

Research Study

Value-Based Care in America: State-by-State

A 50-State Review of Value-Based Care and Payment Innovation

Commissioned by Change Healthcare

StateVBRstudy.com

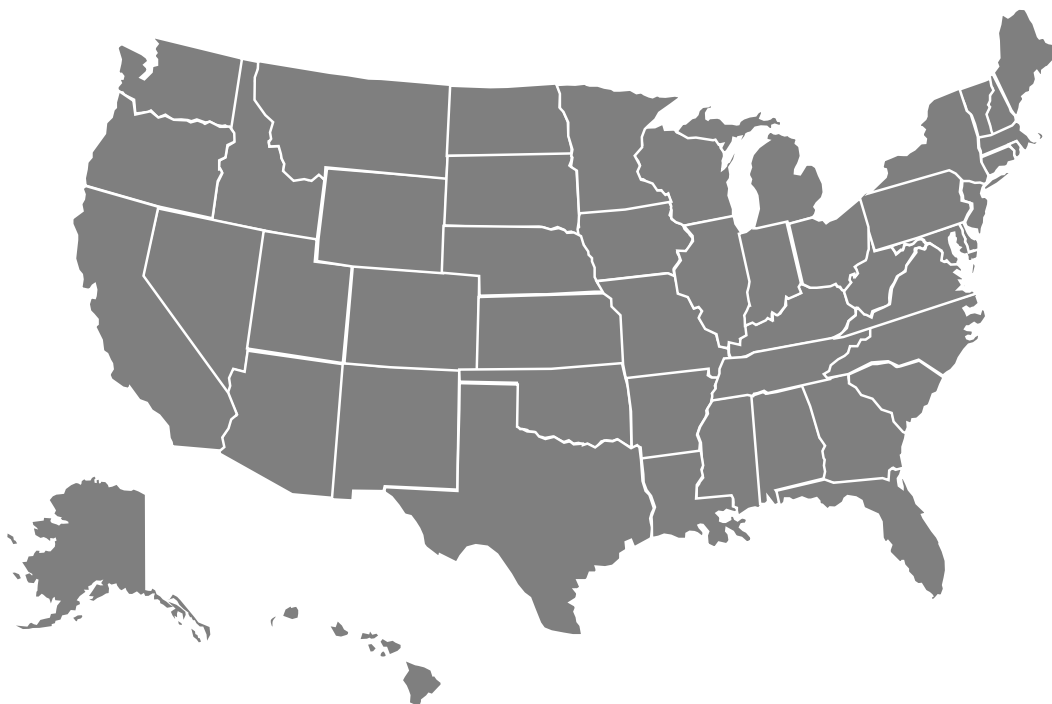


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Key to Terms

ACO: Accountable Care Organization

APM: Alternative Payment Model

CCO: Coordinated Care Organization

CMMI: Center for Medicare and Medicaid Innovation

CMS: Centers for Medicare & Medicaid Services

CPC+: Comprehensive Primary Care Plus

DSRIP: Delivery System Reform Incentive Payments

EOC: Episodes of Care

FFS: Fee-For-Service

FQHC: Federally-Qualified Health Center

HIE: Health Information Exchange

LTSS: Long-Term Services and Supports

MCO: Managed Care Organization

MPC: Multi-Payer Collaborative

P4P: Pay-for-Performance

P4V: Pay-for-Value

PCMH: Patient-Centered Medical Homes

PMPM: Per Member, Per Month

PSN: Provider Service Network

RCO: Regional Care Organization

SIM: State Innovation Models

TCOC: Total Cost of Care

Executive Summary

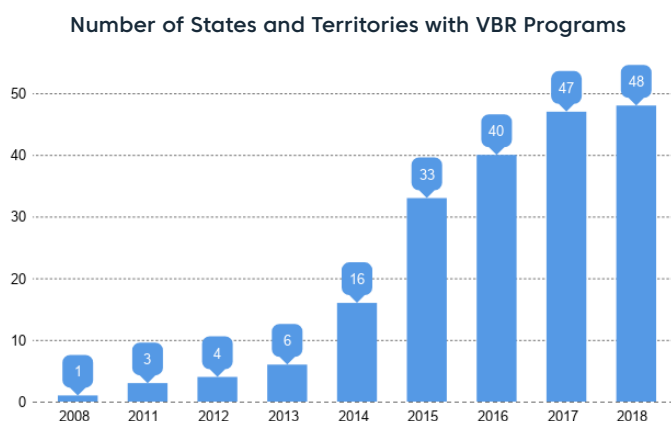
State Initiatives Continue to Drive Value-Based Care and Payment Reform

Value-based care (VBC) is being delivered across the U.S. New care and payment models designed to improve quality and reduce costs are changing the way providers practice medicine and how they are compensated for their services. The federal government's role in driving these changes is highly visible due to the nationwide impact; however, state-initiated efforts are in many cases an equal if not surpassing force in transforming the healthcare industry and are the focus of this report.

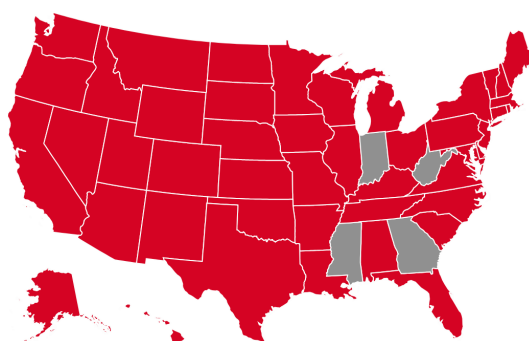
In 2017, Change Healthcare introduced its inaugural study, which highlighted state governments' efforts to explore and implement VBC and reimbursement models. This study provides a state-by-state update of subsequent progress made in the past 18 months.

Summary of Cumulative Findings

1. In just five years, there has been a seven-fold growth in the number of states and territories implementing value-based reimbursement (VBR) programs with a total of 48 implementing nationwide (includes the District of Columbia and Puerto Rico).



