) State establishes payment reform % spend targets and provides specific requirements for implementation or care delivery transformation support</li><li>e) State has established payment reform contracts with providers, which MCO administers</li></ul>	<p><b>Care Systems:</b></p> <ul style="list-style-type: none"><li>• Maternity</li><li>• Behavioral Health</li><li>• Pharmacy</li><li>• Social Determinants of Health</li></ul> <p><b>Transformation Strategies:</b></p> <ul style="list-style-type: none"><li>• Prescribed quality measures</li><li>• Provider support</li><li>• Care management integration &amp; delegation</li></ul>

CPR staff then reviewed each contract and created a profile summary for each state. For certain Medicaid agencies with multifaceted programs, CPR interviewed key informants to gather context for this report. The report has two main sections:

- **Part 1** describes cross-cutting findings and insights CPR uncovered in the course of examining the 40 Medicaid MCO contracts. These findings describe the scope and type of payment reform as codified in MCO contracts, and relays some of the insights we gleaned from interviewing Medicaid agency leadership.
- **Part 2** contains excerpts of contract language across the care system and transformation categories, which provide reference material for any state Medicaid agency or other purchaser.

Finally, the appendices contain links to the MCO contracts hosted on Medicaid agency websites, where available, and a list of all agency leaders with whom we conducted interviews. Additional resources, including a recording of our virtual summit on the topic of Medicaid managed care and payment reform, can be found on CPR's website: [www.catalyze.org](http://www.catalyze.org).

## Key Findings

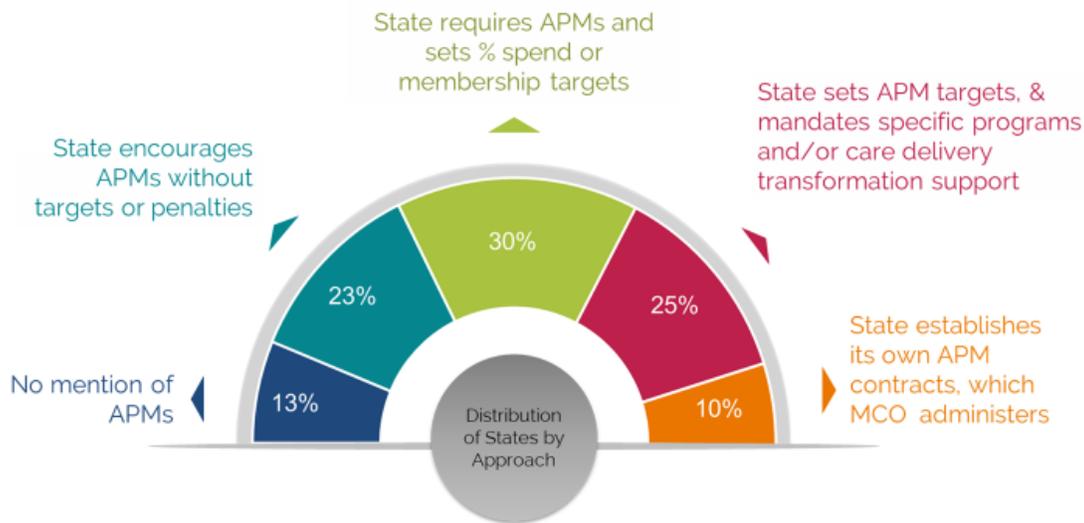
### A. The Landscape of Payment Reform

#### *Approaches to Payment Reform and Target Setting*

Medicaid managed care agencies take varied approaches to leverage MCO contracts as vehicles for advancing payment reform. The spectrum of these approaches points to a central tension in designing and mandating new contracting models: the degree of specificity versus flexibility of directives within the model contracts. Some states exercise a high degree of control, prescribing payment model parameters, quality metrics and telling the MCO how it shall support providers in care delivery transformation. Others go further and initiate the APM contracts themselves, asking the MCO simply to administer and pay claims. Then, there are states on the opposite end of the spectrum that take a more flexible approach; they may set targets and timelines, but then give the MCOs latitude to achieve

the goals however they see fit. The strategy a state deploys depends on market dynamics, needs of the population, and a calculus of the trade-offs between consistency and latitude for innovation. The graphic below describes the five "approaches" we found within the 40 MCO model contracts and shows the prevalence of contracts by type.

The Spectrum of Approaches to Payment Reform in MCO Contracting:  
Analysis of 40 Medicaid Managed Care Model Contracts



Beyond the approach on the far left – not mentioning payment reform at all – the remaining approaches direct or encourage payment reform with varying degrees of specificity:

- State encourages payment reform without targets or penalties:**  
The 23% of states who take this approach allow the MCO to engage in value-oriented contracting and may also encourage the MCO to contract with providers who have already achieved certification as a patient-centered medical home (PCMH) or operate as an accountable care organization (ACO)
- State establishes payment reform % spend targets but does not specify implementation requirements or care delivery transformation support**  
A plurality of state agencies (30%) take this approach with their MCO contractors, requiring and quantifying the type and extent of alternative payment contracting that the MCO must execute. These states stop short, however, of telling the MCO how to structure or implement the payment models. Quantifying payment reform generally takes one of two formats: either the state sets targets around the percent of members impacted by providers in APMs, or the % of medical spend that flows through the contracts. The latter is more common, perhaps because it aligns with HCP-LAN reporting requirements; in fact, of the 18 states that set % spend targets, nearly two-thirds use the LAN's categorical framework for the purpose of target-setting.

- ***State establishes payment reform % spend targets and provides specific requirements for implementation or care delivery transformation support***

About one fourth of the Medicaid Managed Care agencies go a step beyond setting targets for payment reform, and also provide instruction on how the MCO shall support providers who operate under these models. This may include any of the following types of requirements:

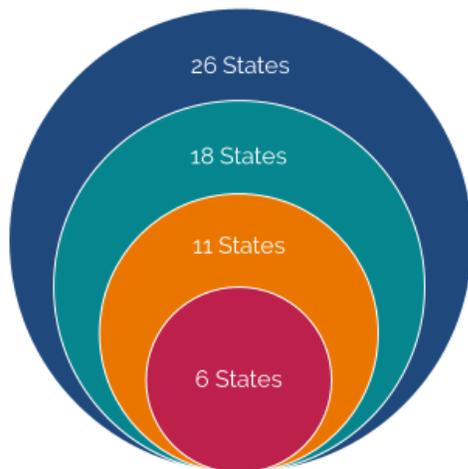
- Provider reporting and data exchange – such as interim performance against cost and quality targets, lists of members with gaps in care or who are frequent utilizers of the emergency room
- Inclusion of specific payment or delivery models – such as episode bundled payment, accountable care organizations or patient centered medical homes
- Prescribing which quality metrics must be included in the provider's contract
- Mandating what types of providers must be included in the APM, or how an anchor provider (usually a PCP) shall coordinate with specialists and other health workers across the continuum

- ***State has established payment reform contracts with providers, which MCO administers***

This final approach is the most prescriptive and the least common, whereby the state establishes value-oriented contracts with providers on its own, and requires the MCO to administer them – by processing claims and providing supportive services such as care and utilization management.

Within this spectrum, the three approaches on the right all include some form of **mandate** to the MCOs to introduce, expand or advance their payment reform efforts. States deploy a variety of strategies to set payment reform goals, but most require or incentivize MCOs to allocate a threshold percentage of their total spend to providers who operate under payment models that reward quality and efficiency (i.e. alternative payment models, or APMs). The LAN offers a framework for categorizing various APMs, and several states have adopted the LAN framework to anchor their payment reform targets. Even so, describing the range of payment reform percent spend targets is complicated. For one thing, contracts differ in length and in how they define or qualify various APM models; in a similar vein, contracts launched prior to the enactment of *The Affordable Care Act* are unlikely to include language around APMs. Based on our review of MCO contracts, 65% of them mandate *some* kind of payment reform, 45% set payment reform goals based on percent of spend, 11% use the LAN framework to set percent spend targets, and 15% set targets for greater than 50% of total spend:

## How Are Medicaid Agencies Setting Payment Reform Targets in Their MCO Contracts?



Of the 40 Medicaid Managed Care Model Contracts...

-  **26 (65%)** mandate some type of payment reform
-  **18 (45%)** specify percent spend targets for payment reforms that MCOs must meet
-  **11 (28%)** use the Health Care Payment Learning and Action Network (HCP-LAN) framework to set percent spend targets
-  **6 (15%)** set percent spend targets for HCP-LAN categories 2 and above at >=50% (ranging from 10% to 90%)

## B. Prevalence of Payment Reform by Focus Area

The previous section catalogs MCO contracts by the approach and degree of mandatory payment reform; this next section analyzes whether and to what extent states are implementing payment reform within specific *focus areas*, which fall into two groups: *care system categories* and *transformation strategies*. These focus areas are described in greater detail below:

### Care System Categories

-  **Maternity**  
E.g. Payment models designed to improve birth outcomes, reduce C-sections, discourage early elective delivery
-  **Pharmacy**  
E.g. Payment models that mandate transparency and rebate pass throughs, prohibit price spreading
-  **Behavioral Health**  
E.g. Incentives to support behavioral health integration, increase access to medication assisted therapy, achieve quality targets
-  **Social Determinants of Health**  
E.g. Incorporating social determinants into broader APM strategy, offering performance bonuses to community health workers

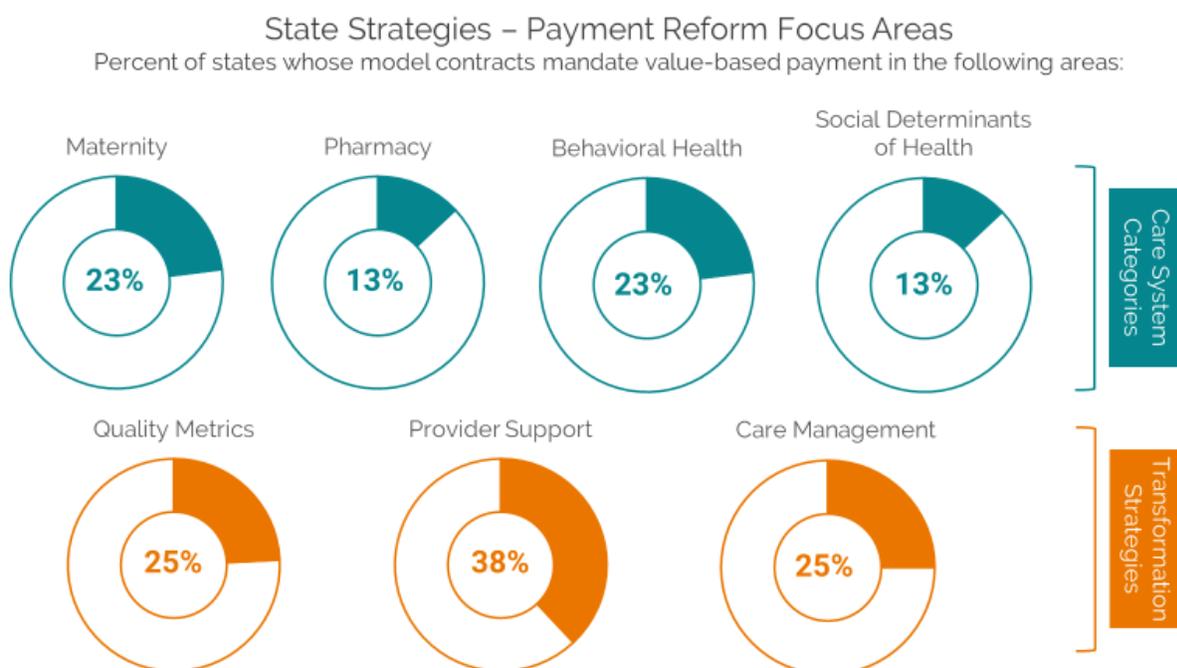
### Transformation Strategies

-  **Quality Measures**  
State prescribes a set of quality measures that the MCO *must* incorporate into its payment reform models
-  **Provider Support**  
State dictates how MCO shall support providers in APMs by supplying population health management resources
-  **Care Management**  
State requires MCO to delegate, share or coordinate care management services with providers (usually through a Health Home)

The analysis of the prevalence of these payment reform focus areas within MCO contracts begins with a few caveats:

1. The scope of our research is limited to payment reform provisions mandated by the states, executed through MCOs and aimed at incentivizing *providers*. Consequently, many Medicaid programs designed to address the key focus areas are only reflected in this report if (a) they include some form of incentive for cost and quality outcomes and (b) focus not on the actions of the MCO, but on the actions of the provider community.
2. We have only included requirements that come from the state Medicaid agency directly and not those initiatives that are required in federal law or regulation.
3. Our scope was limited to contracts covering *acute care* services; contracts specific to behavioral health or long-term support services (LTSS) were excluded.

Within these parameters, the prevalence of payment reform by focus area is shown below:



While these numbers may seem low, it is important to note that they represent prevalence within *all* Medicaid Managed Care states, including those that make no mention of payment reform and those that encourage MCOs to engage in alternative payment models but stop short of a mandate or whose mandate does not relate to a specific focus area.

## C. Payment Reform Content Analysis by Focus Area

### Maternity

Nine of the 40 MCO contracts (23%) include provisions for payment reform in maternity care. Agencies seek to improve outcomes and reduce costs through strategies that include:

- Bundled payment for maternity episodes
- Incentives for meeting quality targets
- Non-payment for early elective delivery before 39 weeks
- Uniform payment rates for c-sections and vaginal deliveries

Although technically outside the scope of payment reform, several Medicaid agencies also target improved maternity care through the inclusion of non-traditional sites for labor and delivery services and non-traditional providers (e.g. doulas and nurse home visit programs).

### Pharmacy

The MCO contracts included little payment reform activity in the pharmacy area, with only 5 Medicaid Agencies (13%) incorporating payment reform into their MCO contracts. This is due in part to the fact that a number of states carve pharmacy out of their MCO contracts. Moreover, the examples of “payment reform” in pharmacy do not meet the classic definition of *alternative payment models* as they lack ties to quality. While a few Medicaid agencies have launched alternative payment model pilots, they have done so by contracting directly through pharmaceutical companies or through Pharmacy Benefit Managers (PBMs) rather than through their MCOs.<sup>9</sup> Among the agencies that addressed pharmacy payment reform strategies through their MCOs, we found strategies geared toward the following goals:

- Curb PBM fees:
  - Prohibitions on spread pricing, which occurs when a PBM keeps some portion of the MCO’s payment, essentially charging the MCO an excess above what the PBM pays to the pharmacy, creating profit for itself, and increasing the spending on prescription drugs
  - Preventing the MCO from receiving rebates from the PBM and/or passing any all rebates back to the Medicaid agency
- Increase transparency:
  - Requiring PBMs to pass through 100% of pharmacy costs to enable claims level auditing
  - Directing the MCO to disclose the full terms of its PBM contracts, including all income, compensation or commissions it pays out or receives from the PBM
  - Instructing the MCO to create policies and procedures to enable an independent audit of PBM performance
- Protect consumers:
  - Ensuring that the MCO eliminate conflicts of interest between the PBM and its affiliated pharmacy providers, including any steerage to PBM-owned or affiliated retail pharmacies
- Close regulatory loop-holes:

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<sup>9</sup> <https://healthpayerintelligence.com/news/alternative-payment-models-rein-in-state-prescription-drug-spending>

- Requiring MCOs to implement a shared savings approach to reimburse providers who receive deeper drug discounts through the federal Health Resources and Services Administration's 340b discount drug program

### Behavioral Health<sup>10</sup>

Nine of the 40 Medicaid MCO contracts incorporate **value-based payment** into their requirements for behavioral health services, although virtually *all* MCO contracts attempt to improve the quality and efficiency of behavioral health services – usually by instructing the MCO to coordinate care among primary care providers (PCPs), behavioral health care providers, community organizations and acute care settings. Agencies differ in their approaches to reforming payment for behavioral health, but all focus on common goals: to improve access, coordination and integration of care, build behavioral health infrastructure, and improve the quality of care and patient outcomes.

In their approaches to payment reform, some Medicaid agencies give discretion to their MCOs to design models that integrate with existing total cost of care models and encourage MCOs to collaborate with the provider community to develop a common set of inter-dependent quality and performance improvement goals. Others took a route of greater specificity, prescribing specific alternative payment models, including:

- Care coordination or incentive payments ear-marked to support specific infrastructure investments, like enhanced reporting, screening and access
- Incentive payments offering providers an enhanced fee schedule for advanced practice (e.g. SAMHSA certification) or for expanding their scope of practice (e.g. enhanced payment to PCPs for behavioral health screening)
- Bundled payment for specific behavioral health diagnoses, such as attention deficit disorder (ADD) or oppositional defiance disorder (ODD)
- Behavioral Health Homes, which are similar to the Patient Centered Medical Home (PCMH) model, designed for members with severe and persistent mental illness

Some agencies use payment reform to promote specific treatment modalities or to address the needs of sub-populations; for example, requiring MCOs to provide incentive payments to deploy evidence-based best practices in the treatment of substance use disorder (SUD), including increasing access to medication assisted treatment (MAT), and babies born with neo-natal abstinence syndrome (NAS).

### Social Determinants of Health

Social determinants of health is another category that is rarely the target of payment reform; this is not to say that addressing social determinants is off the radar of Medicaid agencies – quite the contrary. However, the predominant strategy Medicaid agencies deploy within their MCO contracts is to hold the MCO accountable for coordinating care amongst the numerous agencies providing support to Medicaid enrollees, and/or including alternative or “in lieu of” services in their covered benefits. That said, we did find a few instances where Medicaid agencies direct the MCO to address social determinants through payment reform, including:

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<sup>10</sup> Refers to behavioral health provisions within acute care contracts

- Requiring that APMs include metrics that hold providers accountable for addressing social determinants in addition to more traditional indicators of quality
- Incorporating social determinants data into the provider support tools and analytics to support providers in alternative payment models
- Establishing alternative payment models with community organizations and public health workers

### Quality Metrics

As defined in the scope of this project and consistent with HCP-LAN, a payment reform model must address both cost and quality. While the 26 MCO contracts that mandate payment reform include a quality requirement, only ten contracts actually specify *which* quality metrics the MCOs must measure. Contracts with specific quality measures provide direction through a range of approaches:

- Listing the measures in the contract, or referring to an established quality scorecard with a set list or menu of measures; performance on these metrics may determine provider incentive payments, and/or be used to identify advanced practitioners who qualify for an enhanced fee schedule
- Setting priority areas that alternative payment models must address, such as emergency room utilization, hospital readmissions, or integration of behavioral health and primary care
- Specifying metrics for a particular specialty or program – most notably, a set of quality metrics corresponding to an episode of care

### Provider Support

Provider support for managing population health under APMs (also called *provider enablement*) is the area in which we saw the greatest prevalence of MCO mandates. This was also an area of consistency across Medicaid agencies, many of which require similar types of provider support solutions.

- Training:
  - MCO must coach practices in team-based care
  - MCO must host learning collaboratives in which providers can share best practices
  - MCO must give training and technical assistance to help providers leverage analytic tools and resources
- Operations, workflow and resources
  - Tools and resources to increase the capabilities of providers to deliver care management
  - Fixed cost investments to support non-reimbursable activities, such as disease registries and the purchase/upgrade of electronic medical records
  - Resources for practices to hire physician extenders and care navigators
- Data and analytic reporting
  - Patient attribution/member assignment files, and identification of high-risk patients
  - Reporting gaps in care – particularly gaps related to quality metrics used in the VBP arrangement

- Facilitating data exchange between the MCO and provider practices and among providers across the care continuum
- Reports and analytics on provider performance on cost and quality measures
- Health information technology (HIT) infrastructure deployed in the primary care setting

### Care Management

While care management traditionally falls under the core responsibilities of the MCO, when providers operate under an APM, these responsibilities tend to shift toward providers. Providers in APMs are often required to assume increased accountability for population health management and patient outreach, for which the MCO may compensate them through care coordination payments and care delivery support. When the MCO and provider share care management responsibilities, contracts rarely draw hard lines around which party shall execute which activities, instead requiring them to collaborate and ensure no enrollee falls through the cracks.

For this report, we focused on provisions that describe how the MCO shall share or delegate care management responsibilities to a provider operating under an APM. The degree of required delegation varies by state and by program, but loosely adheres to two models:

- Shared functions model: MCO and provider are jointly responsible for care coordination and care management. Contracts provide varying degrees of detail on which functions shall be shared, the capabilities the provider must have in place, and how the MCO shall support the provider in developing those capabilities. Generally, the provider receives enhanced payment (either as a PMPM or fee schedule increase) for these responsibilities.
- Full delegation model: All care management functions are delegated from the MCO to a provider -- the MCO retains oversight and accountability for outcomes, but vests all outreach and coordination with the provider. Contracts offer varying degrees of specificity regarding the provisions that must be in place to ensure seamless coordination and division of labor between the MCO and the provider.

It is also notable that some contracts customize how they designate care management to providers for specific populations or care settings – for example, an MCO may be required to delegate care management to a specialized long-term services and supports (LTSS) medical home, a behavioral health home, or require hospitals to assume responsibility for managing transitions of care.

## Key findings from Medicaid Agency Interviews

The preceding sections have highlighted the diversity of approaches, priorities, and degree of specificity in Medicaid agencies' MCO contracts. The second phase of this project goes a step further, using interviews with agency leaders and program administrators to understand the strategies and rationale behind MCO contract design. In these conversations, we explored their insights, the lessons they have learned, and the trade-offs agencies face as they leverage their MCOs to deliver high-value care through payment reform.