States/Territories with VBR Programs



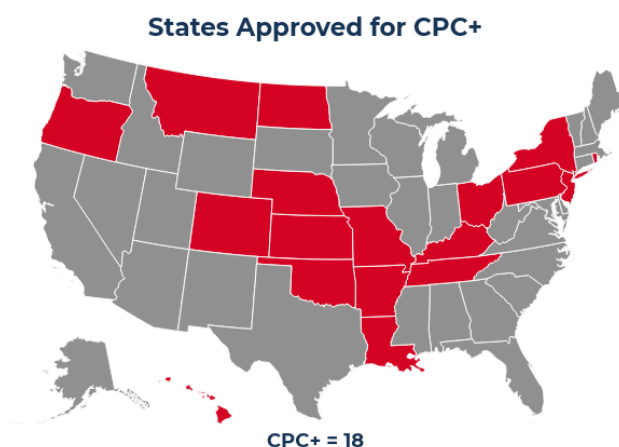
2. Well-developed, value-based payment strategies have been implemented in six states for four years or longer, many with federal support.
3. Thirty-four states have initiatives two years or more into implementation.
4. Eight states are in the early stages of development.
5. Four states have had little-to-no value-based payment (VBP) activity.
6. Among states pursuing value-based care initiatives, half of the programs are multi-payer in scope.
7. As with the federal government, 23 states have established value-based payment targets or mandates that payers and providers agree to achieve.
8. Twenty-two states have adopted or are considering adoption of Accountable Care Organizations (ACOs) or ACO-like entities to help manage costs and deliver better care, and 16 states have adopted or are considering adoption of episodes of care (EOC) programs.
9. Many states have used value-based payment reform to engage with healthcare stakeholders in the redesign of the state healthcare system, identifying unique and innovative strategies that work for their state healthcare markets.

What's New

More than 20 states have evolved their value-based care efforts since the prior study. For detailed descriptions of each state's initiatives, refer to the narrative for each state.

Comprehensive Primary Care Plus (CPC+)

Since 2017, 18 regions have implemented Comprehensive Primary Care Plus (CPC+), a medical home model that seeks to strengthen primary care by reforming care delivery and multi-payer payment. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options.



To learn more about this program visit the [CMS Website on the CPC+ Program](#).

States Leading the Transition

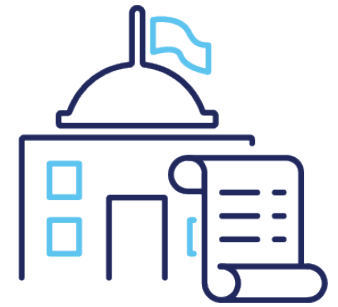
Overall, three states stand out for their breadth of initiatives, embrace of payment models that involve shared risk, and willingness to test innovative strategies. These states include:

- New York, which through its SIM grant and demonstration waiver from the Centers for Medicare and Medicaid Services (CMS), has tested a Medicaid pay-for-performance (P4P) payment model and risk-sharing arrangements with managed care organizations (MCOs), in addition to various VBP pilots focusing on maternity care, HIV/AIDS, and integrated primary care.
- Pennsylvania, whose efforts began in 2013 and have included complementary strategies for achieving reform such as multi-payer EOC payments for acute care; global payments for enhanced primary care through patient-centered medical homes (PCMHs); and a global budget for rural hospitals. The state also required MCOs to shift 30% of their payments into APMs by 2019.
- Vermont, an early adopter, began its transition efforts in 2011, when it initiated a PCMH strategy. Since then, the state has deployed several VBP strategies including an all-payer ACO model, EOC for the Medicaid population, and Health Homes.

For a snapshot view of state VBC efforts, please see the table on page 66.

Report Foundation

It has been nearly a decade since Don Berwick and his colleagues at the Institute for Health Improvement introduced the concept of the “Triple Aim” to the healthcare policy debate.¹ In the article that helped launch the current payment reform movement, the authors argued that the goal of the health system should be to achieve three interdependent outcomes: improved care for individual patients, improved population health, and reduced costs of care. A central and necessary step to achieving the Triple Aim, they posit, is a shift away from the thinking that “more care is better,” and toward better alignment of the care and treatment payment systems with better outcomes and improved health. Instead of simply increasing reimbursements, payment structures should reward the most effective treatment decisions properly coordinated to maximize the quality of outcomes.



What emerged in years since is a concerted effort among commercial and public payers who, in partnership with providers, are moving away from fee-for-service to value-based payment arrangements. Among public payers, Medicare has taken a leadership role in implementing value-based payments, setting a goal in 2014 of tying 30% of Medicare payments to value by 2016 and 90% by 2018.² This goal has led to the rollout of numerous value-based payment initiatives by the Centers for Medicare and Medicaid Services Innovation Center (CMMI), including the creation of the Health Care Payment & Learning Action Network (HCP-LAN), a public-private partnership aimed at spurring payment innovation in the healthcare system at-large. Congress also has passed major legislation (PAMA and MACRA) that require value-based payment in Medicare.

While Medicare is obviously an influential player in the healthcare system, states retain significant authority over their regional healthcare market and can play a critical role in moving healthcare toward value. Medicaid now provides coverage for 21% of the covered lives in the U.S., behind employer-based coverage at 49% but ahead of Medicare at an estimated 14%.³ In addition, individual states have authority over both Medicaid operations and private insurance markets within their jurisdiction. With recent changes to the Medicaid and Children’s Health Insurance Program Managed Care Rule, states now have the affirmative authority to require Medicaid Managed Care Organizations (MCOs) in their state to implement value-based payment arrangements.⁴ If they choose to exercise this authority, states have significant power to move their state health insurance markets toward value-based payment reform.

Not surprisingly, a review of state value-based payment reform initiatives demonstrates significant variation in approach, due in part to factors motivating the shift to value. State payment reform has historically been influenced by factors including state-focused CMS initiatives, state budget challenges, and state policymakers’ interest in healthcare innovation.

Two CMS sponsored programs—the State Innovation Model (SIM) grants and the Delivery System Reform Incentive Program (DSRIP) waivers for Medicaid—require states as a condition of participation to develop a payment reform strategy. SIM grants were released in two rounds beginning in 2013, and in two tracks, known as “Design” and “Test.”⁵ Design grants, which supported more than 20 states in developing a State Innovation Plan, were typically about a year in duration and ranged from \$1-\$3 million. Test grants support implementation of the state-designed innovation plan, and amounted

¹ Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Affairs*, May 2008, 27:3. 759-769.

² [Centers for Medicare & Medicaid Services. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. January 1, 2015.](#)

³ [Health Insurance Coverage of the Total Population, Kaiser Family Foundation, 2017.](#)

⁴ [Centers for Medicare & Medicaid Services, Medicaid and CHIP Managed Care Final Rule, April 2016.](#)

⁵ [State Innovation Models Initiative: General Information. Centers for Medicare & Medicaid Innovation Center.](#)

to tens of millions of dollars per state over a three- to four-year period. In total, 17 states benefited from Test grants, including 11 that are still actively engaged in completing the second round. The SIM program requires a multi-payer reform focus, while DSRIP focuses on Medicaid. The DSRIP has been implemented in 10 states and allows for an incentive payment through Medicaid for providers that meet certain performance goals.⁶

In addition to the programs above, a number of states have been approved to participate in Comprehensive Primary Care Plus (CPC+), a medical home model that seeks to strengthen primary care by reforming care delivery and multi-payer payment. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions:

- 1) Access and Continuity;
- 2) Care Management;
- 3) Comprehensiveness and Coordination;
- 4) Patient and Caregiver Engagement; and
- 5) Planned Care and Population Health.

CPC+ includes three payment elements:

- 1) Care Management Fee (CMF);
- 2) Performance-Based Incentive Payment; and
- 3) Payment under the Medicare Physician Fee Schedule.

Eighteen states and regions are participating in the program including Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Louisiana, Michigan, Montana, Nebraska, North Dakota, Greater Buffalo Region of New York, North Hudson-Capital Region of New York, New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee.⁷

Consistent with an annual survey conducted by researchers at the Kaiser Family Foundation, this analysis finds that value-based payment is firmly rooted in state healthcare policy, with more than 40 states investing in VBP strategies and six states including Alabama, Alaska, Florida, North Carolina, South Carolina, and South Dakota pursuing value-based reimbursement entirely outside of the SIM and CPC+ programs.⁸

Many states have focused on state-financed healthcare, including Medicaid and state employee plans, by requiring contracted plans to implement value-based payment reform as part of their agreements with the state. For example, some states have implemented Medicaid Accountable Care Organizations (ACOs), which are groups of doctors, hospitals, and other health care providers which voluntarily coordinate their services to provide high-quality care to their patients. CMS states the goal of ACOs is, “to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.” CMS introduced the ACO model originally for Medicare beneficiaries. (See CMS website on [Accountable Care Organizations](#).)

Others have moved to an Episodes of Care (EOC) model to ensure greater health outcomes for patients and are reimbursing each episode with a value-based bundled payment. An EOC model includes, “all services provided to a patient for a particular condition within a specific period of time across a continuum of care.” These services might include acute hospital care, ambulatory care, extended care, home care, community outreach, wellness, and housing, among others. (See

⁶ [Gates A, Rudowitz R, Guyer J. An Overview of Delivery System Reform Incentive Payment \(DSRIP\) Waivers. September 29, 2014. Kaiser Family Foundation.](#)

⁷ [CMS Website on CPC+ Program.](#)

⁸ [Gifford K, Ellis E, Edwards BC, et al. Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. Kaiser Family Foundation, October 19, 2017.](#)

[Vanderbilt University Medical Center's explanation of Tennessee's EOC and VBC models](#) as an example.)

Still others have used their status as regulators of the health insurance market to persuade or require commercial payers to join the state in efforts to move toward value-based payment. While the vast majority of states are still in the early phases of value-based payment implementation, a handful are much further ahead and have successfully moved along the APM (Alternative Payment Model) continuum to arrangements that call for shared risk and savings.

A complete review of all 50 U.S. states' approaches to value-based payment follows.

Methodology

This report is based on an extensive analysis of publicly available information compiled in 2017 and updated in February 2019, with a focus on statewide value-based care and payment programs. This report highlights all U.S. states and includes the District of Columbia and Puerto Rico.

The study relies on information gleaned from primary sources, including state resources, federal government resources, and contractors that participate in state-initiated VBP programs. In addition, data available from secondary sources, including research reports from healthcare industry analysts; mainstream, business, and trade media; think tanks, public policy institutes, and research institutes; and other public sources were reviewed.

The research did not include independent verification of publicly available information in the form of interviews with government officials.

As a result, this report will not reflect initiatives that might be ongoing but have not been publicly acknowledged or promoted on government websites, publications, or other official channels, and might not reflect recent changes if those changes have not been published publicly. Further, this report does not catalog all commercial payer VBP programs except as part of a statewide program.

All footnotes/links were reviewed in March 2019.



Defining Value-Based Payment

This paper uses the term “value-based payment” to refer to the full continuum of evolving payment arrangements that payers and providers are using as they move away from fee-for-service to payments that hold providers accountable for quality, outcomes, and total cost of care.

The consensus APM Framework developed by HCP-LAN provides a useful starting point for understanding and communicating the taxonomy of value-based payment models. As demonstrated in the HCP-LAN diagram below, the APM Framework establishes four Categories of Payment:

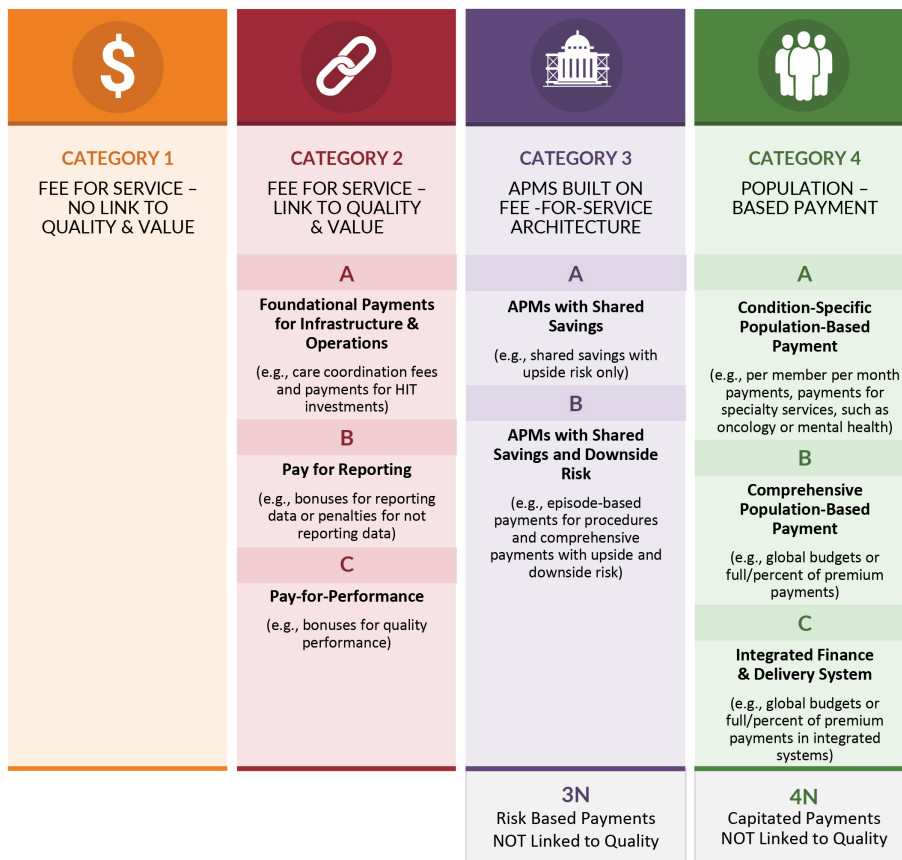
Category 1: Fee-For-Service

Category 2: Fee-For-Service payments with a link to quality and value, including enhanced payments for infrastructure investment, reporting, or quality