A central tension we uncovered in these interviews is the trade-off between *specificity* and *flexibility* in the directives from Medicaid agencies to their contracted MCOs. As shown in the “spectrum of approaches” diagram, agencies deploy a range of strategies to spur payment reform. We learned from these conversations that an agency’s approach is a product of multiple factors, such as provider market dynamics, the unique needs of local populations, and the priorities of the current state government. Even controlling for differences in each market, there are advantages and drawbacks inherent in every approach to MCO payment reform.



Agencies that take a less prescriptive approach to their MCO contracts – perhaps setting APM percent of spend targets without mandating specific programs or payment models – told us that they rely on the contracting and network expertise of the MCOs to facilitate desired quality and efficiency outcomes. Payment innovation, they argue, is only one of many levers they expect the MCOs to use, alongside data-driven population health management and payment for non-traditional visits and services. Medicaid leaders also cautioned against prescribing a “one size fits all” model in markets where

providers operate at different levels of sophistication – providers in rural areas in particular may lack the resources and technology to implement payment models that put them at high financial risk. But beyond provider capabilities, agencies were circumspect about mandating new and experimental programs without sound evidence that these models generate the desired results in their communities.

On the other hand, without consistent instructions relayed to the provider through the MCO, Medicaid agencies recognized that they risk creating an environment in which providers must adapt to multiple payment models according to each MCO’s preferences, each with its own targets, quality metrics, and gain-share opportunity. Several Medicaid administrators told us that they initially took a more agnostic approach to payment reform requirements but found that their contracted MCOs and providers floundered without a roadmap that laid out the key ingredients for successful implementation. These agencies found traction by creating a limited set of payment model options and requiring MCOs to use the same model specifications, quality metrics, and support tools – even requiring data interoperability so that providers can measure their progress from a single set of reports.

A final point: some Medicaid programs have found innovative operational solutions that blend flexibility and specificity. For example, one state crafted relatively general language in the MCO contract, deferring payment model specifications to an external roadmap that can be updated periodically without going through a re-bidding process. By linking the contract to the roadmap, the requirements in the road map become part of the contract, giving the agency flexibility to evolve and adapt year over year. Other agencies have designed a short menu of options – either collaboration models between providers and the MCOs, or delegation models that instruct MCOs how and when to delegate care and utilization management -- thereby offering MCOs and providers a constrained set of choices.

## Conclusion

Across the three major sectors of payers (commercial, Medicare, and Medicaid) Medicaid includes some of the nation's most complex enrollees, but also faces some structural advantages the other two lack in their ability to implement innovative payment and delivery system reform models. Like Medicare, Medicaid has depth and scale' but like the commercial sector, Medicaid can adapt programs to the specific needs and nuances of each state or market in which it operates. This creates a laboratory where, under the right conditions, Medicaid can pilot unprecedented models, with bold steps to address inefficiency and the poorly aligned incentives within the system.

One final note is that many of these new models have yet to be tested at scale, and we lack sufficient data to know which strategies prove most effective under what circumstances. Carefully designed measurement and program evaluation will be a critical next step for these programs to take root, and for Medicaid agencies to adapt, course-correct and learn from each other.

Even at this early interim stage, it is our hope that cataloguing the state of Medicaid MCO contracting as it stands today will enable Medicaid agencies, employers and other health care purchasers to harvest language, tools and perspectives to develop and expand upon their own model contracts. The Medicaid MCO movement may still be evolving, but within the 40 model contracts there is an abundance of forward-thinking and creative program design and wisdom to be gained from states that have already begun to plot this journey.

## Appendices

# General Payment Innovation Language: Contract Excerpts by State

### ALABAMA

#### [Alabama Coordinated Health Network Request for Proposals](#)

*(Contract runs from October 2019 through September 2021)*

No relevant value-oriented contract language detected.

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### ARIZONA

#### [AHCCCS Complete Care Contract for Contractors](#)

*(Contract effective date October 2018)*

##### **D.29 Primary Care Provider Standards** (page 165)

- The Contractor is encouraged to develop a methodology to assign members to those providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes.

##### **D.50 Compensation**

- **Withhold Arrangement** (page 195) Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by APM strategies defined in [ACOM Policy 307](#).
- **Incentive Arrangement** (page 196)
  - This contract provides for the following incentive arrangements between [AHCCCS](#) and the Contractor:
    - The Alternative Payment Model (APM) Initiative – Quality Measure Performance (QMP) incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for performance on select quality measures identified in ACOM Policy 306. Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by APM strategies defined in ACOM Policy 307. AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year and the computation of the quality measures.
    - The Alternative Payment Model (APM) Initiative – Performance Based Payments (PBP) incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care. In accordance with ACOM Policy 307, for those APM arrangements which result in performance-based payments to providers, AHCCCS will

make a lump-sum payment to the Contractor after the completion of the contract year.

- The Contractor shall not receive incentive payments in excess of five percent of the approved capitation payments attributable to the members or services covered by the incentive arrangements.

#### **D.72 Value-based Purchasing** (page 240)

- Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value-based health care systems where members' experience and population health are improved, per-capita health care cost is limited to the rate of general inflation through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. The Contractor shall participate in VBP efforts.
  - Alternative Payment Model Initiatives: The purpose of the Alternative Payment Model (APM) initiatives (further described in the Section D, Paragraph 50, Compensation) is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through APM strategies in the Health Care Payment Learning and Action Network (LAN) APM Framework with a focus on Categories 2, 3, and 4. Requirements are further delineated in ACOM Policy 306 and ACOM Policy 307 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables
  - Value-Based Providers: The Contractor shall develop strategies that ensure that members are directed to providers who participate in VBP initiatives and who offer value as determined by measurable outcomes. The Contractor shall submit to AHCCCS/DHCM a Value-Based Providers/Centers of Excellence report describing its strategies to direct members to valued providers...

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## **COLORADO**

### **Rocky Mountain Health Plan**

*(Contract runs from State FY 2019 - 2020)*

#### **10.5 Health Neighborhood and Community Report** (page 75)

- 10.5.1 (page 75) The Contractor shall create a report to the Department describing the Contractor's recent activities to engage and build the Health Neighborhood and Community, including the following information:...
  - 10.5.1.3 (page 76) Collaboration with hospitals, including helping the Department create and administer a hospital survey to the Contractors which evaluates the hospital's level of cooperation with the Contractor, as determined by the Contractor. Survey results may drive value-based payments to hospitals.

#### **12.12 Financial Support** (page 87)

- 12.12.1. The Contractor shall make administrative/performance payments directly to [PCMP](#) Network Providers to support the provision of Medical Home level of care and to incentivize improved outcomes.
- 12.12.2. The Contractor shall detail individual PCMP administrative/performance payment arrangements in their written contract with the Network Provider.
- 12.12.3. Administrative Payments

- 12.12.3.1. The Contractor shall distribute, in aggregate, at least thirty-three percent (33%) of the Contractor's administrative PMPM payments received from the Department to their PCMP network.
  - 12.12.3.1.1 The Contractor shall offer PCMPs the option of receiving, at a minimum, a standard two dollars (\$2.00) PMPM. The Contractor may work with providers to design different value-based payment arrangements in place of the two dollars (\$2.00) PMPM.
  - 12.12.3.1.2. The Contractor shall work with Network Providers to develop a strategy to evolve administrative payments over the course of the Contract by tying a greater proportion of the dollars to value and aligning with other Department alternative payment methodologies.
- 12.12.3.2. The Contractor shall provide Stakeholders with opportunities to participate in and provide input toward the development of the Contractor's value-based payment strategies with Network Providers.
  - 12.12.3.2.1. The Contractor shall have final decision-making authority in creating the strategy while ensuring a collaborative and transparent process. The Contractor shall give Stakeholders advance notice of all forums and shall give them an opportunity to participate in and provide input toward the development of the incentive/administrative payment strategy.

**12.12.4. Pay for Performance** (page 88)

- 12.12.4.1 The Contractor shall share incentive payments earned for performance with PCMP Network Providers and other Health Neighborhood participants in a manner that is aligned with meeting the objectives of the Accountable Care Collaborative structure and program as the Contractor deems appropriate. The Contractor has the flexibility to design innovative approaches to distribute funds in a way that maximizes performance at the Provider level.
  - 12.12.4.1.1. The Contractor in its discretion shall negotiate payment arrangements and amounts with its Network Providers and Health Neighborhood participants.

**13. Primary Care Alternative Payment Model (APM)** (page 88)

- 13.1 The Contractor shall assist the Department with implementing the APM and support PCMPs in transitioning toward a value-based FFS system...
- 13.2 The Contractor shall assist PCMPs in the selection of appropriate structural and performance APM measures, and the Contractor shall assist PCMPs in completing all required documentation for the Department by December of each year. Selection of measures should account for the following:
  - 13.2.1 A PCMP's client panel and/or community
  - 13.2.2. Alignment with other initiatives the PCMP may be participating in...
- 13.6. For PCMPs that have selected any structural APM measures, the Contractor shall conduct site visits to confirm PCMPs are on track to meet structural measures for the current performance year.

## DC

### Medicaid Managed Care Program (MMCP) for District Health Families Program (DCHFP), District Healthcare Alliance Program (Alliance), and Immigrant Children's Program (ICP)

*(Solicitation issued on 12/22/16. The term of the contract shall be for a period of 12 months from date of award specified on cover page of this contract. Model contract did not specify start date of contract)*

#### **C.5.31 Value Based Purchasing (p.179-180)**

- C.5.31.1 Contractor shall utilize payment arrangements with its contracted Provider network to reward performance excellence and performance improvement in targeted priority areas conducive to improved health outcomes and cost savings for [DHCF](#) beneficiaries. [Value-based payment] VBP arrangements with Providers include both FFS-based bonus arrangements and Alternative Payment Models (APMs) designed to align financial incentives its Network Providers to increase the value of care provided and not focus exclusively on the volume of care provided. APMS are defined as shared savings, shared risk, or capitated financial arrangements with Network Providers that specifically include quality performance as a factor in the amount of payment a Provider receives.
- C.5.31.2.1 A VBP model which aligns payment more directly to the quality and efficiency of care provided, by rewarding Providers for their measured performance across the dimensions of quality. VBP strategies for this initiative may include any combination of the payment model classifications as defined by the Learning Action Network:
  - Category 2 Fee for Service-Link to Quality and Value
  - Category 3 APM Built on Fee-For Service Architecture
  - Category 4 Population Based Payment
- C.5.31.3 Value Based Purchase Adoption Requirements
  - The Contractor shall incorporate value based purchasing initiatives with Network Providers. The Contractor shall have thirty five percent (35%) of their total dollar amount spent on the delivery of health care services linked to Alternative Payment Models by the end of Option Year One (1).
  - C.5.31.3.2 The Contractor has discretion in designing value-based purchasing models to meet the requirements of this section of this Contract; however, eligible APMs shall be consistent with LAN categories 3 and 4.
  - C.5.31.3.3 To the extent that DHCF has established clinical outcomes objectives that can be supported by value-based Provider agreements, the Contractor shall implement payment reform strategies to support the Department's initiatives
  - C.5.31.3.4 DHCF reserves the right to approve/disapprove all payment reform initiatives submitted by the Contractor.
  - C.5.31.3.5 Failure to meet the minimum target will result in a CAP and/or sanctions as determined by DHCF.
- C.5.31.4 VBP Reporting Requirements
  - C.5.31.4.1 The Contractor shall submit an annual report of all implemented VBP strategies to DHCF (Categories 2-4). The report shall include a brief summary of all VBP initiatives for the Provider network serving DHCF beneficiaries, the performance and quality measures used to monitor and evaluate the initiative, the percentage of Provider payments link to quality (categories 2-4) and APMs (categories 3-4) and an estimate of the number of beneficiaries served by the initiative.

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## DELAWARE

### Division of Medicaid and Medical Assistance 2018 Medicaid Managed Care Master Service Agreement

(Contract runs from January 1, 2018 through December 31, 2019)

#### **3.9.8. Primary Care Provider (PCP), PCP Responsibilities 3.9.8.1.3** (page 190)

- The State encourages the Contractor to promote and support the establishment and use of patient-centered, multi-disciplinary, team-based approaches to care, including but not limited to: patient-centered medical homes (PCMHs); nurse-managed primary care clinics; integrated primary and behavioral health services; use of non-traditional health workers; and accountable care organizations (ACOs).

#### **APPENDIX 2: VALUE-BASED PURCHASING CARE INITIATIVE**

##### **SECTION 7 TWO-PART STRATEGY ii. Value-Based Purchasing Strategies (VBPS)** (page 391)

- The Contractor will be required to implement provider payment/contracting strategies that promote value over volume and reach minimum payment threshold levels in each year of operation. The Department will impose a financial penalty for any year in which the minimum threshold level for VBPS, as defined in this Appendix, is not achieved for that year.

##### **SECTION 9 VALUE-BASED PURCHASING STRATEGIES (VBPS)** (page 395)

- b. The Contractor is required to enter into payment arrangements/models with providers that align payment more directly to the quality and efficiency of care provided, by rewarding providers for their performance across different dimensions of quality and/or transferring the financial risk for member care to providers. The goal is to transition away from traditional FFS-based volume of care payment systems.
- c. For purpose of the VBPS, acceptable arrangements/models between the Contractor and providers are described as follows. While some of these arrangements/models may still use a traditional FFS payment method for the payment of services, the Department seeks VBPS that progressively diminish the use of traditional FFS in Delaware's health care delivery system. *(Note: the contract language includes definition and calculations for each category of VBPS)*
  - i. Shared Savings
  - ii. Bundled/Episodic Payments
  - iii. Risk/Capitation/Total Cost of Care
  - iv. Other Innovative Payment Arrangements
- e. VBPS Threshold Level: The Contractor is expected to achieve an annual threshold level for VBPS that will be measured as the portion of total medical/service expenditure to all providers for all members enrolled with the Contractor during the respective performance/measurement year that are associated with one or more of the acceptable VBPS arrangements/models. The same VBPS-related medical/service expenditures cannot be counted more than once for purposes of measuring against the respective threshold levels. The Department intends that the minimum threshold level will grow each year according to the following schedule:
  - i. Calendar Year 2018: A minimum of 20% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in

writing to the Contractor may be counted towards the expenditure threshold as approved/specified by the Department.

- For a Contractor that newly enters the program on January 1, 2018, the minimum threshold will be 10%, but all other requirements remain the same.
- ii. Calendar Year 2019: A minimum of 30% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the expenditure threshold as approved/specified by the Department.
  - For a Contractor that newly enters the program on January 1, 2018, the minimum threshold will be 20%, but all other requirements remain the same.
- iii. Calendar Year 2020: A minimum of 40% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 1/3 of the 40% (i.e., 13%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department.
- iv. Calendar Year 2021: A minimum of 50% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 1/2 of the 50% (i.e., 25%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department.
- v. Calendar Year 2022: A minimum of 60% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 3/4 of the 60% (i.e., 45%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department.

#### **SECTION 10 DATA SHARING AND REPORTING** (page 399)

- **a. From the Contractor to Providers:** The Contractor must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:
    - i. Identification of high risk patients;
    - ii. Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and
    - iii. Service utilization and claims data across clinical areas such as primary care, inpatient admissions, non-inpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.
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## GEORGIA

### CONTRACT BETWEEN THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH AND ICARE MANAGEMENT ORGANIZATION] FOR PROVISION OF SERVICES TO GEORGIA FAMILIES

*(Contract runs from July 2017 through June 2018 with 1-year renewal options through July 2021)*

#### **4.10.4 Provider Payment** (page 198)

- 4.10.4.1...The Contractor shall also develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets.

#### **4.12.12 Value-Based Purchasing (VBP) Program** (page 244)

- 4.12.12.1 The Contractor shall collaborate with DCH to implement a Value- Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Contractors and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.
  - 4.12.12.5 Attachment U outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets.... Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold") from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.
  - 4.12.12.6 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the eighteen (18) performance measures. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.
    - Contractor Payout Amount = (Number of Performance Targets Achieved/Total Number of Performance Targets) x Total VBP Withhold
  - 4.12.12.8 The Contractor shall incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor...
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**HAWAII**

**Quest Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals**

*(Contract is effective February 3, 2020 through December 31, 2025<sup>11</sup>)*

**Section 7.2(B)3(a), Health Plan General Responsibilities, Value Driven Healthcare Schedule** (page 377)

- The Health Plan shall incorporate value-driven healthcare concepts as described in this Section 7.2(B) and into its payment strategy and be required to attain VBP targets according to the following schedule below:

<b>CY 2020</b>	<b>CY 2021</b>	<b>CY 2022</b>	<b>CY 2023</b>	<b>CY2024</b>	<b>CY 2025</b>
35% of spend by major provider type in LAN Category 2A (Pay for Infrastructure - P4I) or above.	50% of spend by major provider type in LAN Category 2A or above (Pay for Reporting - P4R); 10% 2C or above (Pay for Performance - P4P).	Increasing over 50% of spend by major provider type in LAN Category 2A or above (P4I); 20% 2C or above (P4R); 10% 3A or above (population or condition-specific payments).	<u>VBP Targets to be set by DHS during the contract term.</u>	<u>VBP Targets to be set by DHS during the contract term.</u>	<u>VBP Targets to be set by DHS during the contract term.</u>

**Section 7.2(B)4(c), Health Plan General Responsibilities, Value-Based Payment, Specific Requirements for VBP for Hospitals** (page 380):

- The Health Plan will implement VBP on the schedule set forth in the table below, except for critical access hospitals (CAH). This schedule is not to be construed to reduce existing VBP practices, but to develop additional VBP practices where they may be limited or do not exist. In CY2020, the Health Plan will spend at least five percent of inpatient hospital dollars through VBP at the LAN Category level 2C or above. Under the current LAN framework, level 2C represents payments which incentivize improved provider performance. For the remainder of the contract, the Health Plan will incrementally increase the VBP investment to twenty percent by CY2023. The table below demonstrates the schedule.

<sup>11</sup> Note: Hawaii updated the timelines and targets for value-based spend in an RFP amendment not yet available online. The tables included in this document reflect the new targets and timelines.

CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
5% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	10% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	15% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	20% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	VBP Targets to be set by DHS during the contract term.	VBP Targets to be set by DHS during the contract term.

**Section 7.2(B)4(d), Health Plan General Responsibilities, Value-Based Payment, Specific Requirements for VBP for Hospitals, Critical-Access Hospital VBP Requirements** (page 381):

The Health Plan will implement a CAH-specific VBP on the schedule set forth in the table below. This schedule is not to be construed to reduce existing VBP practices, but to develop additional VBP practices where they may be limited or do not exist. In CY 2020, the Health Plan will spend one percent of total CAH dollars through VBP at the LAN Category level 2C or above (P4P). Under the current LAN framework, level 2C represents payments which incentivize improved provider performance. For the remainder of the contract, the Health Plan will incrementally increase the VBP investment to ten percent by CY 2023. The table below demonstrates the schedule by Calendar Year.

CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
1% of CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	5% of CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	8% of CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	10% CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	<u>VBP Targets to be set by DHS during the contract term.</u>	<u>VBP Targets to be set by DHS during the contract term.</u>

**Section 7.2(B)4(e), Health Plan General Responsibilities, Value-Based Payment, Specific Requirements for VBP for Hospitals, Advanced Hospital VBP Option** (page 382):

- The Health Plan will work with [DHS](#), providers, and the stakeholders to advance VBP within the healthcare system. In addition to following the schedule for implementing VBP for hospitals described in this Section, the Health Plan shall invite hospitals with advanced VBP capabilities to engage in multi-payer models, test evidence based models that address specific [HOPE](#) goals, require coordination with [RHPs](#), and provide opportunities to advance along the VBP continuum.
- CY 2020 will be a planning year. The first year is a planning year only for purposes of planning for a new VBP model. Health Plans are still responsible for meeting the minimum VBP requirements described in this Section. During subsequent years, participating hospitals will move from Pay for Participation or infrastructure building models, to Pay for Performance. The table below provides a high-level schedule.

Advanced VBP Option					
CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Planning Phase	Pay for Participation in APM test model.	Pay for Reporting in APM test model.	Pay for Performance in APM test model.	<u>Model parameters to be set by DHS during the contract term.</u>	<u>Model parameters to be set by DHS during the contract term.</u>

**Section 7.2(B)5, Health Plan General Responsibilities, Value-Based Payment, Specific Requirements for Patient Centered Medical Homes** (page 383):

- The Health Plan shall develop a reimbursement methodology that provides higher payment to the more advanced Tier 2 PCMH compared to the Tier 1 PCMH as defined in Section 3. The methodology may be reviewed by DHS to ensure plan compliance with this requirement.
- The Health Plan payment methodology shall be based on outcomes, including both patient-oriented outcomes and utilization in order to incentivize increased quality and efficiency of care including proactive population management. For example, the Health Plan may utilize a monthly patient management reimbursement to the PCMH that is reconciled with earned financial incentives. Such financial incentives could be based on achieving thresholds on certain quality measures and/or could be based on reduction in overall utilization compared to that predicted. The available incentive amount may be dependent on the degree of financial risk the provider assumes.

**Section 7.2(B)6, Health Plan General Responsibilities, Value-Based Payment, Multipayer VBP Initiatives** (page 383):

- Health Plans are encouraged and may be required to participate in multipayer VBP programs or initiatives through a directed payment program or other methods in accordance with other Federal and State law and authorities.

**Section 7.2(B)7, Health Plan General Responsibilities, Value-Based Payment, Vertically Integrated Organizations** (page 383):

- Health Plans are encouraged and may be required to pursue a shared risk and shared savings program with integrated care organizations if available. Such a health care delivery model may be provider led, and the organization assumes responsibility (i.e., becomes accountable for providing at a minimum, primary, acute, and chronic care services).

**Section 7.2(B)8(c), Health Plan General Responsibilities, Value-Based Payment, Health Plan Support for VBP Transformation** (page 384): The Health Plan will support providers by:

- Adopting payment strategies and testing models that encourage specified provider participation, such as models designed around a certain specialty provider or bundled payments for episodes of care;

## ILLINOIS

### MODEL CONTRACT for Furnishing Health Services by a Managed Care Organization

*(Contract runs from 2018 – 2022)*

#### **5.7.7 Provider Reimbursement** (page 79)

- The department may define an alternative payment methodology to which Contractor must adhere to when reimbursing Providers for provided services.
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## INDIANA

### Healthy Indiana Plan

*(Contract runs from 2017 through 2020)*

#### **Exhibit 2 - Section 9.2.1 - Provider Incentive Programs** (page 336):

- Contractors shall establish a performance-based incentive system for its providers for the Contractor's HIP providers... The Contractor will determine its own methodology for incentivizing providers. The Contractor shall obtain [OMPP](#)-approval prior to implementing its provider incentive program and before making any changes thereto.

#### **Exhibit 3.B** (page 393) **and 4.B** (page 415) – **Note sections are identical:**

- **3.B.1 FSSA** has established a pay for outcomes program under which Contractor may receive additional compensation if certain conditions are met. The state encourages plans to share earned incentive payments with members and providers.
  - **3.B.2** The "Pay for Outcomes" program withholds a percentage of the health plan's approved capitation payments, which increase in weight year over year (e.g. in 2017, withhold = 1.82%, but by 2022, withhold = 4.56%). See pp 415 for full capitation withhold schedule.
  - **3.B.2.b** Contractor may be eligible to receive a bonus payment based on achievement of maternity related performance targets as described in Section 3.B.4.b of this Exhibit. (See maternity section.)
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## IOWA

### Iowa Department of Human Services MCO Contract-MED-20-001

*Contract runs from July 2019 through June 2023*

#### **6.1.2 Provider Agreements** (page 122)

- The Contractor must have at least 40% of the population defined by the Agency in a value based purchasing (VBP) arrangement with the healthcare delivery system by the end of State Fiscal Year 2020. The VBP arrangement shall recognize population health outcome improvement as measured through the value-index score (VIS)<sup>12</sup> combined with a total cost of care measure for the population in the VBP arrangement.
- Driving population health through delivery system reform under VBP means that providers need a clear understanding of the specific lives for which they are accountable. As such, any members that are part of a VBP must be assigned by the Contractor to a designated primary care provider (PCP). This PCP information shall be

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<sup>12</sup> [The 3M Value Index Score \(VIS\)](#) is a single score that represents how well a primary care physician (PCP) cares for his or her patients, regardless of their health status (i.e., healthy to chronically ill).

immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency, such as provider alerts through the Iowa Health Information Network (IHIN)

**10.3.2 Provider Incentive Program** (page 191)

- **10.3.2.1 General** The Contractor shall establish a performance-based incentive system for its providers. The Contractor shall determine its own methodology for incenting providers. The Contractor shall obtain the Agency approval prior to implementing any provider incentives and before making any changes to an approved incentive. The Agency encourages creativity in designing incentive programs that encourage positive member engagement and health outcomes which are tailored to issues prevalent among enrolled membership as identified by the Contractor.

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**KANSAS**

**KANSAS MEDICAID MANAGED CARE REQUEST FOR PROPOSAL FOR KANCARE 2.0**

(Contract runs from January 1, 2019 through December 31, 2023)

➤ **5.5.15.F.2 Provider Payment** (page 91):

- The CONTRACTOR(S) and Participating Provider can negotiate higher per diem rates without approval from the State for situations, including, but not limited to, dually-certified facilities, limited Provider access areas, and difficult or expensive cases. All alternative payment methodologies, including value-based payment arrangements with Nursing Facilities (NFs), Nursing Facilities for Mental Health (NFMHs), Psychiatric Residential Treatment Facilities (PRTFs), and Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/IIDs) must be reviewed and approved by the State pursuant to Section 5.7.

➤ **5.7.CONTRACTOR(S) PROPOSALS FOR VALUE BASED MODELS AND PURCHASING STRATEGIES** (page 101)

- CONTRACTOR(S) are required to implement innovative Provider payment and/or innovative delivery system design strategies that incorporate performance and quality initiatives in service delivery models, referred generally herein as Value Based Models and Purchasing Strategies. Innovative programs may impact the delivery system but may not require innovative Provider payment. The State is interested in both so long as the strategies support the goals and objectives of KanCare 2.0.

➤ **5.7.1.A.1 Value Based Models and Purchasing Strategies** (page 104)

- Alternative Payment Models (APMs): APMs are innovative approaches to Provider payments that hold promise for controlling or reducing costs while improving Outcomes. CONTRACTOR(S) may propose APMs but the models, in order to be considered an APM, must include quality and/or outcome measures as part of the reimbursement strategy. Such models could include episodic bundled payments, shared savings strategies with Providers, or risk based payment strategies to Providers capable of managing such payment arrangements. For proposals including shared savings arrangements, CONTRACTOR(s) must identify financial, quality and utilization thresholds, including the marginal savings rate and proportional gain-share arrangements. For proposals that would include a risk arrangement, the CONTRACTOR(S) must identify the Providers that would be taking risk and describe why the CONTRACTOR(S) believes that the particular Provider type

can accept risk. Any proposed APMs that impose risk on the Provider must be consistent with the physician incentive plan requirements specified in 42 CFR § 438.3(i) and must be approved by the State prior to implementation. In addition to more traditional Provider types that are reimbursed according to APMs, the State is particularly interested in payment models for NFs, PRTFs, and ICF/IDDs.

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## LOUISIANA

### LOUISIANA MEDICAID MANAGED CARE ORGANIZATION MODEL CONTRACT

*(Contract runs from January 2020 – December 2022)*

#### **2.17.1 Value Based Payment** (page 219)

- The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks ... and paying providers based on performance.
- In developing its VBP Strategic Plan, the Contractor shall refer to this Contract, the MCO Manual and the Alternative Payment Method (APM) Framework developed by the Health Care Payment Learning and Action Network (HCP-LAN).
  - CY2020 → Contractual arrangements linked to VBP model need to account for at least 20% of total provider payments in the measurement year and the Contractor's total potential provider incentive payments related to this measurement year exceed 4 million dollars in total provider payments or incentive payments exceed 8 million in total provider payments
  - CY2021 → 30% of total provider payments through VBP model- 5 million and 10 million respectively
    - CY2022 and Future → At least 40% of total provider payments linked to VBP and 6 million and 12 million respectively

#### **2.17.3 Qualifying VBP Arrangements** (page 221):

- The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met:
  - The payment model includes a Category 2A foundational payment as one component of a broader payment model that includes Category 2C or 3 APMs for the same provider(s); and/or
  - The payment model falls within Categories 2C, 3 and 4 of the LAN Alternative Payment Model Framework; and
  - The payment model is linked to applicable incentive-based measures from Attachment G

#### ➤ **2.17.5.2 Overall VBP Strategy** (page 222)

- The Contractor's VBP strategy shall place emphasis on the establishment of provider payment arrangements designated as Category 3 and 4 models and the evolution of providers along the LAN APM model continuum with consideration of provider readiness to take on financial risk, and recognize that some providers may not ever be in a position to take on financial risk models.
  - 2.17.9.1 Preferred VBP Arrangements- Contractor shall implement 3 different types of preferred VBP models within 3 years from following list: PCMH, Models supporting PH and BH integration, Hospital VBP arrangements, Maternity focused VBP arrangements, ACO, Other models identified by [LDH](#)

- 2.17.10 – 2.17.14 Additional Specifications including attribution, data sharing requirements, financial benchmarks, shared savings calculation and risk mitigation (pages 224-229)
- 2.17.14.1 Accountable Care Organizations: By January 2021, the Contractor shall contract with and maintain at least one (1) Accountable Care Organization (ACO) Agreement, as described in this Section and as further specified by LDH.
- 4.1.1.1-2 Financial incentives for MCO performance (page 299) LDH shall withhold a portion of the Contractor's monthly capitated payments to incentivize quality, health outcomes, and value-based payments... At least half...of the total withhold amount shall be considered the Value-Based Payment (VBP) Withhold and applied to incentivize the Contractor's use and expansion of VBP arrangements with providers.

## MASSACHUSETTS

### Accountable Care Partnership Plans First Amended and Restated Contract

*(Contract runs through December 31, 2022)*

#### **2.3.A.2 ACO Partner** (page 47)

The Contractor may have an ACO Partner. If Contractor has an ACO Partner, Contractor shall:

- F. At a minimum, have functional integration, including developing processes for and demonstrating implementation of joint decision-making, with the ACO Partner across all of the following domains, as determined and approved by [EOHHS](#):
  - i) Joint decision making for use of DSRIP Payments, such that the ACO Partner participates in a joint decision-making process with the Contractor to determine Contractor's use of DSRIP Payments. Such joint decision-making process may include but is not limited to the following:
    - a) A joint operating committee, comprised of representatives from Contractor and the ACO Partner, that has legal authority over capital investments made using DSRIP Payments; or
    - b) The Contractor and ACO Partner developing a mutually agreed upon plan for spending a defined portion of DSRIP Payments that Contractor provides to the ACO Partner to spend directly;
  - ii) Financial accountability, as follows:
    - a) The Contractor shall have a financial accountability arrangement with the ACO Partner whereby:
      - i) The Contractor holds the ACO Partner financially accountable to some degree for the Contractor's performance under this Contract, with potential for the ACO Partner to receive partial gains or losses.
      - ii) Under such arrangement, the ACO Partner's maximum annual potential for losses or gains based on Contractor's performance shall not be less than 5% of the Contractor's risk-adjusted Medical Component of the Capitation Rate for the Contract Year;

- iii) Clinical integration [see Care Management]
- iv) Data integration [see Population Health Management]

**2.7.c.1 Additional Responsibilities for Certain Providers** (page 156)

➤ 1. Primary Care Providers

- b. The Contractor shall develop, implement, and maintain value-based payments for PCPs. Such value-based payments may be for individual Network PCPs or for practices, pods, or other groupings of Network PCPs. Such value-based payments shall:
  - 3. Shift financial incentives away from volume-based, fee-for-service delivery for PCPs by:
    - a) Holding each PCP or group of PCPs financially accountable to some degree for the Contractor's performance under this Contract and for the PCP's or group's contribution to that performance, with potential for the PCP or group to share gains from savings or share financial responsibility for losses, such that PCPs or groups of PCPs experience a meaningful portion of their annual Medicaid patient service revenue opportunity being tied to value-based performance measures;
    - b) Making the value-based payments based on a performance measurement and management process ...and
    - c) Reducing the influence of volume-based, fee-for-service incentives on PCPs;
  - 4. Include performance measurement and management activities such as but not limited to:
    - a) Regularly evaluating each PCP's performance on costs of care, Quality Measures, or related measures of performance under this Contract, and performing practice pattern variation analysis to identify opportunities for individual PCPs to improve;
    - b) Transparently reporting to each PCP the performance of the PCP on such measures;
    - c) Identifying PCPs with unsatisfactory performance or opportunities to improve performance on the Contractor's identified measures, and implementing a performance improvement plan for such PCPs; and
    - d) Adjusting value-based payments based on PCPs' performance to provide financial incentives for improved performance;
  - 5. Be accomplished through payment arrangements approved by EOHHS. Such payment arrangements may include:
    - a) Making monthly payments to PCPs for the anticipated costs of Primary Care services in lieu of or reconciled against fee-for-service payments for such services. Such an arrangement may be expanded to include BH Services if a PCP is also a provider of such services. Such payments may also include adjustments for performance;

- b) Stand-alone performance incentives or prize pools for PCPs based on performance on process or outcomes measures identified by the Contractor that are related to costs of care, the Contractor's Quality Measures ...and utilization;
- c) Augmented rates (e.g., supplemental medical home loads) paid to PCPs to support new costs associated with their responsibilities. Such payments shall include adjustments for performance; and
- d) Partial distribution of the Contractor's financial surplus or responsibility for contributing to the Contractor's financial deficit to PCPs based on performance

**2.7.c.4 Participating Safety Net Hospitals** (page 165)

- a. Ensure that each Network Provider arrangement with a Participating Safety Net Hospital:
  - 5) Requires that the Participating Safety Net Hospital share meaningfully in the Contractor's financial accountability for performance under the Contract, as follows and as further specified by EOHHS:
    - a) Such financial accountability shall include the potential for the Participating Safety Net Hospital to share gain and share responsibility for loss through one or more of the following:
      - i. Financial and performance accountability for the cost and quality of episodes of care (e.g., bundled payments);
      - ii. A Total Cost of Care (TCOC) sub-budget with accountability for quality
      - iii. Other performance accountability including financial penalties and bonuses; or
      - iv. An arrangement under which the Participating Safety Net Hospital otherwise financially participates in the savings and losses of the Contractor or ACO Partner, such as through the Participating Safety Net Hospital's corporate affiliation to or common ownership with the Contractor or ACO Partner.
    - b) As determined by EOHHS, the Participating Safety Net Hospital shall bear more than nominal risk in the financial accountability arrangement, such that the cumulative maximum annual potential for loss or gain based on the Participating Safety Net Hospital's performance is not less than one of the following:
      - i. 25% of the annual value of the Participating Safety Net Hospital's [DSTI](#) Glide Path payment;
      - ii. 1% of the Participating Safety Net Hospital's total Medicaid patient service revenue; or
      - iii. If applicable, 30% of the difference between the Participating Safety Net Hospital's TCOC sub-budget benchmark and actual TCOC sub-budget performance

**2.7.D.6 Payment rates for Hospitals** (page 168)

- a. The Contractor shall not enter into provider agreements with hospitals that provide for payment exceeding 100% of MassHealth-equivalent rates...with the exception of

Emergency and Post-Stabilization Services...and Behavioral Health services. This maximum payment rate shall not apply if:

- 1) A higher rate is necessary for the Contractor to retain its ability to reasonably manage risk or necessary to accomplish the goals of this Contract (e.g., meet access and availability standards or an EOHHS-approved APM). The Contractor shall report any such provider agreements to EOHHS and explain the reason(s) such payments are necessary...
  - 2) The provider agreement is with a specialty cancer hospital; or
  - 3) The provider agreement is with a freestanding pediatric hospital for any service other than an inpatient discharge with a MassHealth DRG Weight of 3.5 or greater.
- b. The Contractor shall not enter into a provider agreement with a freestanding pediatric hospital for an inpatient discharge with a MassHealth DRG Weight of 3.5 or greater for a rate other than 100% of the MassHealth-equivalent rate

#### **2.8.L Integrated Care Incentive Payment** (page 202)

- For any Contractor whose ACO Partner is a Non-Federal, Non-State Public Hospital, as defined in the Commonwealth's State Plan, the Contractor shall:
- 1. For each Contract Year, collect the following information, in a form and format and at times specified by EOHHS, from such Hospital:
    - a. At the time of the midpoint evaluation specified by EOHHS:
      - 1) Progress on certain quality measures and related performance goals specified by EOHHS; and
      - 2) Additional information as specified by EOHHS.
      - 3) At the time of the year end evaluation specified by EOHHS:
      - 4) Performance information on certain quality measures specified by EOHHS; and
      - 5) Additional information as specified by EOHHS...
  - 3. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments at a frequency specified by EOHHS, within 3 days of receiving payment from EOHHS, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to such Non-Federal, Non-State Public Hospitals.

#### **2.13.D EOHHS-Directed Performance Incentive Program** (page 243)

- 2. Provider Performance Incentives: The Contractor shall implement Provider Performance Incentives (or pay-for-performance), as directed by EOHHS and as appropriate, to promote compliance with guidelines and other QI initiatives, in accordance with Section 6.1.H. The Contractor shall:
- a. Implement Provider Performance Incentives with best efforts to collaborate with Network Providers in development and revision of the incentives;
  - b. Take measures to monitor the effectiveness of such Provider Performance Incentives, and to revise incentives as appropriate, with consideration of Provider feedback;
  - c. Collaborate with EOHHS to design and implement Performance Incentives that are consistent with or complimentary to Performance Incentives established by the PCC Plan;

- d. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Provider Performance Incentives; and
- e. Ensure that all Provider Performance Incentives comply with all applicable state and federal laws

## MARYLAND

### HEALTHCHOICE MANAGED CARE ORGANIZATION AGREEMENT

*(Contract runs from January 1, 2019 through December 31, 2025)*

Maryland's unique all-payer model for hospital payment allows the state to set a single hospital payment rate for all payers (Medicaid, Medicare and Commercial.). In 2009, the state introduced quality measures into its payment system, adjusting rates for hospitals' quality performance. This program then added cost and utilization measures in 2017 through the state's [Care Redesign Program \(CRP\)](#)

In January 2019, Maryland and CMS agreed to a new [Total Cost of Care \(TCOC\)](#) model, expanding on the CRP to include incentives for care coordination and efficiency across the delivery system. The TCOC outlines provisions for hospital and primary care payment models, care redesign, and payment for quality; however, since these are agreements between CMS and the State, they do not contain applicable model contract language for Medicaid MCOs.

## 8. Hospital Payment Program

### a ii Population-based Payment (page 16)

- Over the Performance Period of the Model, the State must use its all-payer rate-setting authority under Md. Code Ann. Health-Gen. §19-201 et seq. to ensure that 95 percent of all Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology and that such Population-Based Payments are subject to adjustments based on the hospital quality and value-based payment programs developed and administered by the State in accordance with Section 8.d.
  - 1. For purposes of this Section 8.a.ii, the term Population-Based Payment is defined to mean hospital payment that either (1) is directly population-based, such as prospectively tying hospitals' reimbursement to the projected utilization of services by a specific population or subpopulation of Maryland residents, or (2) establishes a fixed budget for Regulated Maryland Hospitals for services projected to be furnished.

### 8.c.i MPA Proposal (page 19)

- A proposed methodology to calculate an MPA-specific quality score for each Regulated Maryland Hospital ("Quality Adjustment Score"). The State's proposed Quality Adjustment Score methodology must utilize a subset of the quality measures included in Appendix D of this Agreement, at least one of which must satisfy the requirements of 42 CFR § 414.1415(b)(2), and at least one of which must satisfy the requirements of § 414.1415(b)(3). To meet these requirements, the State's proposed Quality Adjustment Score methodology must include the following two measures in its proposed quality Adjustment Score methodology:

- a. The all-payer case-mix adjusted readmission rate for patients who were hospitalized at an acute care hospital and experienced an unplanned readmission to an acute care hospital.
- b. The composite result for Maryland's Hospital Acquired Condition program.

#### **8.d Maryland Hospital Quality and Value-based Payment Program** (page 23)

- During the Performance Period of the Model, the State will develop and administer hospital quality and value-based payment programs in accordance with this Section 8.d. The State will use the results of the State's hospital quality and value-based payment programs to adjust Population-Based Payments for Regulated Maryland Hospitals on an all-payer basis in accordance with Section 8.a.ii.
  - i. Quality and Value-Based Program Performance Targets. For each Model Year, the State will set performance targets and select quality measures for the State's hospital quality and value-based payment programs in accordance with the following:
    - 1. The State shall select annual performance targets that meet or exceed the results achieved under the Maryland All-Payer Model. The State may change the performance targets in consultation with CMS.
    - 2. The State shall utilize similar categories of quality measures to those used for the programs established under Section 1886(o) (Hospital Value Based Purchasing program), Section 1886(p) (Hospital Acquired Condition Reduction program), and Section 1886(q) (Hospital Readmissions Reduction program) of the Act,

#### **9. Care Redesign Program** (page 29)

- **g. Incentive Payment Pool** (page 31)
  - a. The [HSCRC](#) shall determine each [CRP](#) Hospital's Incentive Payment Pool for a CRP Performance Period by calculating the amount by which [Potentially Avoidable Utilization] PAU Savings achieved by the CRP Hospital for the relevant CRP Track exceeds the Intervention Resource Allocation, if any, for that CRP Track and multiplying that amount by 1 + the Quality Adjustment Score.

#### **10. Maryland Primary Care Program** (page 33)

- Care Management Fees ("CMFs"). CMS will pay primary care practices and [Care Transformation Organizations] CTOs participating in the MDPCP a risk-stratified per-beneficiary per-month CMF based on the number of attributed Medicare FFS Beneficiaries.
- Other Primary Care Payments. CMS will pay primary care practices and CTOs participating in the [MDPCP](#) an at-risk Performance Based Incentive Payment ("PBIP") on a per-beneficiary per-month basis, which must be repaid to CMS by MDPCP participants that fail to meet the applicable utilization and quality targets.

## **MICHIGAN**

### **[Comprehensive Health Care Program for the Michigan Department of Health and Human Services](#)**

*(Contract runs from 2016 through 2020)*

#### **Exhibit A, Statement of Work, Background** (page 20)

- [MDHHS](#) will support Contractors to implement payment reform initiatives that pay providers for value rather than volume; value defined as health outcome per dollar

of cost expended over the full cycle of care. In this regard performance metrics will be linked to outcomes. Paying for value in the Medicaid population will move away from fee-for-service (FFS) models and embrace accountable and transparent payment structures that reward and penalize based on defined metrics.

- Contractor must fully participate with MDHHS-directed payment reform initiatives implemented throughout the term of the Contract and the expansion of patient-centered medical homes. Contractor must fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs, are served by person-centered models across all health care domains. Contractors are encouraged to propose and pilot innovative projects.