Category 3: Alternative payments based on fee-for-service with either shared savings or shared savings and risk, including episode-based payments

Category 4: Population-based payments, which provide a risk-adjusted per-patient payment to providers that agree to manage all care for a patient or for a particular condition

Where possible, this paper references the HCP-LAN categories of alternative payments to ensure consistent nomenclature across the analysis. For the purposes of this paper, “APM” refers to payment arrangements in Categories 3 or 4 of the HCP-LAN framework, while “value-based payment” refers to the entire spectrum of payments that fall into Categories 2-4.



This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.

Figure 1 - Credit: Health Care Payment Learning & Action Network. Alternative Payment Models (APM) Framework. July 11, 2017. Reprinted with permission from the MITRE Corporation. © 2017 The MITRE Corporation All Rights Reserved.

How Change Healthcare Can Help

As one of the largest, independent healthcare technology companies in the United States, Change Healthcare’s mission is to inspire a better healthcare system. We are a key catalyst of value-based healthcare, working alongside our customers and partners to help accelerate the journey toward improved lives and healthier communities.

Our solutions are designed to enable improved efficiencies and insights for major stakeholders across healthcare, including commercial and governmental payers, employers, hospitals, physicians, and other providers, laboratories, and consumers.

We champion improvement before, after, and in-between care episodes, striving to provide a visible measure of quality and value. Our solutions add value across three distinct areas—Software and Analytics, Network, and Technology Enabled Services—by helping payers, providers, and consumers improve the full spectrum of healthcare.

Change Healthcare solutions are designed to promote the following:

For Payers	For Providers	For Consumers
Payment accuracy	Revenue and financial risk management	Access to personal health information
Member engagement, and provider, cost, and quality transparency	Patient access	Engagement with providers
Network management	Support for clinically appropriate care	Electronic payments
Transition to value-based payment	Claims payment management	Tools to help evaluate healthcare choices based on quality, cost, and convenience
Claims payment management	Optimize diagnostic and clinical data	
Support for clinically appropriate care	Imaging, workflow, and extended care	

Change Healthcare’s Industry Profile At a Glance*

5,500 Hospitals	900,000 Physicians	2,200 Payer Connections	\$1.0 Trillion Healthcare Claims
118,000 Dentists	600 Laboratories	1 in 3 U.S. Patient Records	14 Billion Healthcare Transactions

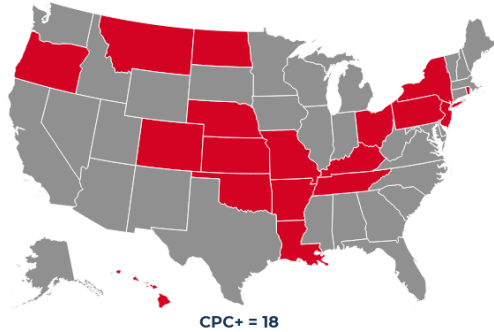
* Change Healthcare internal statistics

To learn more about how Change Healthcare can help in the transition to value, visit our value-based payments [resource center](#).

State-By-State Summaries

A review of the 50 states' value-based payment reform initiatives (plus Puerto Rico and the District of Columbia) reveals a range of approaches and significant variation in levels of sophistication, leadership commitment, and resources devoted to the transition from fee-for-service to value-based reimbursement. More than 40 states, many with federal support, have developed value-based payment strategies that have been in implementation for two years or longer, and eight more states have initiatives that are in development or in the early stages of implementation. Only four have little-to-no activity on value-based payment. The following maps offer a quick overview of where states have focused their programs.

States Approved for CPC+



CPC+ = 18

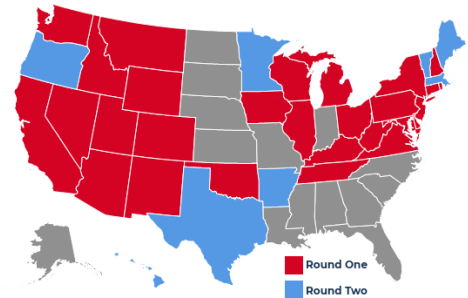
States Approved for CPC+

18 states are taking part in the recently introduced CPC+ program. This program seeks to strengthen primary care by reforming care delivery and multi-payer payment. As a new program, few results are currently available.

States Awarded SIM Grants

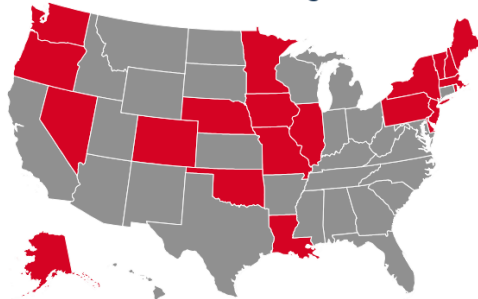
69% of states are pursuing SIM Grants. CMS issues these grants to support states in planning and implementing individually designed innovation plans that involve multi-payer reform efforts.

States Awarded SIM Grants



SIM Grants = 38 (including Puerto Rico and D.C.)

States with ACO Programs



ACO = 22 (including Puerto Rico)

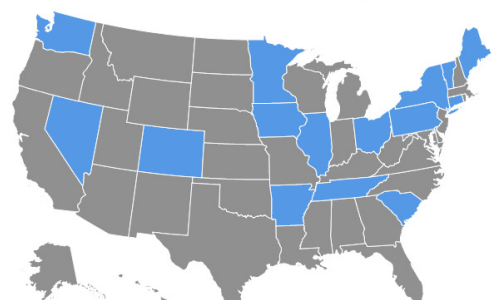
States with ACO Programs

More than 35% of states have adopted or are considering adoption of ACOs or ACO-like entities to help manage costs and deliver better care. ACOs are groups of doctors, hospitals, and other healthcare providers that voluntarily agree to coordinate the care of a group of patients.