#### **Exhibit A, Statement of Work, III. Payment Reform, A. Value-Based Payment Models**

(page 25)

- Consistent with MDHHS's policy to move reimbursement from FFS to value-based payment models, Contractor agrees to increase the total percentage of health care services reimbursed under value-based contracts over the term of the agreement.
- Contractor recognizes value-based payment models as those that reward Providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries. Value-based payment models include, but are not limited to:
  - Total capitation models
  - Limited Capitation models
  - Bundled payments
  - Supplemental payments to build practice-based infrastructure and
  - Enrollee management capabilities
  - Payment for new services that promote more coordinated and appropriate care, such as care management and community health work services, that are traditionally not reimbursable
- Contractor will report at least semi-annually to MDHHS on [MHP](#) health care services reimbursed under value-based payments using the format specified by MDHHS in Appendix 3b, and will comply with payment reform goals and threshold targets established by MDHHS in consultation with contracted MHPs.

#### **Exhibit A, Statement of Work, III. Payment Reform, B. Patient-Centered Medical Homes and Primary Care Transformation** (page 26):

- Contractor must comply with MDHHS guidance related to payer partner participation in the PCMH Initiative including, but not limited to:
  - Establishing payment arrangements and making payments according to the PCMH Initiative payment APM to participating practices or physician organizations as determined by MDHHS for Enrollees attributed to participating Providers. Contractor must make payments based on the Primary Care Provider selected by or assigned to each Medicaid Enrollee (as determined by the Contractor and communicated to MDHHS), or to the physician organization of that Primary Care Provider, as instructed by MDHHS. Contractor may determine the frequency of payment provided it is no less often than quarterly (i.e. every three months). Contractor will not be responsible for making PCMH Initiative payment for retroactive Medicaid eligibility periods or for attempting to recoup

payments previously made for an Enrollee that experiences a change in eligibility type or status.

- Contractor acknowledges that the PCMH Initiative and the APM used will evolve under direction from MDHHS with the goal of increasingly promoting payment reform, primary care transformation and improvements in patient care.
- Contractor's payments to PCMH Initiative participants will be included in the Contractor's APM reporting requirements for this Contract.

**Appendix 5d, 2018 Pay for Performance – Healthy Michigan Plan, Cost-Sharing and Value-based Services, Provider Incentive Performance Area** (page 172) Submit a policy/program description for the Healthy Michigan Plan (HMP) provider incentive which must include:

- Description of provider incentive, including identification of any codes to determine eligibility.
- Health plan process for educating physicians on the Health Risk Assessment and provider incentive program, including outreach related to revisions to Healthy Michigan Plan Health Risk Assessment and new Healthy Behaviors Incentives.

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## MINNESOTA

### **CONTRACT FOR PREPAID MEDICAL ASSISTANCE AND MINNESOTACARE**

*(Contract runs from January 1, 2019 through December 31, 2019 with 1 year automatic renewal)*

**2.67 IHP Entity** (page 22) means a health care delivery system demonstration Integrated Health Partnership (IHP) entity that has a contract with the STATE to develop alternative and innovative health care delivery methods, pursuant to Minnesota Statutes, §256B.0755.

#### **4.16 PAYMENT FOR HEALTH CARE HOME CARE COORDINATION; VARIANCE.** (page 70)

- 4.16.1 The MCO shall pay a care coordination fee to Providers for qualified Enrollees of a certified Health Care Home within the MCO Provider network, unless the MCO is using an alternative comprehensive payment arrangement or the Enrollee is attributed to an Integrated Health Partnership (IHP), that is receiving a population-based payment, identified in section 4.17.1.2(2) below.

#### **4.17 INTEGRATED HEALTH PARTNERSHIPS DEMONSTRATION.** (page 70-71)

- 4.17.1.1 The MCO and the STATE will participate in a quarterly population-based payment and shared savings and losses payment methodology through the Integrated Health Partnerships (IHP) Demonstration with the STATE's contracted IHP Entities in the MCO's provider network,
- 4.17.1.2 The STATE will provide the MCO with the following information:
  - (1) A list of the STATE's contracted IHP Entities no later than thirty (30) days after the IHP contracts take effect.
  - (2) Data identifying the MCO's Enrollees that are attributed to a particular IHP Entity at that time for the purposes of the quarterly population-based payments as well as for the shared savings and shared losses payment...
  - (3) For the shared savings and losses payment, the STATE will provide:
    - a. Information on the total cost of care for the MCO's attributed Enrollees, including an estimate of the IHP settlement(s) no later than ten (10) days after the end of the Contract Year; and

- b. Subsequently, the STATE will calculate an interim payment and a final payment for the performance periods...
- (4) The STATE will notify the MCO in writing of the shared savings for the interim and final payments to be paid to the IHP Entity or Entities; ...The MCO shall issue payment to the IHP Entity as identified by the STATE within thirty (30) days from the date of the notification from the STATE.
- (5) The STATE will notify the MCO in writing of the quarterly population-based payment amounts paid to the IHP Entity or Entities by the state agency...

## MISSISSIPPI

### CONTRACT BETWEEN THE STATE OF MISSISSIPPI DIVISION OF MEDICAID OFFICE OF THE GOVERNOR AND A COORDINATED CARE ORGANIZATION (CCO)

*(Contract runs from July 1, 2017 through June 30, 2020)*

#### **7.B.5 Patient Centered Medical Homes** (page 95)

- The Contractor shall encourage the development of NCQA-recognized Patient-Centered Medical Homes and coordinate with any Division-level initiatives related to the development and NCQA recognition of Patient-Centered Medical Homes, as defined by the Division. Based on the collaboration with the Division, the Division will define specific reporting requirements which may change as the initiative is implemented. The Division will notify the Contractor of the reporting requirements in writing at least sixty (60) days before the report containing the required information is due.

#### **10.H Value-based Purchasing** (page 131)

- At its option, the Division may implement a value-based purchasing model within the MississippiCAN Program...
- The Contractor will have an opportunity to provide recommendations on selections for priority areas, measures, and targets based on the results of gaps analysis and root cause analyses performed by the Contractor.

## MISSOURI

### MO HealthNet Managed Care - Central, Eastern, Western, and Southwestern Region (Request for Proposal)

*(Contract runs from May 1, 2017 through June 30, 2018)*

#### **2.21.6 Physician Incentive Plan Reports** (page 121)

- On an annual basis and in compliance with the Federal regulation, the health plan shall disclose physician incentive plans to CMS and the state agency. The disclosure statement shall include the following:
  - c. The type of incentive arrangement;
  - d. The percent of withhold or bonus applied, if applicable

#### **2.26 Claims Processing and Management Information Systems** (page 139)

- 2.26.9 In accordance with Executive Order 07-12, signed by the Governor of the State of Missouri on March 2, 2007, the health plan shall:
  - d. Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results.

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## NEVADA

### [2016 RFP 3260](#)

*(Contract runs from July 1, 2017, to June 30, 2021 with possibility of two (1) year extensions)*

#### **3.6.3.5 Use of Medical Homes and Accountable Care Organizations** (page 93)

- The vendor is encouraged to use existing patient-centered medical homes/health homes, when available and appropriate. Vendor should use supportive provider services and contracting to support the expansion of patient-centered medical homes/health homes. Vendor is encouraged to use Accountable Care Organizations (ACOs) and other innovative models, when available and appropriate.

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## NEBRASKA

### [Request for Proposal Number 5151 Z1](#)

*(Contract begins January 1, 2017 and runs for approximately 5 years effective from date of award, with possibility of 2 additional 1-year period renewals)*

#### **I.7 Patient-Centered Medical Homes** (page 97)

- The MCO must describe in its response to the RFP, and provide a final PCMH Implementation Plan within 90 calendar days of the date of this contract that also describes, its methodology for promoting patient centeredness/PCMHs within its provider network. The plan should include, but not be limited to:
  - ii. Any payment methodology, such as incentive payments, to the PCPs to support this transformation.

#### **Q. 6. Value-Based Contracting** (page 150)

- a. It is the policy of [MLTC](#) that [MCO] should promote added value for members and providers. Value is captured through programs that improve outcomes and lower costs. Contracted providers shall be engaged in the pursuit of improved value. A key mechanism to achieve this is through value-based contracting arrangements. For purposes of this contract, value-based contracts are defined as payment and contractual arrangements with providers that include two components:
  - i. Provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics, and
  - ii. Payment methodologies that align their financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

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## NEW HAMPSHIRE

### [New Hampshire Medicaid Care Management Services Model Contract](#)

*(Contract runs from July 1, 2019 through June 30, 2024)*

#### **4.13.5 Provider Contract Requirements** (page 174)

- 4.13.5.1 General Provisions

- The MCO shall keep participating physicians and other Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.12.3 (Quality Assessment and Performance Improvement Program). The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

#### **4.13.5.11 Payment Models** (page 178)

- The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

#### **4.14 Alternative Payment Models** (page 179)

- As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community. In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to: (1) clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN; (2) encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and (3) provide an established framework for monitoring MCO performance on APMs.
- Prior to and/or over the course of the Term of this Agreement, [DHHS](#) shall develop the DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement. Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14.2) consistent with the DHHS Medicaid APM strategy. The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings, planning efforts, the provision of all required and otherwise requested information related to APMs, and other activities as specified by DHHS.
- For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:
  - Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;
  - Uses a common set of performance measures across all the Providers;
  - Does not set the amount or frequency of the expenditures;
  - Does not allow DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

#### **4.14.1 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver** (page 180)

- Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14.3 (MCO Alternative Payment Model Implementation Plan)) that fifty percent (50%) of all MCO medical expenditures are in

Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions...

**4.14.1.1 MCO Incentives and Penalties for APM Implementation** (page 181)

- Consistent with the requirements set forth in SB 313, the MCO shall include through APMs and other means provider alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.
- MCOs shall be subject to incentives and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

**4.14.2 Qualifying Alternative Payment Models** (page 181)

- A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section 4.14 (Alternative Payment Models) and the DHHS Medicaid APM Strategy.
- At minimum, a Qualifying APM must meet the requirements of the HCP-LAN APM framework Category 2C, ... HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy. DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.4.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.
- Under no circumstances will DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

**4.14.2.1 Standards for Large Providers and Provider Systems** (page 181)

- The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

**4.14.2.3 Accommodations for Small Providers** (page 182)

- The MCO shall develop Qualifying APM models appropriate for small Providers, as further defined by the DHHS Medicaid APM Strategy. For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

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**NEW JERSEY**

**[Contract to Provide Services for federally qualified/ state defined health maintenance organization for prepaid, capitated comprehensive health care services](#)**

*(January 2016)*

➤ **Article Eight: Financial Provisions, 8.5.10 Payment for Increased Access to Physician Services** (page 295)

- Requirement: Beginning January 1, 2016 (State Fiscal Year 16B), to encourage new and continued provider participation in the Medicaid/NJ FamilyCare program while strengthening recipients' access to primary care physician services, preventative care physician services and postpartum physician services, (a list of target codes is located in Appendix B.8.5.10) [DMAHS](#) has allocated additional funds to the capitation rates for the Contractor to increase provider reimbursement for such services. While the amount will vary each State Fiscal

Year that the program is in force, the allocation for State Fiscal Year 16B is \$30.11 Million. The contractor shall submit to DMAHS a plan for how it will distribute these additional capitation funds (i.e., code-specific rate increase; quality-based initiative; alternative payment methodology such as bundled payments, shared savings, patient centered medical home payment models and/or ACO collaboration; etc.), including the rationale for the distribution and the manner in which the methodology addresses both individual network needs as well as the overall goals of the Medicaid/NJ FamilyCare program within thirty (30) calendar days prior to the start of the State Fiscal Year. Prior to implementation of such plan, DMAHS must review and approve the plan in writing. The contractor is encouraged to depart from the code-centered methodology and employ alternative payment methods to distribute a greater percentage of the target funds each contract year.

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## NEW MEXICO

### Managed Care Services Agreement among NM Human Services Department, NM Behavioral Health Purchasing Collaborative and XX, Centennial Care 2.0

*(Contract runs from March 15, 2018 through December 31, 2022; updated June, 2019)*

#### **Attachment 3.A Value-based Purchasing Performance Improvement Targets** (page 316).

- Percentage of provider payments as a component of a VBP payment arrangement. The CONTRACTOR must meet minimum targets for three levels of value-based purchasing arrangements
  - Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets. Additional Requirements:
    - 1. Must include a mix of physical health, behavioral health, long term care and nursing facility providers.
    - 2. The CONTRACTOR shall establish a process for providers in VBP arrangements to have access to data that provides information about members' utilization of services including total cost of care on a quarterly basis.
  - Level 2: Fee schedule based, upside-only shared savings-- available when outcome/ quality scores meet agreed-upon targets (may include downside risk). Additional Requirements:
    - 1. Must include two or more bundled payments for episodes of care.
    - 2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with high volume hospitals and require avoidable readmission reduction targets of at least 5% of the hospital's CY 2017 or MY 2016 baseline as outlined in definitions below.
    - 3. The CONTRACTOR shall establish a process for providers in VBP arrangements to have access to data that provides information about members' utilization of services including total cost of care on a quarterly basis.
  - Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk. Additional Requirements:

- 1. Global or capitated payments with full risk. Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in bullet 2 below. Full Delegation of Care Coordination within Level 3 VBP arrangements as outlined in definitions below.
- 2. (see level 2).
- 3. (see level 2)

<b>Contract Period 1</b> (Jan 1 – Dec 31, 2019)	<b>Contract Period 2</b> (Jan 1 – Dec 31, 2020)	<b>Contract Period 3</b> (Jan 1 – Dec 31, 2021)	<b>Contract Period 4</b> (Jan 1 – Dec 31, 2022)
Level 1: 8%	Level 1: 10%	Level 1: 11%	Level 1: 12%
Level 2: 11%	Level 2: 13%	Level 2: 14%	Level 2: 15%
Level 3: 5%	Level 3: 7%	Level 3: 8%	Level 3: 9%
Total: 24%	Total: 30%	Total: 33%	Total: 36%

**4.13.1 Patient Centered Medical Homes** (page 163)

- The CONTRACTOR shall work with PCP Contract Providers to implement PCMH programs. PCMHs are not required to attain NCQA or Joint Commission recognition but are encouraged to achieve recognition as soon as possible.
- Attachment 3 (page 312) For Legacy CONTRACTORS, a minimum of a five percent (5%) ...[and] For non-Legacy CONTRACTORS, a minimum of ten percent (10%) of the CONTRACTOR's total Members assigned to a PCP who is a provider with a Patient-Centered Medical Home (including both PCMHs that have achieved NCQA accreditation and those that have not) by the end of the calendar year.

**NEW YORK**

**MEDICAID MANAGED CARE/FAMILY HEALTH PLUS/HIV SPECIAL NEEDS PLAN/HEALTH AND RECOVERY PLAN MODEL CONTRACT DRAFT**

*(Contract runs from March 1, 2019 through February 29, 2024)*

**22.18 Value Based Payment (VBP) Arrangements** (page 264)

- a. For the purposes of this Section, "On Menu VBP Arrangements" means Value-Based Payments arrangement types that are specifically identified in the NYS VBP Roadmap and the Clinical Advisory Groups (CAG) Playbooks, which are available on the STATE website. "Off Menu VBP Arrangements" means Value-Based Payments arrangements that are not specifically identified in the NYS VBP Roadmap or the CAG Playbooks, but are aligned with the principles of VBP
- b. Pursuant to Section 22.5 (a)(vii) of this Agreement, the Contractor shall include VBP arrangements in subcontracts with Participating Providers. VBP arrangement types include:
  - i. On-Menu VBP Arrangements
    - A) The Contractor may utilize On-Menu VBP Arrangement types, as set forth in the NYS VBP roadmap and the CAG Playbooks. These Playbooks contain the definitions of these VBP arrangements as well as the performance measures that the Participating Providers have to report to the MCO and the State. On-Menu VBP Arrangement types include:
      - I. Total care for general population;

- o II. Integrated primary care;
  - o III. Selected care bundles; and/or
  - o IV. Special needs subpopulations.
- li. Off-Menu VBP Arrangements
  - A) In addition to utilizing On-Menu VBP arrangement options, the Contractor may also develop Off-Menu VBP arrangements with Participating Providers that are aligned with the principles of VBP. All Off-Menu VBP arrangements included in subcontracts are required to meet the criteria that is described in the NYS VBP Roadmap.
- The contractor shall ensure that the Level of the arrangement (1, 2 or 3) is consistent with the Level definitions as outlined in the NYS VBP Roadmap.
- STATE shall classify subcontracts containing VBP arrangements pursuant to the NYS VBP Roadmap, and the STATE-issued "Provider Contracting Guidelines." STATE shall review such subcontracts according to the degree of provider risk included in the subcontract.
- The VBP Innovator Program<sup>13</sup>
  - i. STATE shall notify the Contractor of designated qualified providers for participation in the VBP Innovator Program. Upon notification by STATE of qualified providers for participation in the VBP Innovator Program, the Contractor shall modify subcontracts with such designated providers to include the parameters of the VBP Innovator Program, as set forth in the NYS VBP Roadmap.

### **3.18 Payment for Patient Centered Medical Home and Adirondack Health Care Home Multipayor Demonstration Program**

- a) Patient Centered Medical Home (PCMH) (page 51)
  - i. State Department of Health (STATE) will provide payments to the Contractor for the sole purpose of the Contractor making enhanced payments to contracted office based physicians/practices and Article 28 clinics that meet New York's medical home standards and provide primary care services to persons enrolled in Medicaid Managed Care and Family Health Plus.
    - A) Effective April 1, 2015, enhanced PCMH payments will not be included in the Capitation Rate. PCMH payments will be made by STATE twice per year to the Contractor based on PCMH expenses detailed in the Contractor's Annual and 2nd Quarter financial reports that are submitted to comply with the requirements set forth in Section 18.5 (a) of this Agreement...
  - ii. To be eligible for the medical home payment, contracted office based physicians/practices, nurse practitioners and Article 28 clinics, both freestanding and hospital outpatient facilities, must meet the National Committee for Quality Assurance (NCQA) Physician Practice Connections – Patient Centered Medical Home Program standards and be designated as the Enrollee's primary care provider.
  - iii. STATE will provide the Contractor with a "master list" of providers eligible to receive an enhanced payment in accordance with this Section that will be updated monthly.
  - iv. The Contractor will make payments to those providers on the master list that are the PCP of record for identified Enrollees...

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<sup>13</sup> "VBP Innovator Program" means a program that is for qualifying providers that are supporting the total cost of care for both VBP subpopulations and the general population of their attributed members under an advanced VBP Level 2 or a VBP Level 3 arrangement. STATE is responsible for identifying providers that qualify to participate in this program.

- b) Payment for Adirondack Health Care Home Multipayor Demonstration Program (AHCHMDP). (page 52)
  - i. STATE will provide payments to the Contractor for the sole purpose of the Contractor making enhanced payments to contracted office based physicians/practices and Article 28 clinics that operate in the upper northeastern region (Clinton, Essex, Franklin, Hamilton, Saratoga and Warren Counties) of New York and are participants in the Adirondack Health Care Home Multipayor Demonstration Program authorized pursuant to Article 29-A of the Public Health Law.
    - A) Effective April 1, 2015, enhanced AHCHMDP payments will not be included in the Capitation Rate. AHCHMDP payments will be made by STATE twice per year to the Contractor based on AHCHMDP expenses detailed in the Contractor's Annual and 2nd Quarter financial reports that are submitted to comply with the requirements set forth in Section 18.5 (a) of this Agreement...
    - C) Enhanced payments received by the Contractor in accordance with this Section may not be retained or used for any other purpose. The Contractor cannot use the payments received from STATE to reduce or augment reductions in reimbursement to its contracted primary care providers.

**NORTH CAROLINA**  
**[RFP 30-190029-DHB](#)**

*(Contract runs from 2020 through 2023)*

**7.4.p Advanced Medical Home Payments (page 165)**

- i. In addition to the payment for services provided, the [PHP](#) shall pay [AMH](#) practices each of the following components:
  - a) Medical Home Fee (all Tiers);
  - b) Care Management Fee (Tiers 3 and 4 only); and
  - c) Performance Incentive Payments (required only for Tier 3 until such time the Department expands the required payment to other tiers).
- ii. The PHP shall pay Medical Home Fees to AMH Tiers 1 – 3 practices no less than the following amounts (as allowed under 42 C.F.R. § 438.6(c)) for the first two contract years:
  - a) \$1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the Medicaid Fee-for-Service program);
  - b) \$2.50 PMPM for Members not in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the Medicaid Fee-for-Service program); and
  - c) \$5.00 PMPM for Members in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the Medicaid Fee-for-Service program).
- iii. The PHP shall pay Care Management Fees to Tier 3 practices that are negotiated between the PHP and Tier 3 practice and that adequately compensate Tier 3 practices for the additional care management responsibility assumed. The PHP shall not be required to contract with any particular entity as an Advanced Medical Home
- iv. In Contract Years 1 and 2, the PHP shall pay Performance Incentive Payments to Tier 3 AMH practices, with the following requirements:

- a) The PHP shall design Tier 3 Performance Incentive Payments to be in addition to Medical Home Fees (i.e., the PHP shall not place all or part of the Medical Home Fees at risk based on performance).
  - b) The PHP shall use the HCP LAN Levels 2 through 4 as a framework for the design of the Performance Incentive Payments for AMH Tier 3.
  - c) The PHP shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set, once finalized.
- v. The PHP shall have flexibility to develop its own payments within AMH Tier 4  
*For additional information about the tiering criteria for Advanced Medical Homes can be found in supplemental document - [Attachment M](#)*

## **E.2 Value-based Payments/Alternative Payment Models (page 175)**

- c. The Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by twenty (20) percentage points, or represent at least fifty percent (50%) of total medical expenditures.
  - d. PHPs shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in moving toward value-based payment, including having systems that can support alternative payment arrangement models which require shared savings and/or risk-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract...
  - e. To ensure the PHP's response aligns with the Department's strategy and goals, the PHP shall provide a description of the PHP's Value Based Purchasing/Alternative Strategy over the initial three (3) year period and its alignment to the Department's short- and long-term goals to shift from a fee-for-service system to VBP...
  - g. The PHP shall submit an updated VBP/APM Strategy to the Department on an annual basis that includes the following updates:
    - i. Updates to the HCP-LAN APM assessment;
    - ii. Progress towards the PHPs goals, strategies and interventions for moving providers through higher levels of the LAN framework;
    - iii. The PHP's progression over time, if applicable, in advancing providers through higher levels of the LAN framework.
    - iv. Progress toward the PHP's annual targets for amount of funding in VBP/APM arrangements by year;
    - v. Updates against all Physician Incentive Plans (as applicable); and
    - vi. Results of the PHP's outcome measurements and analysis of the ROI by year and to-date.
    - vii. Changes or improvements in the PHP's IT capabilities necessary for the successful implementation of the targeted VBP/APM arrangements.
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## OHIO

### Ohio Medical Assistance Provider Agreement for Managed Care Plan

(Year started: July 2018, updated February 2019).

#### **Appendix K Quality Improvement, 3. d** (page 133)

- The [MCP](#) shall perform the following administrative activities in support of the Comprehensive Primary Care (CPC) initiative: Reimburse [CPCs](#) the agreed upon 'per member per month' (PMPM) payment for attributed members and any shared savings for meeting model requirements in accordance with requirements set forth by ODM.

#### **Appendix Q Payment Reform** (page 253)

- **Introduction.** On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery.
  - **2. ODM's Expectations.** ODM expects the MCP to support and advance initiatives to develop a health care market where payment is increasingly designed to improve and reflect the effectiveness and efficiency with which providers deliver care...The MCP shall achieve progress in the following areas:
    - **a. Value-Oriented Payment.** The MCP shall design and implement payment methodologies with its network providers designed either to cut waste or reflect value. For the purposes of this Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those tied to provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.
  - **3. Obligations of the MCPs.** The MCP shall implement payment strategies that tie payment to value or reduce waste. In doing so, the MCP shall provide ODM with its strategy to make 50% of aggregate net payments to providers value-oriented by 2020.
  - **4. State Sponsored Value Based Initiatives.** Ohio is committed to pursuing payment models that increase access to patient-centered medical homes and support episode-based payments for an acute medical event. The purpose of both models is to achieve better health, better care, and cost savings. Participation of the MCP is critical to the success of both models. The MCP shall implement value-based initiatives in accordance with Ohio Administrative Code rules [5160-1-70](#) (episode-based payments), [5160-1-71](#), (PCMH: eligible providers) and [5160-1-72](#) (PCMH: payments).
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## OREGON

### Health Plan Services Regional Contract

(Contract runs from October 1, 2019 through December 31, 2024)

#### **Exhibit B – Statement of Work - Part 4 - Providers and Delivery System – 7. Patient Centered Primary Care Homes** (page 69)

- A. Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes as identified by OHA. Contractor shall develop and assist in advancing Providers along the spectrum of the [PCPCH](#) model (from Tier 1 to Tier 5). Contractor shall assist Providers within its delivery system to establish PCPCHs...
- D. Contractor shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of Health System Transformation

#### **Exhibit H – Value Based Payment** (page 180)

- Contractor shall demonstrate...how it will use Value-Based Payment methodologies alone or in combination with delivery system changes to achieve the Triple Aim Goals of better care, controlled costs, and better health for Members.
- Contractor shall implement a schedule of Value-Based Payments, with benchmarks and evaluation points identified that demonstrate direct support for transformation of care delivery and the sustainability of care innovations across the care continuum.
- 1. VBP Minimum Threshold - Starting on the Effective Date of this Contract, Contractor shall make at least twenty percent (20%) of its projected annual payments to its Providers in contracts that include a VBP component as defined by the Health Care Payment Learning and Action Network's "Alternative Payment Model Framework White Paper Refreshed 2017" (<https://hcp-lan.org/apm-refresh-white-paper/>), Pay for Performance LAN category 2C or higher... In addition to the LAN Framework, , Contractor shall use the VBP Roadmap for Coordinated Care Organizations and the [OHA](#) VBP Technical Guide for Coordinated Care Organizations for the VBP specifications and the appropriate LAN VBP category for each payment model.
- 2. Expanding VBP beyond primary care to other care delivery areas
  - A) Contractor shall develop new, or expanded from existing contract, VBPs in care delivery areas which include Hospital care, maternity care, children's health care, Behavioral Health care, and Oral Health care.
  - B) Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher throughout the Term of this Contract . Contractor shall implement care delivery area VBPs, according to the following schedule:
    - (1) In 2020, Contractor shall develop three (3) new or expanded VBPs. The three (3) new or expanded VBPs shall be in three of the listed care delivery areas, and one of the areas must be Behavioral Health care, and one of the two remaining care delivery areas must be either Hospital care or maternity care. However, nothing precludes Contractor from designing new or expanded VBPs in Hospital care, maternity care, and Behavior Health care. A VBP may encompass two care delivery areas; e.g. a Hospital maternity care VBP that met specifications for both care delivery areas could count for both Hospital care and maternity care delivery areas;
    - (2) Commencing on January 1, 2021, Contractor shall implement the three (3) new or expanded VBPs that were developed during Contract Year one (2020)

- (3) Commencing on January 1, 2022, Contractor shall implement a new VBP in one additional care delivery area. By the end of 2022, new VBPs in Hospital care, Behavioral Health care, and maternity care shall be in place
  - (4) Commencing on January 1, 2023 and then on January 1, 2024, Contractor shall implement one new VBP each year in each of the remaining care delivery areas; and
  - (5) By the end of 2024, Contractor shall implement new or expanded VBPs in all five care delivery areas.
- 3. Patient-Centered Primary Care Home (PCPCH) VBP requirements
- a. Contractor shall provide per-Member-per-month payments to its PCPCH clinics as a supplement to any other payments made to PCPCHs, be they Fee-for-Service or VBPs.
- 4. VBP Targets by Year
- a. Contractor must increase the level of VBPs each Contract Year during the Term of this Contract and must meet minimum annual thresholds, according to the following schedule:
    - (1) For services provided in 2021, no less than thirty-five percent (35%) of Contractor's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
    - (2) For services provided in 2022, no less than fifty (50%) ... must ... fall within LAN Category 2C...or higher
    - (3) For services provided in 2023, no less than sixty percent (60%) ...must ... fall within LAN Category 2C...or higher, and no less than twenty percent (20%) ... must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards Contractor's annual VBP targets.
    - (4) For services provided in 2024, no less than seventy percent (70%) ... must...fall within LAN Category 2C ... or higher, and no less than twenty-five percent (25%) ... must also fall within LAN Category 3B... or higher. These payments will apply towards Contractor's annual VBP targets.

## PENNSYLVANIA

### [HealthChoices Physical Health Agreement](#)

*(Contract begins on January 1, 2018)*

#### **VII.E.7 Value Based Purchasing** (page 135)

- a. Goals
- The [PH-MCO](#) must enter into arrangements with Providers that incorporate value based purchasing strategies such as:
    - i. Provider pay for performance programs
    - ii. Patient Centered Medical Homes (PCMH)
    - iii. Shared savings contractual arrangements
    - iv. Bundled or global payment arrangements
    - v. Full risk or Accountable Care Organization payment arrangements
  - The financial goals for the VBP strategies for each calendar year are based on a percentage of the PH-MCO's expenditures to the medical portion of the risk adjusted capitation and maternity revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments. These goals apply collectively to all

HealthChoices Agreements between the PH-MCO and the Department in all HealthChoices Zones. For the purpose of this requirement, Capitation revenue is gross of premiums for risk sharing or risk pool arrangements without adjustment for risk sharing or risk pool results. The PH-MCO must achieve the following percentages through VBP arrangements:

- Calendar year 2017 – 7.5% of the medical portion of the capitation and maternity care revenue must be expended through VBP strategies. The 7.5% may be from any combination of the five (5) strategies listed.
- Calendar year 2018 – 15% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP strategies. At least 50% of the 15% must be from a combination of strategies ii. through v.
- Calendar year 2019 – 30% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 30% must be from a combination of strategies iii. through v.

➤ b. Reporting

- The Department will measure compliance through required reports that have been accepted by the Department. By January 1 of each calendar year, the PH-MCO must submit its proposed VBP plan to the Department that outlines and describes its plan for compliance in that calendar year. The Department will review and provide feedback on the plan to the PH-MCO. By the last work day of every quarter, the PH MCO must submit a progress report.
- By June 30 of the subsequent calendar year, the PH-MCO must submit a report on accomplishments from the prior year. This annual report must include a listing of the VBP arrangements by provider; and an explanation of each arrangement; and the dollar amount spent for medical services provided during the previous year through these arrangements. The dollar amounts that qualify toward meeting the VBP goals are as follows:
  - i. Provider pay for performance programs – dollar value of performance (bonus) payments and direct payments made to the Provider for Members attributed to the provider's panel during the calendar year.
  - ii. Patient Centered Medical Homes – dollar value of any PCMH payments, performance (bonus) payments, direct payments made to the provider and total medical costs, incurred by the PH-MCO for Members of the provider's panel during the time period of the calendar year the Member was attributed to the provider's panel.
  - iii. Shared savings contractual arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the PH-MCO for Members of the provider's panel during the time period of the calendar year the Member was attributed to the provider's panel.
  - iv. Bundled or global payment arrangements – dollar value of bundled payments made to providers.
  - v. Full risk or Accountable Care Organization payment arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the PH- MCO for Members of the provider's panel inclusive of any previous (bonus) payments during the

time period of the calendar year the Member was attributed to the provider's panel.

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## **RHODE ISLAND**

### **Rhode Island MCO Base Contract**

*(Contract runs from 2017 through 2022 with five 1-year option periods)*

See also [Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners](#)

#### **1.01 PATIENT CENTERED MEDICAL HOME** (page 28)

- A PCMH must: be participating in or have completed a formal transformation initiative (i.e., [CTC-RI](#), PCMH-Kids or a payer-sponsored program) and/or practice has obtained NCQA Level 3 recognition, within 24 months of seeking PCMH status under the Rhode Island Office of the Health Insurance Commissioner (OHIC) Affordability Standards, demonstrate meaningful performance improvement over an annual two-year look back period, or within 12 months of seeking PCMH status under the RI OHIC Affordability Standards, have implemented the following specific cost-containment strategies (strategy development and implementation at the practice level rather than the practice site level is permissible): (a) develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future; (b) practice uses data to implement care management, focusing on high-risk patients and interventions that will impact ED and inpatient utilization; (c) implements strategies to improve access to and coordination with behavioral health services; (d) expands access to services both during and after office hours; (e) develops service referral protocols informed by cost and quality data provided by payers; and (f) develops/maintains an avoidable emergency department use reduction strategy. C. Within 24 months of seeking PCMH status under the Affordability Standards, Practices demonstrate meaningful performance improvement over an annual two-year look back period.

#### **2.01 General** (page 38)

- Executive Office of Health and Human Services (EOHHS) requires that the Contractor will work towards incorporating value based purchasing initiatives into their provider contracts. EOHHS is committed to creating partnerships with organizations using accountable care delivery models that integrate medical care, behavioral health, substance use disorders, community health, public health, social determinants, related social services, and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.
- ... the State anticipates the implementation of hospital and nursing home incentive payments on a pre-determined schedule as defined by EOHHS. Payment are to be made in the current contract period based on performance by the specified providers in fiscal year 2016. These incentive payments are not being considered part of the medical component of the premium payment made to the Health Plan, but will be paid directly by EOHHS to the Contractor. Total incentive payment inclusive of performance goal and/other provider performance based payments cannot exceed five percent of capitation.

#### **2.01.01.01 Alternative Payment Methodologies** (page 40)

- EOHHS' FY 2016 contracts with MCOs included the provision that Contractor would have 20% or more of their total payments to providers in alternative payment arrangements by the last quarter of SFY 2016.
- For Contract Period 2 beginning July 1, 2018, EOHHS will withhold 1% of capitation amounts. The withheld amounts will be repaid as monthly adjusting payments subject to the Contractor's demonstration that it has achieved the threshold values in APM payments
- <for all contract periods> The percent of high need members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost as defined in Section 6 of RI EOHHS, Alternative Payment Methodology Guidelines for Medicaid Managed Care Organizations shall be equal to or greater than the percent of high cost, high need persons in the MCOs entire enrolled membership.

<b>Percent Spend and Membership Requirements for Alternative Payment Models</b>			
Contract Period & Date	% Payment through Alternative Payment Methodology	% Payment through Total Cost of Care Model with EOHHS Certified Accountable Entities <sup>14</sup>	% Members assigned to PCMH
03_2018 – 06_2018	60%	35%	-
07_2018 – 06_2019	80%	50%	65%
07_2019 – 06_2020	80%	65%	80%
07_2020 – 06_2021	80%	65%	80%
07_2021 – 06_2022	80%	65%	80%

**2.01.01.02 Accountable Care Entities** (page 41)

- During Contract Period the Contractor will subcontract with three (3) or more Type 1 EOHHS certified Accountable Entity or have at least 30,000 Medicaid attributed lives in a contractual arrangement with a certified AE and will subcontract at least one Specialized Accountable Entity, as applicable.

**2.05.07 Assignment of PCPs** (page 57)

- The EOHHS recognizes the importance of members enrolling in a Patient Centered Medical Homes (PCMHs) and building a relationship with the Primary Care Provider (PCP). EOHHS expects that the Contractor to auto-assign to providers in a PCMH practice before auto assigning to non-PCMH providers. The Contractor will provide EOHHS with quarterly reports of the number and percent of total members assigned to PCMH sites either by auto-assignment or member choice.

**2.06.05.08 Hospital and Nursing Home Incentive Payments** (page 84)

<sup>14</sup> The total cost of care (TCOC) calculation...includes a historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement. Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to keep their attributed population well, in the hope that they will earn savings. Shared savings distributions must be scaled in light of comprehensive and well-defined quality and outcomes metrics. (page 36)

- EOHHS will initiate the Hospital and Nursing Home Incentive Program for SFY 2017 and 2018. Participating hospitals and nursing homes will be awarded incentive payments based on a set of measures which demonstrate efforts towards value-based contracting and achieving outcome-based clinical and utilization metrics as defined by EOHHS.
- Contractor will use identified benchmarks and specific performance measures established by EOHHS to determine those hospitals and nursing home that receive incentive payments. Contractor will distribute payment to each participating hospital and nursing home based on a schedule provided by EOHHS. If the hospital or nursing home does not meet the requirements no incentive payments will be provided

**2.08.02.01 Contracting with Accountable Care Entities** (page 91)

- The Contractor will establish total cost of care (TCOC) calculation methodologies that adhere to EOHHS APM Guidance to serve as the basis of their shared savings and/or risk arrangements with AE subcontractors

**2.09.10 EOHHS Affordability Standards** (page 103)

- The Contractor shall comply with the Affordability Standards issued by the RI Executive Office of Health and Human Services (EOHHS). The Affordability Standards aim to improve the affordability of health in the State by requiring companies issuing health insurance to: (1) expand and improve primary care infrastructure, (2) adopt patient centered medical homes, (3) support Current Care the State's information exchange, and (4) work toward comprehensive payment reform across the delivery system.

**2.15.01.03 Incentive Payments** (page 135)

- *Hospital and Nursing Home Incentive Program*
  - EOHHS is developing and implementing the Hospital Incentive program, inclusive of data collection, performance measurement and scoring, dollar allocation for payment to providers, and funds distribution. The program will include one-time payments made to hospitals by contracted MCO with total payments not to exceed \$13.5 million with all payments to be made on or before December 31, 2017.
  - EOHHS shall provide Contractor a specific provider performance report that details each specific hospital, the performance measure, baseline for each measure, identified benchmark, performance score, and dollars allocated for each measure.
  - In advance of Contractor's payments to hospitals, Contractor shall receive payment from EOHHS in the amount and schedule set forth stipulated in the provider performance report. Contractor will use this report to make the incentive payment to each applicable hospital on a scheduled basis as determined by EOHHS.
  - The total amount to be paid for each provider will be equally distributed among each contracted Health Plan. Payments to the applicable hospitals as specified in the provider performance report will be based on demonstrated achievement of pre-determined performance benchmarks for established measures; if a hospital does not achieve the benchmark, no payment will be made.
  - These incentive payments are not to be considered part of the medical component of the premium payment made to the Health Plan. Neither the payment to Contractor by EOHHS nor the incentive payments made by Contractor to hospitals shall be included in any risk/gain share calculations or in any total cost of care calculations pertaining to arrangements with Accountable Entities. Total incentive payment inclusive of performance goal and/other provider performance based payments cannot exceed five percent of capitation
- Accountable entities (funded through Rhode Island DSRIP)

- For each MCO the identified Total Incentive Pool shall consist of two parts: (a) the MCO Incentive Program Management portion that can be earned by the MCO for effective and timely implementation and management of the incentive program and (b) the Accountable Entity Incentive Pool. The MCO Incentive Program Management Pool shall minimally be five percent of the Total Incentive Pool. To the degree that the MCO has more than the minimally required number of contracts with AEs as set forth in Section 2.01.01.02 the MCO Incentive Program Management Pool shall be increased by one percent for each AE contract to a maximum of eight percent.
- The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the MCO Incentive Program Management Pool
- Incentive payments actually earned by the AE may be less than the amount they are potentially eligible to earn. Contractor shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE

## **SOUTH CAROLINA**

### **South Carolina Healthy Connections**

*(Contract runs from July 1, 2018 through June 30, 2021)*

**Section 15.5.1.1, Quality Withhold and Bonus Program** (page 190): The CONTRACTOR shall: Meet the Alternative Payment Model (APM) target, as described in Section 15 of this contract. Failure to meet the APM target shall result forfeiture of twenty five (25) percent of the withhold dollars.

**15.6. Alternative Payment Models (APM)** (page 191): The purpose of APMs is to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes.

- 15.6.1. The CONTRACTOR shall: Adopt reimbursement models that shift away from standard FFS reimbursement towards Alternative Payment Models (APM).
- 15.6.2. Design and implement payment methodologies with its network Providers that
- adopt the following parameters, as defined in the Department and detailed in the Managed Care Policy and Procedure Guide:
  - 15.6.2.1. Payment for Performance.
  - 15.6.2.2. Episodes of Care.
  - 15.6.2.3. Shared Savings Arrangements
  - 15.6.2.4. Shared Risk Arrangements.
  - 15.6.2.5. Capitation Payments with Performance and Quality Requirements.
- 15.6.3. Agree that Prior Authorization and utilization management activities do not satisfy the definition of APM.
- 15.6.4. Implement APMs and reach the following targets for each measurement year as outlined in Exhibit 5.

#### **Exhibit 5. CONTRACTOR Targets for APMs by Calendar Year**

<b>Year</b>	<b>Target</b>
January 1, 2018 – December 31, 2018	30% of total payments
January 1, 2019 – December 31, 2019	30% of total payments
January 1, 2020 – December 31, 2020	30% of total payments
January 1, 2021 – December 31, 2021	30% of total payments

- 15.6.5.2. Failure to meet the minimum target for each measurement year will result in the CONTRACTOR forfeiting twenty-five (25%) percent of withhold dollars as described in Section 15.

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## TENNESSEE

### Statewide Contract with Amendment 6, Published July 1, 2017

*(Contract runs from January 1, 2014 through December 31, 2020 updated July, 2019)*

#### **Supplemental Documents:**

- [Patient Centered Medical Homes for the TennCare population](#)
- [TennCare Episode of Care Program Description](#)
- [Tennessee HealthLink: Provider Operating Manual](#)

#### **A.2.13.1: General (page 308)**

- 2.13.1.9 The CONTRACTOR shall implement Episodes of Care (retrospective episode based reimbursement for specialty and acute care) and Primary Care Transformation strategies, inclusive of PCMH (comprehensive primary care program) and Tennessee Health Link (integrated care coordination for members with the highest behavior health needs), consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes but is not limited to:
  - 2.13.1.9.1 Using a retrospective process to administer value-based outcome payments for the initiative's payment reform strategies that is aligned with the models designed by TENNCARE
  - 2.13.1.9.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode, and the definition of quality measures for the initiative's payment reform strategies
  - 2.13.1.9.3 Implementation of payment reform strategies and improvements at a pace dictated by the State. This includes actively participating in episodes-related stakeholder conversations.
  - 2.13.1.9.4 Implementation of aligned TennCare PCMH strategy shall include at least thirty-seven percent (37%) of the CONTRACTOR's TennCare population beginning January 1, 2019 and at least thirty-seven percent (37%) of the population beginning January 1, 2020.
- 2.13.1.9.9 The CONTRACTOR shall update cost and quality thresholds annually for all episodes in performance. The updated cost and quality thresholds shall be included in the Episodes of Care Performance Reports.

#### **Patient Centered Medical Homes for the TennCare Population** (see supplementary documents)

- PCMH participating providers in Tennessee receive support in addition to fee-for-service payments to support the practices new PCMH activities (page 4):
  - Training: Organizations receive free practice transformation training from Navigant, a State funded trainer, through January 31, 2020. Beginning in January 2020, training and support will continue with the MCOs.
  - Transformation Payment: Providers receive a per-member per-month payment for the first year to support PCMH transformation efforts.
  - Activity payment: Providers receive a risk-adjusted per-member per-month payment to support PCMH activities for their panels of assigned members.

- Outcomes payment: Providers may earn outcomes-based payments to reward practices that succeed in increasing efficiency and quality.
  - Large panel providers: Organizations with greater than 5,000 members with a single TennCare MCO will be evaluated for quality improvement and shared savings on total cost of care.
  - Small panel providers: Organizations with 500 to 5,000 members with a single TennCare MCO will be evaluated for quality improvement and efficiency performance metrics that serve as a proxy for shared savings on total cost of care.