States with EOC Programs

16 states have implemented EOC programs. EOC programs reimburse providers for a specific medical condition across the full cycle of care for that condition.

States with EOC Programs



EOC = 16 (including Puerto Rico)

Alabama

In response to legislation passed in 2013, Alabama adopted a Regional Care Organization (RCO) model for the state Medicaid program through a 1115 Demonstration Waiver with CMS.⁹ The program was slated to begin full implementation on October 1, 2017. However, in summer 2017, the state announced it would abandon implementation of the RCO model due to “major changes in federal regulations, funding considerations, and the potential for new opportunities for state flexibility regarding Medicaid spending and services under the Trump Administration.”¹⁰ The 1115 Demonstration Waiver for the RCO model was then terminated effective July 1, 2018.

Throughout 2017 and 2018, the Alabama Medicaid Agency undertook dozens of individual rulemakings to rewrite most of the Medicaid provisions in the state administrative code. Several provisions, including those governing regional care organizations, primary care case management entities, and integrated care networks were amended multiple times during this regulatory overhaul with the aim of moving from an RCO model to a new Integrated Care Network (ICN).¹¹ On October 1, 2018, CMS approved Alabama’s ICN proposal, which is focused on Medicaid long-term care recipients in both home and community-based services and institutional settings.¹²

⁹ [Alabama Medicaid’s Regional Care Organizations Fact Sheet, State of Alabama Medicaid Office, 2016.](#)

¹⁰ [News: Alabama Medicaid to Pursue an Alternative to Regional Care Organizations. Alabama Medicaid Office News Release, July 27, 2017.](#)

¹¹ [Current \(February 2019\) Text of Ala. Admin. Code 560-X-37, Managed Care.](#)
[Current \(February 2019\) Text of Ala. Admin. Code 560-X-62, Regional Care Organizations.](#)
[Current \(February 2019\) Text of Ala. Admin. Code 560-X-64, Integrated Care Networks.](#)

¹² [Alabama Integrated Care Network.](#)

Alaska

Alaska passed legislation in 2016 to facilitate comprehensive reform of the state's Medicaid program, Healthy Alaska.¹³ There are 16 separate initiatives that make up the reform effort. Of these, three are delivery system reforms: a Health Home Initiative, a Coordinated Care Demonstration Project (ACO model), and Behavioral Health Reform. A request for proposals (RFP) for the Coordinated Care Demonstration Project was released in December 2016.¹⁴ In June 2018, the Department of Health and Social Services released its intent to contract with the United Healthcare Insurance Company to operate an MCO model in Anchorage and the Mat-Su Valley.

The Department also contracted with the Providence Family Medicine Center to operate a patient-centered medical home (PCMH) model in the Anchorage area under a Provider Based Reform medical home model.¹⁵ Additionally, the Innovative Provider Payment workgroup met throughout 2018 to discuss a number of value-based payment options including bundled payments, shared-savings, Health Homes, PCMHs and ACOs. The workgroup provided a final report to the Department, included in the 2018 Annual Medicaid Reform Report, which contained recommendations for bundled payments, home health services, and Health Homes.¹⁶

¹³ [State Medicaid Redesign Webpage includes information and updates about the redesign.](#)

¹⁴ [Request for Proposals, State of Alaska. Medicaid Coordinated Care Demonstration Project, RFP 170007291, issued December 30, 2016.](#)

¹⁵ [Alaska DHSS Annual Medicaid Reform Report, p. 25](#)

¹⁶ Ibid. at Appendices A and B.

Arizona

Arizona's state Medicaid program is operated by the Arizona Health Care Cost Containment System (AHCCCS: pronounced "access") and provides coverage for 25% of the state's population, or approximately 1.6 million people.¹⁷ Arizona Medicaid has a large percentage of patients in managed care, with roughly 85% of the Medicaid population participating in managed care plans.¹⁸ AHCCCS has had a "Payment Modernization Plan" in place since 2014, which requires the 17 state-contracted MCOs to adopt value-based purchasing strategies.¹⁹

In 2016, Arizona received a Model Design Round Two award to create and refine proposals for multi-payer payment and health delivery system transformation. The SIM grant focused on three areas of coordination to close gaps in care: individuals served by the American Indian Health Program, individuals transitioning out of incarceration, and behavioral and physical health integration for individuals with complex health conditions.²⁰ Pursuant to that plan, in 2019, MCOs in Arizona are required to have 50% of all payments to providers subject to value-based payment.²¹ According to the state, MCOs have implemented pay-for-performance (P4P), PCMH, shared savings, and bundled payment programs as a result of this flexible value-based payment requirement.

¹⁷ [Arizona State Health Care Innovation Plan, Arizona Health Care Cost Containment System, Submitted July 5, 2016.](#)

¹⁸ [State Health Facts, Total Medicaid Managed Care Enrollment, 2016. Kaiser Family Foundation.](#)

¹⁹ [AHCCCS Payment Modernization – Value-Based Purchasing. Arizona state website.](#)

²⁰ [Arizona State Innovation Plan July 5, 2016.](#)

²¹ [Arizona State Health Care Innovation Plan, Arizona Health Care Cost Containment System, Submitted July 5, 2016.](#)

Arkansas

Arkansas received a \$42 million SIM Test grant from CMMI to engage in Medicaid payment innovation.²² A State Innovation Plan was submitted to CMS in 2012, which lays out the state's plan to implement delivery system reform.²³ The state's reform initiative is called the Arkansas Health Care Payment Improvement Initiative and is centered on two strategies: (1) Medical/Health Home Implementation and (2) Episode-Based Care Delivery. Both reform strategies are multi-payer in nature, involving Medicaid as well as the largest private health plans—Arkansas Blue Cross Blue Shield and QualChoice of Arkansas—in the design and implementation of the state payment reform initiative.²⁴

The goal for the Episode-Based Care strategy is to manage several acute and chronic conditions by designating a Principal Accountable Provider for each episode of care. The state initially implemented six surgical bundles, four medical bundles, and two behavioral health bundles. Since initial roll-out, the state has halted the behavioral health bundles and, as of 2018, added four additional information bundles.²⁵ In 2018, Arkansas also implemented the Arkansas Independent Assessment (ARIA) system, contracting with a coordinated care organization to improve outcomes and save costs on care provided to the Long-Term Services and Supports (LTSS) patient population. This system is a new assessment tool that allows for coordination care planning and coordination and will be used in conjunction with new payment rates that map to different levels of LTSS care.²⁶ Finally, Arkansas is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.²⁷

²² [State Innovation Models Initiative: Model Test Awards Round One. Centers for Medicare and Medicaid Services.](#)

²³ Arkansas Health System Transformation, State Innovation Plan, September 21, 2012. No longer available online.

²⁴ [Arkansas Health Care Payment Improvement Initiative. Why Payment Improvement?](#)

²⁵ [Arkansas Episode of Care website.](#)

²⁶ [Arkansas LTSS Transformation Overview.](#)

²⁷ [CMS Innovation site on CPC+.](#)

California

In partnership with health plans and physician groups, the Integrated Healthcare Association launched a P4P program for commercial plans in 2001. In 2017, the program involved 10 health plans, more than 200 provider organizations and nine million patients.²⁸ Provider participants in the P4P program must meet cost savings, quality, and health information technology thresholds to qualify for participation in the shared savings incentive part of the program. Though widespread, the initiative does not encompass the state's Medicaid program, Medi-Cal, which provides coverage to 13.5 million individuals or about a third of the state's population.²⁹

In 2013, California was the recipient of a SIM Design grant,³⁰ used to develop a Health Care Innovation Plan, which the state finalized in March 2014.³¹ The state received a second SIM Design grant from CMMI in 2015.³² At the end of 2015, California received approval from CMS for its 1115 Demonstration Waiver, and commenced implementation in 2016.³³ The waiver, known as Medi-Cal 2020, authorized California's DSRIP program, and is comprised of four initiatives, including the Public Hospital Redesign and Incentives in Medi-Cal (PRIME), which aims to incorporate value-based principles into the hospital payment system. In addition to achieving clinical quality goals, PRIME aims to have 60% of public hospital payments subject to an APM by 2020.³⁴

The state had planned to implement an APM pilot program for federally qualified health centers (FQHC) that serve Medicaid patients. Under the terms of the voluntary pilot, which was slated to begin in October 2017, MCOs pay a risk-adjusted per member, per month (PMPM) rate to FQHCs for care of the Medicaid population.³⁵ However, CMS would not approve the pilot unless California asked to waive the Prospective Payment System (PPS) in favor of a capitated rate. As this was contrary to state law, the pilot did not move forward.³⁶ Nevertheless, In December 2017, CMS approved California's State Plan Amendment (SPA) and accompanying Section 1115 Demonstration Waiver allowing the state to develop prospective risk-based rates for the health homes services provided under the managed care plans.³⁷

²⁸ [Value Based Pay for Performance in California, Fact Sheet, Integrated Health Association, September 2016.](#)

²⁹ [Lally, S. Aligning Performance Measures Across Medi-Cal Initiatives. Integrated Healthcare Association Issue Brief No. 23. December 2016.](#)

³⁰ [State Innovation Models Initiative: Model Design Awards Round One. Centers for Medicare & Medicaid Services.](#)

³¹ [California State Health Care Innovation Plan, March 31, 2014. California Health & Human Services Agency.](#)

³² [State Innovation Models Initiative: Model Design Awards Round Two. Centers for Medicare & Medicaid Services.](#)

³³ [Department of Health & Human Services, Letter to California Department of Health Care Services, dated 12/30/2015.](#)

³⁴ [Pagel L and Schwartz T. The Public Hospital Redesign & Incentives in Medi-Cal \(PRIME\) Program: Continuing California's Delivery System Transformation. Harbage Consulting, January 2017.](#)

³⁵ [Howe G, Moses K, & McGinnis, T. Advancing Payment Innovation within Federally Qualified Health Centers: Lessons from California. Center for Health Care Strategies, Inc. May 2017.](#)

³⁶ [Howe G. Payment Innovation in Federally Qualified Health Centers: Lessons from California, September 12, 2018](#)

³⁷ [Medicaid State Plan Amendment \(SPA\) #: 16-007](#)

Colorado

In 2011, Colorado Medicaid became one of the first states in the nation to utilize ACOs to manage care of Medicaid enrollees. Regional Care Collaborative Organizations receive a PMPM payment to manage the care of patients as well as fee-for-service (FFS) payments. Incentive payments are paid annually based on performance. In 2014, Colorado received a \$65 million SIM Test grant from CMMI to implement a multifaceted health reform initiative.³⁸ The payment reform strategy builds on the work of the Multi-Payer Collaborative (MPC), which had existed prior to the grant.

Ten public and private Colorado payers have joined the MPC, agreeing to use a common set of measures and to achieve a joint goal of having more than 80% of Colorado residents receive integrated behavioral and physical healthcare through value-based payment programs by 2019. Under the model, providers would receive a care coordination payment plus a pay-for-performance bonus. In a 2016 report,³⁹ the state indicated its intent to ask Medicare, the Veteran's Administration, and Tricare to join the initiative and to engage with the Colorado Business Group on Health, which represents 17 self-funded groups in the state. In addition, Colorado is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.⁴⁰

In a parallel development, Colorado adopted a transition plan concerning full-benefit Medicare-Medicaid enrollees. In 2014, the state began the Accountable Care Collaborative: Medicare-Medicaid Program (ACC: MMP), a demonstration program for dual-eligibles. The initiative transitioned affected enrollees into the broader Accountable Care Collaborative (ACC) delivery system. State staff worked with stakeholders and providers to identify and incorporate lessons learned and best practices from the demonstration into the ACC. The MMP ended and the transition plan took effect on December 31, 2017.⁴¹

³⁸ [State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare & Medicaid Services.](#)

³⁹ [Colorado SIM Operational Plan, State of Colorado SIM Model, January 6, 2016.](#)

⁴⁰ [CMS Innovation site on CPC+.](#)

⁴¹ [Accountable Care Collaborative Webpage.](#)

Connecticut

Connecticut received a four-year, \$45 million SIM Test grant award from CMMI in 2014.⁴² The Connecticut SIM program chose to implement a value-based payment strategy that sets up a “glide path” for providers to transition from a P4P payment program to a shared savings model.⁴³ The ultimate goal, according to the state’s innovation plan, is to have 88% of the state’s population being treated by a clinician who is responsible for quality and cost of care.⁴⁴ As part of this strategy, the state will align all payers in the state to a common set of measures spanning the domains of quality, care experience, health equity, and cost. Payers and providers would be free to negotiate the terms of the performance payments and the degree to which they prefer to share in savings and risk.