## TEXAS

### Texas Health & Human Services Commission Uniform Managed Care Terms & Conditions

*(Year started: September 2011, updated September 2018).*

- **Attachment B-1, Section 4.3.5.7. Provider Incentives** (page 148): The Respondent must submit a proposal for a pilot "gain sharing" program. The program should focus on collaborating with Network physicians and Hospitals in order to allow them to share a portion of the Respondent's savings resulting from reducing inappropriate utilization of services, including inappropriate admissions and readmissions. The proposal should include mechanisms whereby the Respondent will provide incentive payments to Hospitals and physicians for quality care. The proposal should include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for payment.
- **Attachment B-1, Section 8.1.7.8.2 MCO Alternative Payment Models with Providers** (page 284): HHSC requires the MCOs to transition the provider payment methodologies from volume based payment approaches, i.e. fee for service, to quality-based alternative payment models, increasing year-over-year percentages of provider payments linked to measures of quality and/or efficiency. Alternative Payment Models (APMs) should be designed to improve health outcomes for Members, empower Members and improve experience of care, lower healthcare cost trends, and incentivize Providers. Examples of APMs are programs to improve access to primary care, support care coordination and/or integration, and reduce inappropriate utilization of services.
- **Attachment B-3, Performance Standard 15.2** (page 496) The MCO must meet minimum APM ratios as follows:
  - CY2018: Overall APM Ratio: >=25%, Risk Based APM Ratio: >=10%
  - CY2019: 125% of CY2018 Minimum Target APM Ratios
  - CY2020: 125% of CY2019 Minimum Target APM Ratios
  - CY2021: Overall APM Ratio: >=50%, Risk Based APM Ratio: >=25%
  - Failure to meet calendar year target for overall APM, and not eligible for exception, based on HHSC's exception criteria: Up to \$0.10 per member per month (PMPM) for period of measurement.
  - Failure to meet target for Risk Based APM, and not eligible for exception: Up to \$0.10 per member per month (PMPM) for period of measurement.

## VIRGINIA

### MEDALLION 4.0 Program

*(Contract runs annually from January 2018 with provisions for six (6) twelve-month renewal options).*

#### **Section 9.2 Value-Based Payments (VBP)** (page 274):

- Value-based payment (VBP) encompasses a broad set of payment strategies that link provider financial incentives to the provision of high-quality, efficient patient care. Provider performance on designated measures of quality, cost and/or resource use, and patient access and satisfaction can serve to determine the level and direction of incentives. [DMAS](#) is interested in the creation of VBP arrangements as a vehicle to improve care delivery for Medicaid members through implementation of payment reforms that move providers away from volume based financial incentives, instead enhancing flexibility and rewarding high-quality, efficient patient care.
- The Offeror shall propose a VBP implementation and development strategy that (see <http://hcp-lan.org/workproducts/apm-whitepaper.pdf>). This strategy shall place emphasis on the establishment of provider payment arrangements designated as categories 3 and 4 and the evolution of providers along the APM model continuum (i.e. from less sophisticated to more advanced categories and to more sophisticated models within a general category).
- The Offeror's VBP implementation and development strategy for MEDALLION 4.0 members shall clearly indicate what steps will be in place by contract execution. The strategy also shall indicate how the Offeror plans to expand or further enhance these initial efforts through articulation of steps to be taken in the first and second contract years.
- The submission shall discuss the Offeror's specific goals for VBP implementation and development over the life of the Contract. Such goals shall incorporate the following:
  - The form of specific models and VBP arrangements the Offeror shall implement if selected.
  - The quantitative, measurable, clinical outcomes the Offeror seeks to improve through implementation of such models (e.g. reducing emergency department utilization associated with a specific patient population). Potential areas of priority Offerors should consider may include, but are not limited to, the following Departmental goals:
    - 1. Improved birth outcomes
    - 2. Appropriate, efficient utilization of high-cost, high-intensity clinical settings
    - 3. Reduce all-cause hospital readmissions
    - 4. Reduce hospital admissions for chronic disease complications
- The expectation that the portion of the Offeror's medical expenditures (including drugs) governed under VBP arrangements shall either 1) increase by at least 20 percentage points by the end of year three of the Contract or 2) represent at least 50% of the Offeror's total medical expenditures by the end of year three of the Contract. To the extent that the Offeror's medical expenditures governed under VBP arrangements would already represent at least 50% of total medical expenditures, the Offeror's strategy shall demonstrate how it plans to increase the implementation of HCP-LAN APM categories 3 and 4 arrangements by at least 15 percentage points by the end of year three of the Contract, while also maintaining or expanding overall VBP arrangement

penetration levels. For the purposes of these expectations, percentage increases are presumed off of the Offeror's prior year experience. The Department reserves the right to adjust targeted penetration percentages, including increases or decreases of such percentages, at its discretion.

- These goals shall pertain to specific measurable outcomes that are meant to improve quality, reduce costs, and increase patient satisfaction and engagement. This strategy shall place emphasis on the establishment of provider payment arrangements designated as HCP-LAN APM categories 3 and 4, as well as the evolution of providers along the APM model continuum. Emphasis will be placed on proposals that present a logical and realistically attainable strategy for implementation and evolution of such models. Additionally, the strategy shall include:
  - 1. Designation and contact information for the individual in the Offeror's organization responsible for development and execution of the Offeror's VBP implementation and development strategy
  - 2. Discussion of specific models and VBP arrangements proposed for implementation
  - 3. Discussion of plans and strategies to develop provider readiness for VBP and evolution along the VBP continuum
  - 4. Discussion of Offeror's approach to and experiences (if applicable) with episodic payment arrangements and the challenges and opportunities they present for implementation among providers serving the member population
  - 5. Specific health outcomes and efficiency goals that will be tracked and evaluated for performance as part of each model
  - 6. Description of how proposed or developing VBP arrangements align across books of business in Virginia or other markets. To the extent such alignment is relevant, the strategy should address how provider performance measurement and incentives align or will align across books of business in a way that maximizes the impact of such incentives while minimizing provider confusion caused by multiple, differing VBP arrangements
  - 7. Discussion of how Offeror systems are designed to identify providers operating under VBP arrangements and track its performance
  - 8. Discussion of how Offeror will share data with providers and support providers in using the data to improve performance
  - 9. Methods and frequency for collecting and providing performance data to providers (please provide an example or template of a relevant, current data sharing report issued to providers)
  - 10. Specific objectives for VBP arrangement implementation, including scope, provider performance, and a timeline for implementation related to each of the proposed VBP approaches, and
  - 11. Plans for the provision of provider support to facilitate successful implementation and development of VBP arrangements, such as technical support, establishment of new data feedback systems, and financial support for provider infrastructure necessary to execute select model concepts.
- To the extent the Offeror has prior experience implementing VBP arrangements among its provider network, the Offeror's VBP submissions shall include a table indicating all of

its current VBP arrangements across all lines of business and states. The table shall separately and explicitly identify any applicable VBP arrangements across lines of business. To the extent the Offeror has extensively implemented VBP arrangements, entries may be generalized across a specific model type (e.g. Accountable Care Organizations). Offeror's tables should address the following:

- 1. Name of the VBP program
- 2. Line(s) of business to which the program applies
- 3. State(s) in which the program applies
- 4. Description of the VBP program
- 5. Whether the VBP program was required by the state
- 6. Applicable HCP-LAN APM category/sub-category (e.g. Category 2c) in which the arrangement best fits
- 7. Provider types governed under the arrangement
- 8. Service types governed under the arrangement
- 9. Quality requirements under the VBP program
- 10. Percent of total medical spending (including drug spending) governed under the arrangement for the relevant line of business in CY 2016
- 11. Percent of total projected medical spending (including drug spending) governed under the arrangement for the relevant line of business in CY 2017

#### *Test Cases*

- As part of the Offeror's submission, the Offeror shall submit responses to both of the test cases presented below and develop a summary proposal for how it might address implementation of a VBP arrangement.
- *Test Case #1:* How would the Offeror propose to approach the development and implementation of an episodic payment with the primary goals of improving birth outcomes while decreasing health care spending associated with a perinatal episode? As part of this submission, please address the 10 elements of a maternity care episodic payment identified below. Additionally, please address anticipated challenges with implementation of such an episode, including provider readiness and data sharing issues. Offerors can find additional detail and examples of these 10 elements as enumerated in Appendix D of the HCP-LAN White Paper on Accelerating and Aligning Clinical Episode Payment Models at the following link (<https://hcp-lan.org/groups/cep/clinical-episode-payment/>):
  - 1. Episode Definition
  - 2. Episode Timing
  - 3. Patient Population
  - 4. Services
  - 5. Patient Engagement
  - 6. Accountable Entity
  - 7. Payment Flow
  - 8. Episode Price
  - 9. Type and Level of Risk
  - 10. Quality Metrics
- *Test Case #2:* Within an Offeror's member group there is likely to be a group of individuals who are high-utilizers or emerging high-risk members who use a very high

number and intensity of services. Part of implementing an effective VBP strategy that improves patient outcomes while reducing unnecessary utilization should include identification of this population of members and tailoring interventions that address the root causes driving their health care utilization. How would the Offeror propose to tailor a VBP approach that would determine and address these root causes?

- Questions to consider include:
  - 1. What characteristics would the Offeror use to define this group (e.g. number of chronic conditions, emergency department utilization, etc.)?
  - 2. Following determination of the size and composition of this group, please describe the process the Offeror might undertake to determine what types of interventions would be most effective at improving the quality of care and utilization patterns exhibited by these members?
  - 3. What utilization, quality, and outcome measures would the Offeror consider to assess performance under the intervention?
  - 4. How might the Offeror determine and address non-clinical features of this patient population contributing to the poor health and high utilization exhibited by the group?
  - 5. What provider incentives would be most appropriate as part of this VBP arrangement? Why are such incentives well suited to facilitating the desired outcomes of the VBP arrangement?

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## WASHINGTON

### [Washington State Health Care Authority, Washington Apply Health Managed Care Contract](#)

*(Contract runs from January 1, 2019 – December 31, 2019)*

**4.2 Remaining Challenge Pool Funds** (page 355): Each MCO with Apple Health<sup>15</sup> Contract(s), will be eligible to earn a Challenge Pool Remaining Funds Share that is determined by two factors as follows:

- **4.2.1. HCP LAN 3A-4B Threshold Score:** First HCA will determine if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year set out in Table 2... If the MCO's annual HCP LAN 3A-4B achievement percentage is equal to or greater than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share shall be calculated under subsection 4.2.2 below.
- **4.2.2. Relative QIS Adjusted for Relative Membership:** Second, if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year then the MCO will receive a percentage of the Challenge Pool Remaining Funds that is determined by the relative magnitude of each MCO's all contract QIS score established under the Contractor's Apple Health Contract(s), adjusted for attributed member months per MCO.

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<sup>15</sup> The public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance program (CHIP), and the state-only funded health care programs.

**Table 2  
P4P Weights, Targets and Thresholds**

Year	Performance Targets & Thresholds			Calculation Weight		
	HCP LAN 2C-4B Target	HCP LAN 3A-4B Threshold Score*	MACRA A-APMs Target	Achievement Score	Achievement Subset Score	Improvement Score
PY1	30%	N/A	N/A	40%	0%	60%
PY2	50%	10%	N/A	35%	5%	60%
PY3	75%	20%	10%**	45%	5%	50%
PY4	85%	30%	TBD	50%	5%	45%
PY5	90%	50%	TBD	55%	5%	40%

\* In all years the HCP LAN 3A-4B Threshold Score applies under Section 4 of this Exhibit. In PY4 and PY5 the HCP LAN 3A-4B Threshold Score is additionally applicable under subsection 3.3.5 of this Exhibit.

\*\*This percentage is subject to approval by the Centers for Medicare and Medicaid Services (CMS).

- **5.16 Provider Payment Reform** (page 81): Washington Health Care Authority (HCA) intends to reform provider payment. The Contractor shall collaborate and cooperate with HCA on provider payment reform. The Contractor will provide in a timely manner any information necessary to support HCA's analyses of provider payment.
- **5.25.1** (page 95) The Contractor shall require all providers to report PPC associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (42 C.F.R § 434.6(a)(12)).

## **WISCONSIN**

### **BADGERCARE PLUS AND MEDICAID SSI CONTRACT - BadgerCare Plus or BadgerCare**

*(Contract runs from January 1, 2018 through December 31, 2019)*

#### **Article X. Section N. Alternative Payment Models.** (page 191)

- 1. Goal: The Department's APM program goals are aligned with Learning Action Network (LAN)'s goals to move "payments away from fee for service (FFS) and into APMs that reduce the total cost of care (TCOC) and improve the quality of care."
- 2. Definition of APM: 2. Definition of APM. The Department defines APMs as payments made by Wisconsin Medicaid HMOs to their providers through quality and value-based purchasing arrangements. The APM numerator is defined as the total dollar value of all payments could potentially be made by Wisconsin Medicaid HMOs to their providers for services rendered to BadgerCare Plus and Medicaid SSI members, that are directly linked to attainment of quality goals by the providers, or are "at-risk" for quality achievements. The numerator includes capitation payments made by HMOs to their providers for which the providers assume the full insurance risk. The numerator does not include any surplus or profit sharing by HMOs with the providers if such sharing is not directly related to attainment of quality goals by the providers. The denominator is defined as the total payments made by Wisconsin HMOs to their providers for services rendered to BadgerCare Plus and Medicaid SSI members. The denominator includes any APM-related payments. Providers include non-hospital providers (community-based providers, and home health agencies, among others) and hospitals. Additional details will be provided in the "MY2018 HMO Quality Guide" (the Guide).
- 3. Geographic Coverage: APMs are applicable across the State of Wisconsin, i.e., all six Medicaid HMO regions.

- 4. Timeframe: The 2018 Measurement Year (MY 2018) will begin on January 1, 2018 and end on December 31, 2018.
- 5. Benefit Plans in Scope: The scope includes BadgerCare Plus (this includes the Childless Adult population) and Medicaid SSI Plan.
- 6. HMO Withhold: There are no withholds, incentives or penalties applicable to HMOs for APMs in MY 2018. HMOs are required to report the potential dollars for the APM-related numerator and denominator, and the percentage of their total potential payments to providers based on quality and value-based payments. HMOs will be asked to attest to the accuracy of their report.
- 7. APM Threshold Target: The Department will set a threshold target percentage for combined BadgerCare Plus and Medicaid SSI dollars, and list the target in the Guide. HMOs are expected to meet that threshold in their APM payments to providers.
- 8. APM Data Submission: HMOs will be asked to submit their APM data annually. The submission process is described in the Guide.

## WEST VIRGINIA

### State Fiscal Year 2019 Purchase of Service Provider Agreement;

*(Contract commences July 1, 2018 and is effective through June 30, 2019)*

#### **1.6 .1 PCP Responsibilities** (page 66)

- A patient-centered medical home is, "a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team...to meet the needs of the patient in all aspects of ... care using evidence-based medicine and technology. At the point in time that the Center for Medicare and Medicaid Services includes the nurse practitioner as a leader of the multidisciplinary health team, this state will automatically implement this change."

#### **2.7.10 Alternative Payment Models (APM)** (page 85)

- The MCO is required to implement alternative payment models (APMs) that shift from fee-for-service reimbursement to reimbursement that rewards improved delivery of health care. In SFY 2019, the MCO is required to implement APMs that include ten (10) percent of members enrolled during the State Fiscal Year. Bureau for Medical Services (BMS) intends to increase this target in future years. The MCO shall design and implement payment models with network providers that tie reimbursement to measurable outcomes. APMs may include, but are not limited to the following:
  - 1. Primary care incentives;
  - 2. Payment for performance;
  - 3. Shared savings arrangements;
  - 4. Risk sharing arrangements;
  - 5. Episodes of care/bundled payments; and
  - 6. Capitation Payments with Performance and Quality Requirements.
  - 7. Prior authorization and utilization management activities do not qualify as APMs.

# Contract Excerpts by Topic:

## Maternity

### LOUISIANA

#### **2.11.9 Non Payment** (page 149)

- The Contractor shall deny payment to providers for deliveries occurring before thirty-nine (39) weeks without a medical indication.

### NORTH CAROLINA

#### **D.4.d.ii** (page 162)

- The PHP shall reimburse all in-network physicians and physician extenders no less than one hundred percent (100%) of the Medicaid Fee-for-Service rate for obstetrics services, which includes an enhanced rate on all vaginal deliveries (equal to the Medicaid Fee-for-Service rate for caesarian deliveries) unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

### OHIO

#### **Appendix Q Payment Reform** (page 212)

- **3. Obligations of the MCPs** (page 213) The MCP shall implement payment strategies that tie payment to value or reduce waste. In doing so, the MCP shall provide ODM with its strategy to make 50% of aggregate net payments to providers value-oriented by 2020. In addition, the MCP shall submit a quarterly progress report as specified by ODM that addresses progress towards meeting these obligations. Implementation strategies include the following: **c.** At a minimum, the MCP shall address policies to discourage elective deliveries before 39 weeks...
- **6. Care Innovation and Community Improvement Program (CICIP) Requirements. d. Quality Measures** (page 214). CICIP was developed to increase alignment of quality improvement strategies and goals between ODM, the MCP, and both public and nonprofit hospital agencies. The four agencies are large Medicaid safety-net and academic medical centers. CICIP goals align with ODM goals: improve healthcare for Medicaid beneficiaries at risk of or with an opioid or other substance abuse disorder, along with improving care coordination. Implementation of CICIP is contingent on CMS approval...ODM's actuary will estimate a per member per month (PMPM) amount associated with the CICIP program. This amount will be reduced by a predetermined percentage, with the difference being allocated to annual bonus payments based on adherence to data reporting requirements and achievement of performance improvements...After the second year of the program, ODM will calculate the bonus payments to the agencies based on the agreed upon value based/ quality measures. ODM will provide the bonus payments to the MCP so it can be distributed to the agencies.

The quality measures that were agreed upon between ODM, the MCP, and the agencies are as follows: viii. Improve the Opioid Use Disorder (OUD)/maternity measures with a focus on:

- 1. Timeliness of prenatal care;
- 2. Live births weighing less than 2,500 grams; and

- 3. Postpartum care.

## RHODE ISLAND

### 2.15.01.09 Hospital Services (page 139)

- EOHHS recognizes that providing Long Acting Reversible Contraceptive Devices (LARCs) immediately post-partum in a hospital setting and prior to discharge has been shown to be effective in prolonging inter-birth intervals and preventing pre-term birth. The Contractor is required to reimburse providers for LARCs outside of the global fee for labor and delivery when the device is inserted post-partum in a hospital setting. The Contractor shall reimburse separately for the LARC, outside of the global fee for labor and delivery.

## TENNESSEE

*See Episodes of Care*

## VIRGINIA

### Section 5.2 – Value-Based Payments (page 275)

- The quantitative, measurable, clinical outcomes the Offeror seeks to improve through implementation of such models (e.g. reducing emergency department utilization associated with a specific patient population). Potential areas of priority Offerors should consider may include, but are not limited to, the following Departmental goals:
  - 1. Improved birth outcomes

## WASHINGTON

**17.1.34 Exclusions** (page 238) The following services and supplies are excluded from coverage under this Contract.

- 17.4.4. Early, elective inductions (before 39 weeks) that do not meet medically necessary indicators set by the Joint Commission.

## WISCONSIN

### Article IV. Services (page 97)

D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women

- Requirements: 3. Payment Structure (p. 99) Enhanced payments are available for clinics for pregnant women that meet the defined eligibility criteria above and the criteria for delivery of services articulated below. The Department issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site.

## Pharmacy

## LOUISIANA

### 2.18.17.5.4 PBM Requirements (page 244)

- Any contract for pharmacy benefits manager services shall:
  - 2.18.17.5.4.1 Be limited to a transaction fee, not to exceed \$1.25 per paid claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee;

- 2.18.17.5.4.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and
- 2.18.17.5.4.3 Exclude spread pricing, defined as any amount charged or claimed by a pharmacy benefits manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.

## MISSISSIPPI

### 5-F: Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices (page 56)

- The Contractor is not authorized to negotiate rebates for preferred products. The Division or its Agent will negotiate rebate agreements. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements.
- The Contractor shall not keep a spread between what the Contractor and its Pharmacy Benefit Manager (PBM) pay and what any participating pharmacy receives on any prescription drug claim dispensed to a Member.

## OREGON

### Exhibit B – Statement of Work - Part 2 - Covered and Non-Covered Services – 7. Covered Service Components: Medication Management (page 35)

- Oregon Prescription Drug Program; Agreements with Pharmacy Benefit Managers (2) ... Contractor may Subcontract for PBM services provided that its Subcontracts with its PBM include...
  - (b) Pass through 100% of pharmacy costs such that a claim level audit will clearly show that payments made to a pharmacy by the PBM matches the amount the Contractor has paid to the PBM;
  - (c) Pass through all rebates and other utilization-based payments made to the PBM by the manufacturers
  - (d) ii. If the market check report finds that current market conditions can yield “in the aggregate” gross plan pharmacy cost savings of a one percent (1.0%) or more, the parties shall execute an amendment to the existing pricing terms and other applicable provisions under the PBM contract within thirty (30) days, to be effective on the later of thirty (30) days post signature or by no later than October 1st of the evaluation year.
  - (e) Require full, clear, complete, and adequate disclosure to Contractor and OHA the services provided and all forms of income, compensation, and other remuneration it receives and pays out or expects to receive or pay out under the Subcontract with Contractor.
- (3) No-spread PBM contracting requirements do not preclude Contractor to enter into a pay for performance model contract. However, if Contractor desires to use a pay for performance contract with its PBM, Contractor must provide OHA with Administrative Notice of such intent and include the proposed model pay for performance contract with such Administrative Notice.