To implement this strategy, the state has established a Value Based Insurance Design Consortium (V-BID), which has created information on value-based insurance design for both self-insured and fully insured employers.⁴⁵ In 2017, V-BID developed benefit templates for employers and engaged in continued employer outreach. V-BID is currently providing technical assistance to aid self-insured employers adopting V-BID benefits and updating its existing benefit templates.⁴⁶

⁴² [State Innovation Models Initiative: Model Test Awards Round Two.](#)

⁴³ [Connecticut Healthcare Innovation Plan Executive Summary, State of Connecticut, 2013.](#) Note: State Medicaid providers will only participate in upside risk arrangements rather than shared risk based on concerns about already-low payments and challenges in risk-adjustment for Medicaid patients.

⁴⁴ [Connecticut State Innovation Model, SIM At a Glance.](#)

⁴⁵ [V-BID Employer Manuals.](#)

⁴⁶ [V-BID Initiative Technical Assistance Overview, Connecticut Value-Based Insurance Design Consortium Meeting, January 24, 2018.](#)

Delaware

Delaware received a \$35 million SIM Test grant in 2014 to implement several health improvement strategies.⁴⁷ Delaware's value-based payment model is a combined Pay-for-Value (P4V) and Total Cost of Care approach depending on a given provider's level of sophistication. The state offers two options for providers participating in the state Medicaid program (via MCOs operated by Highmark and United Healthcare Insurance Company): (1) a P4V program in which providers will receive incentive payments for achieving both quality and utilization targets; and (2) a choice of Total Cost of Care Programs—upside only or upside/downside risk-sharing agreements. The goal is for all payers, including both private and public, to implement one P4V program and one Total Cost of Care program in the calendar year.⁴⁸ Ultimately, the state aimed to have 40% of providers participate in at least one value-based payment model by the end of CY 2017, and 95% of providers in at least one model by the end of 2019.

In July 2017, the state Medicaid program announced that it would rebid its Medicaid and Children's Health Insurance Program contracts to include a requirement that 80% of all payments be made through value-based payment programs within three years.⁴⁹ The payment reform portion of the SIM project is managed by the Payment Model Monitoring Committee within the Delaware Center for Health Innovation (DCHI).⁵⁰ The DCHI actively met throughout 2018 and focused on developing common payment models and quality measures.⁵¹ In 2018, the Delaware Healthcare Commission awarded mini-grants to healthcare providers to integrate into ACOs or implement an Alternative Payment Method, which closed January 31, 2019.⁵²

⁴⁷ [State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare & Medicaid Services.](#)

⁴⁸ [Delaware SIM Operational Plan 3, 2017.](#)

⁴⁹ [Delaware Rebidding Diamond State Health Plan Contracts, Planning to Move 80% of Reimbursement to Value-Based Models, Open Minds, July 9, 2017.](#)

⁵⁰ [Delaware Center for Health Innovation.](#)

⁵¹ [Delaware Center for Health Innovation Stakeholder VBP Alignment](#)

⁵² [Delaware Center for Health Innovation VBR Payment Grants](#)

District of Columbia

Washington, D.C., received a \$1 million SIM Design grant from CMS in 2015 to complete a State Health Innovation Plan, which was submitted to CMS in July 2016.⁵³ The plan establishes five strategic goals for the D.C. health system over five years, aiming to improve quality of care and develop payment systems that tie value to payment. Noting that 40% of the District's residents are Medicaid recipients, the District chose to focus on transforming payment and care delivery within the Medicaid system.

The resulting payment reform goal commits the District to linking 85% of the Medicaid payments to quality and 50% of payments to an APM by 2021. In the short-term, DC plans to implement a P4P program within Medicaid, across the Health Home program, MCOs, and in contracts with FQHCs. P4P will allow providers an opportunity to get comfortable with the concepts of care coordination and population health management prior to engaging in risk-sharing. After two years of P4P implementation, the District will offer providers a "menu" of alternative payment options from which they may choose.⁵⁴

The Department of Health Care Finance adopted amendments to its Medicaid managed care rules, effective February 2, 2018, regarding how FQHCs are reimbursed for a variety of services and procedures. Among the affected services are behavioral health services, for which the rules specify reimbursement limits, as well as primary care and dental services. The rules establish an Alternative Payment Methodology program featuring performance-based payments, and a new prospective payment system reimbursement model for new Medicaid providers.⁵⁵

⁵³ [Government of the District of Columbia, State Health Innovation Plan, July 2016.](#)

⁵⁴ Ibid. at page 45.

⁵⁵ [DC DHCF Final Rules addressing Governing Medicaid Reimbursement for Federally Qualified Health Centers.](#)

Florida

While there are several ongoing Medicare and commercial value-based payment programs in the state, Florida has a limited strategy to embrace value-based payment in the state Medicaid program. As part of the state's plan to increase payments for Medicaid providers and to tie those payments to value, the Florida Agency for Health Care Administration established a physician incentive P4P program for Medicaid providers, beginning with pediatricians and OB/GYNs in 2016.⁵⁶ The state plans to include additional physician groups in future years and give the state's 16 contracted MCOs the option to create their own incentive programs that track with the state's goals.

In its approved 1115 Demonstration Waiver, Florida continued its utilization of Provider Service Networks (PSNs). Similar to an ACO, a PSN is an entity established or organized by a single or affiliated group of healthcare providers that can be reimbursed on a fee-for-service basis or on a capitated basis (although the latter are regulated as MCOs). The current 1115 Demonstration Waiver does not add performance-based or other value-based requirements on PSNs.⁵⁷

⁵⁶ [State of Florida, Agency for Health Care Administration, Comprehensive Quality Strategy, 2017.](#)

⁵⁷ [CMS approved 1115 Demonstration Waiver, November 30, 2018, p.21.](#)

Georgia

While there are several Medicare and commercial value-based payment programs in the state, Georgia does not have a coordinated state strategy for achieving increased use of value-based payment in the state.

Hawaii

Hawaii received a SIM Design grant, which was used to complete the Hawaii State Health Innovation Plan in June 2016.⁵⁸ The main objectives of the Innovation Plan are greater integration of behavioral healthcare and improvement in oral health access. There is less emphasis in the plan on value-based payment. However, since 2013, Hawaii Med-Quest (Medicaid) has required its five contracted MCOs to incorporate value-based purchasing requirements into their provider contracts.