## NORTH CAROLINA

### C.3.f Pharmacy Benefit Managers (page 112)

- ii. If the PHP utilizes a PBM, the PHP shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor pharmacy benefit manager performance, and ensure the confidentiality of Member information and the Department information that is not public.
- iv. If the PBM is owned wholly or in part by a retail pharmacy participating provider, chain drug store or pharmaceutical manufacturer, the PHP shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of Member and the Department proprietary information.

### C.3.i Drug Rebates (page 114)

- i. The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid and NC Health Choice Program... If the PHP or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid and NC Health Choice covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements

## TEXAS

- **Attachment B-1, Section 8.1.21.7 Pharmacy Benefit Manager (PBM)** (page 333): Further, the MCO's reimbursement methodology for the PBM must be based on the actual amount paid by the PBM to a pharmacy for dispensing and ingredient costs. However, this prohibition on the industry practice known as "spread pricing" is not intended to prohibit the MCO from paying the PBM reasonable administrative and transactional costs for services, as described in UMCM Chapter 6.1, "Cost Principles for Expenses."
- **Attachment B-1, Section 8.1.21.11 Maximum Allowable Cost Requirements** (page 333): In formulating the MAC price for a "market basket" of drugs (a group of therapeutically related drugs that will be assigned the same price), MCOs and PBMs must use only the prices of the drugs listed as therapeutically equivalent in the most recent version of the Orange Book. Drugs listed as therapeutically equivalent are A-rated drugs. Therefore, MCOs and PBMs can only use A-rated drugs to set MAC prices. B-rated drugs cannot be used in MAC pricing calculation. MCOs and PBMs can include B-rated drugs in the same market basket, but those B-rated drugs must be assigned the same price as the A-rated drugs.
- **Attachment B-1, Section 8.1.21.13. Health Resources and Services Administration 340B Discount Drug Program** (page 335): The MCO must use a shared-savings approach for reimbursing Network Providers that participate in the federal Health Resources and Services Administration's (HRSA's) 340B discount drug program.

## Behavioral Health

## COLORADO

### 14. CAPITATED BEHAVIORAL HEALTH BENEFIT (page 89)

- 14.2. As the administrator of a capitated benefit, the Contractor shall employ strategic health care management practices described throughout the Contract in administering

the benefit, create financial incentives to drive quality care and have strong Member experience protections.

## HAWAII

**Section 3.6, Approach to Care Delivery & Coordination, Health Plan Requirements for a Stepped Approach to Behavioral Health, C) Effective Primary Care and Behavioral Health Integration, 3. Technical Assistance for Behavioral Health Practice Transformation** (page 124):

- The Health Plan shall provide practice transformation for behavioral health providers, including both clinical and operational development, to advance the quality of behavioral health service statewide. Practice transformation for behavioral health providers include areas such as preparation for value based payment.

## KANSAS

**5.7.1.A.2 Behavioral Health Services** (page 105)

- The State seeks innovative Provider contracting strategies to address Behavioral Health service needs including Mental Health and Addiction Services. The alternative payment strategies shall be designed to reduce total cost of care, and address gaps and improvement in access to services, quality of Providers, incentives for "warm handoff" transitions from institutions to less-restrictive and less costly treatment programs in community-based programs and services, seamless follow-up care, and diversions from institutions, particularly ED diversion resulting in reduced inpatient Admissions. Service focus of the strategies shall include, but not limited to, effective Service Coordination with a particular focus on managing individuals behavioral and physical health needs, Peer Support, Supported Employment, Supportive Housing and other evidence-based practices.

**5.7.1.A.5 Physical and Behavioral Health Integration Strategies** (page 106):

- The State seeks innovative models for integration of physical and Behavioral Health services. A 2015 Government Accountability Office report (GAO-15-460) showed that nationally, over half of the Medicaid-only Members in the top 5% of expenditures had a mental health condition and one-fifth had a SUD. That report also observed that "Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens), the health care system is often too fragmented to effectively and efficiently serve them." A particular area of interest is how to better identify, treat, and transition Members to appropriate Behavioral Health services and Providers when presenting at the hospital with an emergent medical condition. In addition, proposals should consider approaches to promote use and collaboration among different Provider systems within the delivery system, such as FQHCs and Community Mental Health Centers (CMHCs).

## MICHIGAN

**Exhibit A, Statement of Work, III. Payment Reform, C. Behavioral Health Integration** (page 26):

- Contractor agrees to work with MDHHS to develop initiatives to better integrate services covered by Contractor and the PIHP(s) serving Contractor's Enrollees and to provide incentives to support behavioral health integration.

**Exhibit A, Statement of Work, VIII. Behavioral Health Integration, C. Collaboration with Prepaid Inpatient Health Plans (PIHPs), 3. Care Management and Quality Metrics for Shared Populations** (page 56):

- Contractor must work collaboratively with PIHPs, Primary Care Providers, and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.

**MINNESOTA**

**6.1.16 Health Homes (BHH; HCH; CCBHC).** (page 86)

- **6.1.16.1 Behavioral Health Home (BHH).** Behavioral Health Home services consistent with Minnesota Statutes, §256B.0757 are covered. BHH services are a set of services designed to integrate Primary Care, behavioral health, and social/community services for children with emotional disturbance (including severe emotional disturbance) and adults with serious mental illness (including serious and persistent mental illness)...
  - (3) MCO Duties. The MCO shall take the following actions to avoid duplication of care coordination activities for Enrollees receiving BHH services.
    - a. The MCO must provide the STATE with a designated MCO contact for BHH-related matters to facilitate the sharing of member information and coordination of services for Enrollees receiving BHH services.
    - b. The MCO must coordinate with BHHs within the MCO's Service Area as specified in the BHH-MCO "Roles and Responsibilities" template document developed by the STATE, with input from managed care organizations, and posted on the DHS web site...
  - (4) Payment.
    - a. The BHH care engagement rate established by the STATE is paid a maximum of six months per Enrollee's lifetime. The MCO shall work with the STATE who is responsible for ensuring that the care engagement payment, together with FFS and other managed care organization payments, does not exceed six payments per Enrollee lifetime...
    - b. The MCO shall pay a certified BHH provider the ongoing standard care BHH rate established in the STATE's fee schedule for each month after the completion of the six month BHH care engagement rate.
    - c. The MCO may not use an alternative comprehensive payment arrangement for BHH services.

**6.1.16.3 Certified Community Behavioral Health Clinics (CCBHC).** (page 87)

- CCBHC services consistent with Minnesota Statutes, Statutes §245.735 and Public Law Number 113-93, §223 are covered. CCBHCs provide a set of services designed to integrate primary care, behavioral health, and substance use disorder services (SUDs), social/community services for children with emotional disturbance (including SED) and services for adults with SMI (including SPMI)...

**NEW HAMPSHIRE**

**4.11.6 Substance Use Disorder** (page 156)

- 4.11.6.2 Payment to Substance Use Disorder Providers
  - The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements: (1) is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or (2) falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval

are further described in Section 4.14.2 (Qualifying Alternative Payment Models). DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

- In accordance with Exhibit O, the MCO shall develop and submit ... a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT38. The plan shall indicate at least two (2) tiers of enhanced payments that the MCO will make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per year (i.e., tier two (2) Providers). The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.
- The MCO is required to develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

#### **4.11.6.3 Provision of Substance Use Disorder Services** (page 157)

- The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes. This can include but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

#### **4.14.2.2 Treatment of Payments to Community Mental Health Programs** (page 181)

- The CMH Program payment model prescribed by DHHS in Section 4.11.5.1 (Contracting for Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.
- At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

#### **4.14.2.4 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health** (page 182)

- The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health. The MCO shall incorporate APM design elements into its Qualifying APMs that allow Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

#### **4.14.6.2 Alternative Payment Models for Substance Use Disorder Treatment** (page 185)

- As is further described in Section 4.11.6.2 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:
  - At least one (1) APM that promotes the coordinated and cost-effective delivery of high- quality care to infants born with NAS.
  - At least one (1) APM that promotes greater use of Medication-Assisted Treatment.
  - At least one (1) APM that promotes the use and accessibility of PRSS.

## **OHIO**

### **Appendix K Quality Care, 4. Partnering with Qualified Behavioral Health Entities (QBHEs) to Improve Population Health. c. ii. (page 137)**

- Reimburse QBHEs (qualified behavioral health entities) incentive payments for meeting quality, efficiency, or total cost of care metrics in accordance with requirements set forth by ODM.

#### **Appendix Q Payment Reform, 6. Care Innovation and Community Improvement Program (CICIP) Requirements** (page 214).

- CICIP was developed to increase alignment of quality improvement strategies and goals between ODM, the MCP, and both public and nonprofit hospital agencies. The four agencies are large Medicaid safety-net and academic medical centers. CICIP goals align with ODM goals: improve healthcare for Medicaid beneficiaries at risk of or with an opioid or other substance abuse disorder, along with improving care coordination. Implementation of CICIP is contingent on CMS approval...ODM's actuary will estimate a per member per month (PMPM) amount associated with the CICIP program. This amount will be reduced by a predetermined percentage, with the difference being allocated to annual bonus payments based on adherence to data reporting requirements and achievement of performance improvements...After the second year of the program, ODM will calculate the bonus payments to the agencies based on the agreed upon value based/ quality measures. ODM will provide the bonus payments to the MCP so it can be distributed to the agencies.

#### **RHODE ISLAND**

*Behavioral Health Requirements for Accountable Entities can be found in the [AE Certification Guidelines](#)*

#### **TENNESSEE**

##### **Tennessee Health Link (see [Tennessee HealthLink: Provider Operating Manual](#))**

- 7.2 (page 18) Activity Payments
  - Activity payments are intended to provide ongoing support to organizations as they commit to the key elements of transformation, including but not limited to care coordination, increasing member access, creating care plans, and several other elements believed to be central to transformation. Although providers are attributed a panel of members, providers only receive activity payments for members who are enrolled and who receive a qualifying Health Link activity each month.
  - Each Health Link is eligible to receive activity payments for those members who, when actively enrolled with the given Health Link, had a claim for a Health Link activity billed during a given month.
- 7.3 (page 19) Outcomes Payments
  - Outcome payments for each Health Link are based on performance on the core quality and efficiency metrics described in Section 8.1 and 8.2

## Social Determinants of Health

### HAWAII

**Section 5.1(A)6(b), Quality, Utilization Management, and Administrative Requirements, Quality Strategy and Quality Program Background, SDOH Transformation Plan** (page 282):

- The statewide SDOH Transformation Plan will be integrated into DHS Quality Strategy when completed, and will outline DHS goals in the following areas:
  - Enhanced use of SDOH data as inputs in predictive and actuarial models, as well as in hot spotting and other advanced analytic methods, leading in turn to:
    - Improved application of SDOH-based adjustment factors into Value Based Payment arrangements.

### MINNESOTA

**6.1.23 Medical Equipment and Supplies.** (page 91)

- Medical equipment and supplies includes durable and non-durable medical supplies and equipment that provide a necessary adjunct to direct treatment of the Enrollee's condition. Covered medical supplies, equipment, including electronic tablets used as an augmentative and alternative communication system as defined in Minnesota Statutes, §256B.0625, subd. 31(e), and appliances suitable for use in the home or in the community where normal life activities take the Enrollee, are those that are Medically Necessary and ordered by a physician.

### NORTH CAROLINA

**C.8: Opportunities for Health** (page 141)

- a. The Department is committed to providing the opportunity for health for North Carolinians, while improving health outcomes and reducing health care costs, and addressing the conditions in which people live that directly impact health...
- d. The PHP shall address these domains to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to...
  - iii. Value-Based Payment: The PHP shall submit a written plan to the Department that indicates how it will incorporate addressing Opportunities for Health into its value-based payment strategy to align financial incentives and accountability around total cost of care and overall health outcomes. For full Value Based Payment requirements, see Section V.E.2. Value-Based Payments/Alternative Payments.

### OREGON

**Exhibit B –Statement of Work - Part 10 - Transformation Reporting, Performance Measures and External Quality Review –**

- 4. Performance Measures: Quality Pool Incentive Payments (page 128)
  - E. Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings. The distribution plan must include:
    - a) An overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners, that provides information related to the Contractor's process of evaluating the contributions of

Participating Providers and connecting those evaluations to distribution of funds;

- F. Performance Measure Incentive Payments for Participating Providers
- 5. Contractor must offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Health-Related services Providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives.

#### **Exhibit k – Social Determinants of Health and Equity**

- 11. Traditional Health Workers (page 227) (see <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/pages/Traditional-Health-Worker.aspx>)
  - a. Contractor shall implement the THW Integration and Utilization Plan developed...The...Plan must describe how Contractor will:
    - (1) Integrate THWs into the delivery of services;
    - (2) Communicate to Members and Providers about the scope of practice, benefits, and availability of THW services;
    - (3) Increase Member utilization of THWs;
  - b. Contractor shall establish a THW Payment Grid, based on OHA's and THW Commission guidelines, a payment model grid, informed by the recommendations of the THW Commissions' Payment Model Committee, that is sustainable . Contractor must provide its THW Payment Grid to OHA via Administrative Notice by no later than April 15 of each Contract Year... The THW payment Grid must include different sustainable payment strategies, including Fee-for-Service, alternative payment models such as bundled payments and per-Member per month payments, direct employment, and other strategies. In the context of the THW Payment Grid, sustainable payment strategies means strategies that enable Contractor to pay THWs on an on going, long term basis as opposed to short or one time grants or other types of payments that result in underpayment, underemployment, or unemployment of THWs.
    - i. Contractor shall also include in its THW Integration & Utilization Report each type of payment model used by Contractor to reimburse THWs and the number of THWs paid under each payment model it utilizes.

### **RHODE ISLAND**

#### **2.01 General** (page 38)

- Executive Office of Health and Human Services (EOHHS) requires that the Contractor will work towards incorporating value based purchasing initiatives into their provider contracts. EOHHS is committed to creating partnerships with organizations using accountable care delivery models that integrate medical care, behavioral health, substance use disorders, community health, public health, social determinants, related social services, and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.
- *SDOH requirements for Accountable Entities can be found in the [AE Certification Guidelines](#)*

# Quality Metrics

## GEORGIA

### 10.3.3 Value-Based Purchasing (VBP) Program (page 244)

- 4.12.12.5 Attachment U outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets...

## MARYLAND

### II.J Financial Requirements (page 12)

- To participate in the Department's Value Based Purchasing program which, pursuant to 42 CFR 438.6(b)(2), shall be applicable only to the rating period under this Agreement. Effective January 1, 2019, the core performance measures are:
  - A. Adolescent well care visits;
  - B. Ambulatory care for SSI adults;
  - C. Ambulatory care for SSI children;
  - D. Asthma medication ratio;
  - E. Breast cancer screening;
  - F. Comprehensive diabetes care — HbA1c control (<8.0%);
  - G. Controlling high blood pressure;
  - H. Lead screening for children 12 through 23 months old; and
  - I. Well child visits in the first 15 months of life

## NEW HAMPSHIRE

### 4.14.6 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters (page 184)

- 4.14.6.1 State Priorities in Senate Bill 313
  - The MCO's APM Implementation Plan shall address the following priorities, as described in State law (Senate Bill 313 2018):
    - Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;
    - Opportunities to reduce preventable admissions and 30-day hospital readmission for all causes;
    - Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;
    - Opportunities to better integrate physical and behavioral health, particularly: efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;
    - Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

- Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.2 (Payment to Substance Use Disorder Providers) of this Agreement); and
- Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

## **NORTH CAROLINA**

### **C.6.b.iv Advanced Medical Home Contracting** (page 130)

- a) General requirements
  - 1. The PHP shall only contract with a PCP as an AMH provider if the PCP has been certified as an AMH by the Department.
- b) Advanced Medical Home Quality Metrics
  - 1. Based on the common quality measure set for the AMH program, which will be a subset of the overall measure set that the Department will be collecting for PHPs, the PHP shall compile and calculate each of the AMH quality metrics for each AMH practice and share them with the Department.
  - 2. The PHP shall provide feedback on quality scoring results to each AMH practice.
    - i. The Department will provide the PHP with AMH measure set and reporting schedule at award.
  - The PHP shall develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics.

## **OHIO**

### **6. Care Innovation and Community Improvement Program (CICIP) Requirements. d. Quality Measures** (page 214).

- The quality measures that were agreed upon between ODM, the MCP, and the agencies are as follows: viii. Improve the Opioid Use Disorder (OUD)/maternity measures with a focus on:
  - 1. Timeliness of prenatal care;
  - 2. Live births weighing less than 2,500 grams; and
  - 3. Postpartum care.

## **OREGON**

### **Exhibit H – Value Based Payment** (page 182)

- 2. VBP Data Reporting; Overview
  - a. OHA desires to ensure that linkage of quality to payment is accomplished with integrity both in terms of size of reward for performance and demonstration for excellence and meaningful improvement to receive the awards. As outlined above, OHA has the right to require Contractor to provide detailed information on the size of the VBPs made pursuant to the terms and conditions of this Contract for the purposes of ensuring that Contractor is implementing meaningful levels of incentives, such that Providers are being encouraged and rewarded for improving overall quality performance. Contractor shall describe the specific quality metrics utilizing the Health Plan Quality Metrics Committee (HPQMC) Aligned Measures Menu, which is located at the following URL:  
<https://www.oregon.gov/oha/HPA/ANALYTICS/pages/Quality-Metrics-Committee.aspx>

- In the event OHA develops an HPQMC Core Measure Set, Contractor shall use such Measure Set for identifying benchmarks and other relevant criteria for VBPs.
- For VBP arrangements that involve Behavioral Health services, Contractor shall additionally use Exhibit M to the Contract for guidance in making metric selection.

## RHODE ISLAND

### 2.06.05.06 Health System Transformation Program (page 82)

- In launching this program, the contractor must comply with specifications setting forth EOHHS requirements for Alternative Payment Methodologies ... The EOHHS APM Guidance shall include:
  - ...Metrics and required use of EOHHS Quality Scorecard;

## TENNESSEE

see [Tennessee Health Link sections 8.1-8.2](#)

see [Tennessee Episodes of Care](#)

## VIRGINIA

### Section 9.2 Value-Based Payments (VBP) (page 274):

- The Offeror's VBP implementation and development strategy for MEDALLION 4.0 members shall clearly indicate what steps will be in place by contract execution. The strategy also shall indicate how the Offeror plans to expand or further enhance these initial efforts through articulation of steps to be taken in the first and second contract years.
- The submission shall discuss the Offeror's specific goals for VBP implementation and development over the life of the Contract. Such goals shall incorporate the following:
  - The form of specific models and VBP arrangements the Offeror shall implement if selected.
  - The quantitative, measurable, clinical outcomes the Offeror seeks to improve through implementation of such models (e.g. reducing emergency department utilization associated with a specific patient population). Potential areas of priority Offerors should consider may include, but are not limited to, the following Departmental goals:
    - 1. Improved birth outcomes
    - 2. Appropriate, efficient utilization of high-cost, high-intensity clinical settings
    - 3. Reduce all-cause hospital readmissions
    - 4. Reduce hospital admissions for chronic disease complications

## WASHINGTON

### 7.2 Performance Improvement Projects

- **7.2.8.2** (page 109) The Contractor shall contract with each participating Hospital District to make pay-for-performance payments based on the quality measures and benchmarks described in 7.2.8.2.1 and 7.2.8.2.2. Each participating Hospital District (Participant) has selected previously whether the payments will be made for its work on either (a) Behavioral Health services or (b) Care Coordination services. The Participant shall collect data for the quality measures using an EHR, registry, or manually collected data. When the Participant achieves one of the specified benchmarks, it must receive a

payment equal to or greater than the applicable amount specified in 7.2.8.3 in addition to any other payments to which it may be entitled.

- **7.2.8.2.1** If the Participant indicates that the majority of the new services delivered will be behavioral health services (including psychiatric collaborative care services), the Participant submits a report on the behavioral health quality measure (Patients Screened for Clinical Depression and Follow-Up Plan – NQF 0418/MIPS 134) for a three month period that shows the Participant has met the benchmark for that period. To meet the benchmark, the Participant shall have screened a minimum of 53 percent of total clinic patients for each three-month period
- **7.2.8.2.2** If the Participant indicates that the majority of the new services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period. To meet the benchmark, the Participant must make contact with a minimum of 40 percent of patients for each three-month period

## Provider Support

### COLORADO

#### **12.11. Practice Transformation** (page 86)

- 12.11.1. The Contractor shall offer practice transformation support to Network Providers interested in improving performance as a Medical Home and participating in alternative payment models, including the Department's APM. Practice transformation efforts may include activities such as: coaching practices in Team-based Care, improving business practices and workflow, increasing physical and behavioral health integration, and incorporation of lay health workers, such as promoters, peers, and patient navigators...
- 12.11.4. The Contractor shall support Network Providers in increasing efficiencies and cost management at both the practice and the health system level by coaching providers to reduce the utilization or delivery of low-value services and supporting the identification and analysis of service overutilization.
- 12.11.7. Based on the needs of the region and the existing practice transformation resources available, the Contractor shall offer trainings, learning collaboratives, and/or other resources to support practices in achieving advanced Medical Home standards.

### DELAWARE

#### **SECTION 10 DATA SHARING AND REPORTING** (page 299)

- **a. From the Contractor to Providers:** The Contractor must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:
  - i. Identification of high risk patients;
  - ii. Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and
  - iii. Service utilization and claims data across clinical areas such as primary care, inpatient admissions, non-inpatient facility (SPU/ASC), emergency department,

radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

## GEORGIA

### 4.8.4 Primary Care Providers

- **4.8.4.6** (page 157) The Contractor shall provide a Medical Home implementation plan within ninety (90) days of the Operational Start Date for DCH review and approval that identifies the methodology for promoting and facilitating NCQA PCMH recognition and/or TJC PCH accreditation. The implementation plan shall include, but not be limited to:
  - 4.8.4.6.2 Provision of technical support, to assist in their transformation to PPC®-PCMH recognition or TJC PCH accreditation (e.g., education, training, tools, and provision of data relevant to patient clinical Care Management);
  - 4.8.3.6.4 Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.

## HAWAII

*See Behavioral Health*

## KANSAS

### 5.7.1.B State-Based Data Registries, Tools, and Resources (page 107):

- The State shall make available the following registries, tools, and resources to the CONTRACTOR(S) to assist in the implementation of Value Based Models and Purchasing Strategies:
  - Defined Cerner condition registries currently under consideration for inclusion by the State in its Kansas Modular Medicaid System development.
  - Both canned and ad hoc reporting available through the State enterprise data warehouse.
  - Public Health Registries
  - Health Information Exchanges
  - [KMAP](#) website containing updated eligibility information
  - KMAP Provider Registry
- Additional resources may be added as they are available. The State will keep CONTRACTOR(S) informed of such resources.

## LOUISIANA

- **2.16.16: Provider Supports for Quality Improvement** (page 215)
  - 2.16.16.1 The Contractor shall provide support to providers tailored to advance state priorities and ensure providers' ability to achieve the goals outlined in the Quality Strategy. Such supports shall assist providers in clinical transformation and care improvement efforts at a regional and practice level.
  - 2.16.16.2 As part of the Contractor's Quality Assessment and Performance Improvement (QAPI) Plan, it shall develop and maintain a Provider Support Plan, which shall be updated on an annual basis. The Provider Support Plan shall...Include: (a) a list of provider supports; (b) how the Contractor will provide ...support opportunities; (c) all planned technical support activities... (d) metrics to evaluate provider engagement and related improvements; and (e) detailed information regarding how its proposed provider supports activities will advance the ...(LDH) Quality Strategy.

- *See also Care Management*

## **MASSACHUSETTS**

### **2.3.A.2.f ACO Partner** (page 49)

- If Contractor has an ACO Partner, Contractor shall at a minimum, have functional integration, including developing processes for and demonstrating implementation of joint decision-making, with the ACO Partner across all of the following domains, as determined and approved by EOHHS:
  - 5. Data integration, such that the Contractor shall share, to the extent permitted under applicable privacy and security laws, data with the ACO Partner to support ACO Partner activities under this Contract. Such data sharing shall include but is not limited to:
    - a) Reports and analytics on Contractor's performance on cost and Quality Measures under this Contract;
    - b) A defined process for providing the ACO Partner relevant claims and enrollment information about Enrollees, including but not limited to a list of Enrollees and periodic updates to such list; and
    - c) A defined and coordinated process for the Contractor to collect relevant clinical information from Providers and provide such information to the ACO Partner

### **2.7.c.1 Additional Responsibilities for Certain Providers** (page 160)

- d. [The contractor shall] Spend a portion of the Contractor's Start-up and Ongoing DSRIP funding on investments in PCPs, as described in Section 5.1.F.3. In addition to the other requirements of this Contract, such investments shall comply with the requirements of Section 5.1, including requirements for proposing such activities and receiving EOHHS approval through Contractor's DSRIP Participation Plan. The Contractor's investments in PCPs shall:
  - 1) Increase the capabilities of PCPs to share information with the Contractor and with other Providers to coordinate care for Enrollees;
  - 2) Increase the capabilities of PCPs to perform and participate in the Contractor's Care Management activities, including providing additional supports to Enrollees;
  - 3) Include but be not limited to investments such as:
    - a) Investment in Primary Care technological infrastructure, including:
      - i) Health Information Technology (HIT) infrastructure deployed in the Primary Care setting;
      - ii) Clinical platforms for PCPs
      - iii) Fixed cost investments to support telehealth and costs for related non-reimbursable activities;
      - iv) Data sharing across Primary Care and Behavioral Health Providers to support Behavioral Health integration in primary care practices; and
      - v) Data analytics and informatics to support individual primary care practices;
    - b) Investment in Primary Care workforce to support the Contractor's activities under this Contract, including hiring practice extenders and other personnel, such as community health workers, licensed social workers, Providers of BH or Primary Care services, or other office personnel to work in primary care settings within their scope of practice under state law; and
    - c) Training and technical assistance that directly supports PCPs to improve performance and increase participation in Contractor's activities under this

Contract, including assistance with analytics, executing plans for performance improvement, quality measurement and management, and care coordination and Care Management activities

## MICHIGAN

### **Exhibit A, Statement of Work, XVI. Health Information Exchange/Health Information Technology, B. State Health Information Exchange Activities** (page 98):

- 3. Contractor must submit to MDHHS a plan to offer incentives for Providers to join a HIE QO and participate in certain Statewide Use cases.

## NEW YORK

*See Care Management*

## NORTH CAROLINA

### **E.2 Value-based Payments/Alternative Payment Models** (page 175)

- d. PHPs shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in moving toward value-based payment, including having systems that can support alternative payment arrangement models which require shared savings and/or risk-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract...

### **C.6.b.iv Advanced Medical Home Contracting** (page 130) *See also Care Management*

- c. Advanced Medical Home Data and Information Sharing (page 130)

In order to support care management activities, the PHP shall provide the following information to all AMH practices, at a minimum:

- Member assignment files...
- Risk stratification information...
- Initial care needs screening information...
- Quality measure performance at the practice level...
- Encounter and other data

## OHIO

### **Appendix C Plan Responsibilities, 41. Provider Feedback** (page 48).

- The MCP shall have the administrative capacity to offer feedback to individual providers on their adherence to evidence-based practice guidelines; and positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

## OREGON

### **Exhibit J - Health Information Technology – 2. Health Information Technology Roadmap** (page 203)

- a. Contractor's HIT Roadmap shall...

- (8) Describe how Contractor will implement and maintain necessary information technology infrastructure necessary to support VBP contract arrangement permitted under this Contract which includes, without limitation using HIT for
  - a) Administering VBP arrangements;
  - b) Supporting contracted Providers with VBP arrangements with actionable data, attribution, and information on performance; and
  - c) Population health management.
- d. For Contract Years two through five, Contractor shall draft an annual Updated HIT Roadmap. Such Updated Roadmap shall include a report detailing the progress made on the HIT Roadmap from the previous Contract Year... the Updated Hit Roadmap shall include, without limitation...
  - (9) Report on how Contractor used HIT to support Providers so they can effectively participate in VBP arrangements, including details regarding:
    - b) How Contractor provided Providers with VBP arrangements with accurate and consistent information on patient attribution;
    - c) How Contractor identified, for Providers with VBP arrangements, (or provided contracted Providers with VBP arrangements with the information needed for those Providers to identify) specific patients who needed intervention throughout the year so they could take action before the year-end;
    - d) How Contractor provided any other actionable data to Providers to support Providers' participation in VBP arrangements, including data on risk stratification and Member characteristics that can inform the targeting of interventions to improve outcomes;
    - e) The percentage of Providers with VBP arrangements at the start of the year who had access to these above data;
  - (10) Contractor shall report on how it used HIT for population health management, including:
    - b) For Years 2-5, Contractor shall report on provision of risk stratification and Member characteristics to contracted Providers with VBP arrangements for the population(s) included in the arrangement(s).

## PENNSYLVANIA

### Section VII: Financial Requirements (page 135)

- E. Other Financial Requirements
  - 7. Value Based Purchasing
    - e. Data Sharing
 

The PH-MCOs must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:

      - Identification of high risk patients;
      - Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and
      - Service utilization and claims data across clinical areas such as inpatient admissions, non-inpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

## RHODE ISLAND

### 2.09.11 High Utilizers (page 104)

- As part of the high utilizer initiative, EOHHS appreciates the importance of sharing high utilizer registries with providers in a secure and easily accessible manner. EOHHS anticipates the Contractor will work within its provider community to design thoughtful data sharing arrangements that are more impactful than the use of the provider portals. Additionally, EOHHS anticipates that the Contractor will bolster contracts with providers to include standards for using high utilizer data information and assisting members with hospital discharge. The Contractor is required to coordinate with PCMH practices and other providers.

## TENNESSEE

### A.2.11.2.: Primary Care Providers (page 267)

- 2.11.2.8 The CONTRACTOR agrees to implement Primary Care Transformation strategies, inclusive of PCMH (comprehensive primary care program) and Tennessee Health Link (integrated care coordination for members with the highest behavior health needs), consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE (*for more detail see [Tennessee Health Link sections 8.1-8.2](#)*)

## Care Management

## KANSAS

### 5.7.1.A.4 Long-Term Support Services (page 106)

- Long-Term Supports and Services: The State seeks innovative contracting strategies to address LTSS service needs including HCBS, Adult Care Home, and institutional services. The alternative payment strategies shall address gaps and improvement in access to services, quality of Providers, incentives for transitions from institutions to community-based programs and services, diversions from and significant reduction in the reliance of institutions for treatment, ensuring choice of in-home vs. residential services. Service focus of the strategies shall include, but not limited to Autism, Agency Directed Personal Care, Assisted Living, Residential Health Care, Home Plus, IDD Residential and other community service settings

## LOUISIANA

- **2.17.14.6** (page 228) The Contractor's ACO agreements shall...Commit the Contractor to provide contracted ACOs with the supports required under this Contract for VBP arrangements, including but not limited to...Assistance identifying high risk enrollees, including enrollees who may benefit from care management activities;

## MASSACHUSETTS

### 2.3.A.2.f ACO Partner (page 48)

- [If Contractor has an ACO Partner, Contractor shall at a minimum, have functional integration, including developing processes for and demonstrating implementation of joint decision-making, with the ACO Partner across all of the following domains, as determined and approved by EOHHS:]
  - 3) Clinical integration, as follows: The contract between Contractor and Contractor's ACO Partner shall obligate the ACO Partner to have responsibilities

related to supporting Contractor's care coordination and Care Management responsibilities as follows:

- a) Contractor and Contractor's ACO Partner shall work together to perform activities associated with this Contract such as but not limited to:
  - i) Coordinating Enrollees' care
  - ii) Developing Care Management protocols and procedures
  - iii) Providing Care Needs Screenings to Enrollees
  - iv) Providing Comprehensive Assessments and documented Care Plans to certain Enrollees
  - v) Coordinating with Contractor's BH CPs and LTSS CPs
  - vi) Developing, implementing, and maintaining Contractor's Wellness Initiatives and Disease Management Programs
  - vii) Developing, implementing, and maintaining Contractor's Transitional Care Management program, including establishing appropriate protocols with Network hospitals
- b) Contractor's ACO Partner shall have defined, delegated responsibility for activities associated with this Contract such as but not limited to:
  - i) Performing and facilitating appropriate follow-up based on Enrollees' identified care needs,
  - ii) Providing Care Management staff such as but not limited to Care Coordinators and Clinical Care Managers;
  - iii) Providing in-person Care Management activities and
  - iv) Convening care teams for certain Enrollees

## MINNESOTA

### 6.1.16.2 Certified Health Care Home. (page 87)

- Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, parts 4764.0010 through 4764.0070.
  - (1) Health Care Home services include pediatric care coordination for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness and who are not receiving care coordination services through another service.
  - (2) Care coordination services must be provided in accordance with Minnesota Statutes, §256B.0751, subd. 9.
- *See Payment Reform for description of Certified Health Care Home payment model*

## MISSOURI

### 2.1.7 Medicaid Reform and Transformation (page 14):

- c. Local Community Care Coordination Program (LCCCP)
  - 1) The health plan shall develop a Local Community Care Coordination Program (LCCCP) to be implemented no later than May 1, 2017. Such program may use any delivery model that focuses on providing care management, care coordination, and disease management through local healthcare providers; however such model shall

be prior approved by the state agency. Models may include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), primary care case management (PCCM), subcapitated entities, a combination thereof, or other similar models consistent with the principles and requirements listed below...

- 10) The health plan is encouraged to contract with ACOs in order to fulfill the requirements of the LCCCP program. A qualifying ACO could be a Medicare ACO or could be an entity providing a comprehensive array of medical services where a portion of reimbursement is performance based such as pay-for-performance programs and/or at financial risk for certain services or populations (subcapitation). The state agency shall monitor the health plan's activity with any identified ACO during the contract period to ensure movement in the process.

## NEW MEXICO

### 4.4.19 Care Coordination Delegation (page 82)

- Two key goals of Centennial Care 2.0 are to transition more care coordination functions to the provider level and to advance Value-Based Purchasing (VBP) arrangements. To align these goals, New Mexico Human Service Department Medical Assistance Division (HSD/MAD) has established two care coordination models, the —Full Delegation Model and the Shared Functions Model
  - 4.4.19.1 Full Delegation Model- In the Full Delegation Model, the CONTRACTOR delegates the full set of care coordination functions to the provider/health system (the delegate) for an attributable membership and only retains oversight and monitoring functions.
  - 4.4.19.2 Shared Functions Model- In the Shared Functions Model, the CONTRACTOR retains some care coordination functions and allows other care coordination activities to be conducted by a partner. It does not require a VBP arrangement (although it may at the discretion of the CONTRACTOR and partner).

## NEW YORK

### 21.27 Health Home (page 236)

- a) The Health Home program provides reimbursement for care management to approved Health Home providers for the following services provided to Enrollees with behavioral health and/or chronic medical conditions who are determined eligible for Health Home services...: comprehensive care management, coordination and health promotion; transitional care from inpatient to other settings, including follow-up; individual and family support, which includes authorized representatives, referrals to community and social support services; and use of health information technology (HIT) to link services.
- b) The Contractor must subcontract with State designated Health Homes. The Contractor's network must include a sufficient number of Health Homes to serve all Enrollees eligible for Health Home services...
  - iii. The subcontract must establish clear lines of responsibility to ensure services are not duplicated. The subcontract must include a process for cooperative and coordinated sharing of Enrollee information and other documentation as necessary...
- d) Health Home Outreach and Engagement...

- iii. The Contractor shall require that the Health Home promptly assign a Care Manager to each assigned Enrollee. The Contractor shall assist the Health Home and its Care management partners with outreach, engagement and enrollment of assigned Enrollees, to the extent possible.
- iv. The Contractor shall share data with Health Homes and care management partners, consistent with the terms of the subcontract between the Health Home and the Contractor, to assist in outreach and engagement efforts,
- e) Comprehensive Care Management for Health Home Participants.
  - i. The Contractor shall assist its subcontracted Health Homes, to the extent possible, with the collection of required care management and patient experience of care data. The Contractor shall share current claims data, demographic data, and information received from the Enrollment Broker, in accordance with HIPAA and State confidentiality requirements.
  - ii. Except where the Enrollee refuses these services, the Contractor shall ensure, consistent with the terms of the subcontract executed between the Contractor and the Health Home, that all Health Homes provide comprehensive Care Management to all Health Home Participants, which shall include the following:
    - A. A comprehensive assessment that identifies the Health Home Participant's medical, behavioral health, and social service needs;
    - B. Integrated medical and behavioral care management services coordinated by a dedicated Care Manager; and
    - C. Development of a person-centered plan of care, as defined in Section 10.41 of this Agreement, by the Care Manager and the Health Home Participant.
  - iii. The Contractor shall require Health Homes provide Health Home Participants access to Health Home Care Management 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if necessary.
  - iv. To promote appropriate and timely follow-up and coordination of services and to ensure that the Health Home Participant is safely transitioned, the Contractor shall inform the Enrollee's Health Home when the Contractor is made aware the Enrollee has received services at an emergency room, Comprehensive Psychiatric Emergency Program, crisis respite, residential addiction treatment program, or inpatient setting. The Contractor will assist the Health Home and its care management partners' access to data to facilitate appropriate and timely follow-up, and coordination of services post-discharge, as needed, and that the Enrollee's plan of care is updated, as necessary.

## **NORTH CAROLINA**

### **C.6.b.iv Advanced Medical Home Contracting** (page 130)

- d) Advanced Medical Homes Oversight
  - 1. The PHP shall monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms.

- 2. In the event of underperformance by an AMH practice, the PHP shall send a notice of underperformance to the AMH practice and copy the Department.
- 3. In the event of continued underperformance (i.e. non-adherence to contract standards, quality of care concerns) by an AMH that is not corrected, the Department shall permit the PHP to stop paying the Care Management Fee and/or Medical Home Payment (as applicable based on Tier status) and downgrade the Tier status of the AMH for that PHP, only.
- 4. In the event that the PHP notifies an AMH practice that it will no longer pay the practice the Care Management Fee and/or Medical Home Payments that would otherwise be required by the Department, the PHP shall notify the Department that it has downgraded the Tier status for the practice. The Department reserves the right to specify the timing and format of this notification.
- 5. In the event a practice is downgraded from Tier 3 to Tier 2, the PHP shall ensure that there are no gaps in care management functions for Members assigned to the practice.
- 6. The requirements of this subsection shall apply to all tiers of AMH practices, including Tier 3 AMHs providing Local Care Management and Tier 1 and Tier 2 AMHs that do not provide Local Care Management, unless otherwise specified.

## RHODE ISLAND

### 2.12.04 Care Transitions (page 116)

- The Contractor shall require participating network hospitals to measure and self-report to the Contractor, in a format and on a schedule determined by the Contractor, and approved by EOHHS, its performance for the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care physician (PCP) about hospital utilization, (2) provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow-up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow-up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end-of-life discussions during hospital visit.

## TEXAS

- **Article 4. Contract Administration & Management, Section 4.04.1(e) STAR+PLUS Service Coordinator** (page 23): The MCO must reimburse a Health Home that provides Service Coordination to its Members through an enhanced rate structure, a per-member-per-month fee, or other reasonable methodology agreed to between the MCO and Health Home.
- **Attachment B-1, Section 8.1.26.1 Health Home Services and Participating Providers** (page 341): HHSC encourages MCOs to develop provider incentive programs for designated Providers who meet the requirements for Member-centered medical homes found in Texas Government Code §533.0029.

# GLOSSARY OF STATE ACRONYMS

## ARIZONA

**ACOM** – AHCCCS Contractors Operations Manual  
**ADHS** - Arizona Department of Health Services  
**AHCCCS** - Arizona Health Care Cost Containment System

## COLORADO

**HCPF** - Department of Health Care Policy & Financing

## DC

**Alliance** - District Healthcare Alliance Program  
**DCHFP** - District Health Families Program  
**DHCF** - Department of Health Care Finance  
**ICP** - Immigrant Children's Program

## DELAWARE

**DHSS** - Delaware Health & Social Services

## GEORGIA

**DCH** - Department of Community Health

## HAWAII

**DHS** - Department of Human Services  
**HOPE** - Hawaii `Ohana Nui Project Expansion  
**RHP** – Regional Health Plan

## ILLINOIS

**HFS** - Department of Healthcare and Family Services

## INDIANA

**FSSA** - Family and Social Services Administration  
**OMPP** – Office of Medicaid Policy and Planning

## IOWA

**DHS** - Department of Human Services

## KANSAS

**KDHE** - Kansas Department of Health and Environment  
**KMAP** – Kansas Medical Assistance Program

## LOUISIANA

**LDH** - Louisiana Department of Health

## **MASSACHUSETTS**

**DSTI** - Delivery System Transformation Initiatives

**EOHHS** - Executive Office of Health and Human Services

## **MARYLAND**

**CRP** - Care Redesign Program

**DHS** - Department of Human Services

**HSCRC** - Health Services Care Review Commission

**MDPCP** - Maryland Care Redesign Program

## **MICHIGAN**

**MDHHS** - Michigan Department of Health and Human Services

**MHP** - Michigan Health Plan

## **MINNESOTA**

**DHS** - Department of Human Services

## **MISSISSIPPI**

**DOM** - Division of Medicaid

## **MISSOURI**

**DSS** - Department of Social Services

## **NEVADA**

**DHCFP** - Division of Health Care Financing and Policy

## **NEBRASKA**

**DHHS** - Department of Health and Human Services

**MLTC** - Medicaid and Long-Term Care

## **NEW HAMPSHIRE**

**DHHS** - Department of Health and Human Services

## **NEW JERSEY**

**DMAHS** - Division of Medical Assistance and Health Services

## **NEW MEXICO**

**HSD** - Human Services Department

## **NEW YORK**

**DOH** - Department of Health

## **NORTH CAROLINA**

**AMH** - Advanced Medical Home

**DHHS** - Department of Health and Human Services

**PHP** - Primary Health care Provider

## **OHIO**

**CPC** – Comprehensive Primary Care

**MCP** – Managed Care Plan

**ODM** - Ohio Department of Medicaid

## **OREGON**

**OHA** - Oregon Health Authority

**PCPCH** – Patient Centered Primary Care Home

## **PENNSYLVANIA**

**BH-MCO** – Behavioral Health Managed Care Organization

**DHS** - Department of Human Services

**PH-MCO** – Physical Health Managed Care Organization

## **RHODE ISLAND**

**CTC-RI** – Care Transformation Collaborative of Rhode Island

**DHS** - Department of Human Services

## **SOUTH CAROLINA**

**DHHS** - Department of Health and Human Services

## **TEXAS**

**HHS** - Health and Human Services

## **VIRGINIA**

**DMAS** – Department of Medical Assistance Services

**DSS** - Department of Social Services

**FAMIS** – Family Access to Medical Insurance Security

## **WASHINGTON**

**DSHS** - Department of Social and Health Services

## **WISCONSIN**

**DHS** - Department of Human Services

## **WEST VIRGINIA**

**DHHR** - Department of Health and Human Resources