The state MCO contracts increase the percentage of providers that must be covered by value-based payment contracts each year (in 2017, 80% were subject to value-based payment). The plans have discretion about how to implement value-based payment, but they are required to use the same quality measures. As of 2015, provider participation in value-based payment ranged from 6% in some plans (Ohana) to 100% in others (Kaiser).⁵⁹ Finally, Hawaii is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.⁶⁰

⁵⁸ [Hawaii State Health Innovation Plan. June 2016.](#)

⁵⁹ *Ibid.* at page 48.

⁶⁰ [CMS Innovation site on CPC+.](#)

Idaho

Idaho received a four-year, \$40 million SIM Test grant in 2014 to implement its state health innovation plan.⁶¹ In that plan, Idaho focuses on transforming the state's primary care practices to PCMHs. The effort to achieve a shift in payment from fee-for-service to value-based payment is a goal of the state plan, and the state commits to transitioning 80% of all payments made in the state to value-based payment. The state is engaging commercial payers in this effort through a Multi-Payer Workgroup and is collecting data on an annual basis.⁶²

To date, Idaho has completed a baseline survey of all payers, which showed that in 2015, 100% of all Medicaid payments and 71% of all commercial and Medicare advantage payments made in the state were fee-for-service with no link to quality.⁶³ In 2016, Idaho restructured their Healthy Connections programs to focus on the PCMH model and to incentivize primary care providers to participate in these models.⁶⁴ With a goal to improve access to care, care coordination, patient involvement, and overall health outcomes, Idaho expanded the program in 2018 to cover Regional Care Organizations, and to add PCMH shared savings incentives as well as specific episodes of care including surgery, oncology, and maternity care. Participation in these programs is optional.⁶⁵

⁶¹ [State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare & Medicaid Services.](#)

⁶² [Idaho Healthcare Innovation Operational Plan, December 2016.](#)

⁶³ [SHIP Payer Financial & Enrollment Metrics for Goal 6: Prepared for the Statewide Healthcare Innovation Plan, September 2018. Mercer, Inc.](#)

⁶⁴ [Idaho Medicaid – Healthy Connections Value Care White Paper Version 5, September 2017.](#)

⁶⁵ Ibid.

Illinois

In 2011, the Illinois legislature passed a Medicaid reform law, which requires 50% of the Medicaid population to be enrolled in coordinated, risk-based care by 2015.⁶⁶ As a result of this directive, the Department of Healthcare and Family Services launched a range of care models, including Care Coordination Entities for special populations, MCOs, and Accountable Care Entities, all with similar quality metrics and escalating risk arrangements. Illinois received two rounds of SIM Design grants in 2013 and 2015 to plan for delivery system and payment reform.⁶⁷

A new governor was elected in 2015 and launched a Health & Human Services Transformation initiative, which included a focus on promoting value-based payment in the state Medicaid program. The initiative has focused on achieving efficiency through reducing the number of contracted MCOs and providers in the Medicaid system. In its most recent Medicaid RFP, the state requires respondents to describe how they will “design and execute value-based payment and payment innovation within [the state’s] managed care program, across its populations and services.”⁶⁸ In July 2018, CMS approved an SPA allowing Illinois to implement health homes for physical and behavioral health condition management.⁶⁹ The Integrated health home program provides for a fully-integrated form of care coordination for the entire Illinois Medicaid population. Payments are PMPM and are based on tiers.⁷⁰

⁶⁶ [Public Act 96-1501, Illinois General Assembly, January 2011.](#)

⁶⁷ [Illinois Department of Public Health, State Innovation Model webpage.](#)

⁶⁸ [Illinois Medicaid Managed Care Organization Request for Proposals, February 2017.](#)

⁶⁹ [State Plan Amendment \(SPA\) #: 17-0014.](#)

⁷⁰ [Presentations from Illinois Integrated Health Homes Town Hall Meetings, August 2018.](#)

Indiana

While there is some participation in commercial value-based payment programs as well as those administered by CMS, including the Bundled Payments for Care Improvement (BPCI) initiative and the Next Generation ACO Model, Indiana does not have a coordinated statewide strategy to move in the direction of value-based payment.

The state has implemented a handful of targeted pay-for-outcome programs based upon selected outcome metrics, such as the Indiana State Department of Health's Maternal and Child Division infant mortality metrics. For example, one 2014 initiative targeting smoking cessation and pregnant women was designed to pay for outcomes and managed care entity contracts.⁷¹ Indiana has also created a process to review performance standards for the application of the Quality Strategy Plan to managed care plans in Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect. The Office of Medicaid Policy and Planning's Quality Team meets regularly to develop the Quality Strategy Plan and assess program progress toward performance metrics.⁷²

⁷¹ [Indiana Medicaid Managed Care Quality Strategy Plan -2017, p. 11](#)

⁷² Ibid.

Iowa

In 2014, Iowa received approval for its 1115 Demonstration Waiver from CMS to expand Medicaid and develop an ACO-based, value-based payment program called the Iowa Wellness Plan, to manage the expansion population.⁷³ As part of the waiver, the Iowa Medicaid Office established a set of incentives to help providers achieve the state's goals of increasing healthy behaviors among Medicaid recipients. These incentives are aligned with quality data that is tracked by the state's Value Index Score (VIS) Dashboard, which is made available to providers and payers.⁷⁴

Recently, Iowa abandoned the Iowa Wellness Plan in favor of a strategy geared toward full managed care, which took effect January 1, 2016. While still in flux, Iowa's Medicaid program remains committed to value-based payment and the VIS quality reporting system—MCO contracts require that 40% of the MCO's covered lives be within a value-based payment model.⁷⁵ These contracts must be based on both total cost of care and VIS quality measurements.

Also in 2014, Iowa received a \$43 million SIM Test grant to implement its State Innovation Plan.⁷⁶ Among the goals in the Iowa SIM is to increase participation in value-based payment in the state by having 50% of payments made through Medicaid, Wellmark, and Medicare linked to value-based payment contracts by 2018. In addition to setting targets for the percentage of payments made via value-based payment, the state has also set a goal of increasing the percentage of value-based payment arrangements that involve shared risk.⁷⁷

The state is implementing three strategies to support the transition to value-based payment: (1) a real-time alert system for ACOs so they know when one of their assigned members has an inpatient admission, discharge, or emergency department visit; (2) a statewide technical assistance program to help stakeholders transition to value-based payment; and (3) development of community care teams to identify and coordinate community resources that address the social determinants of health.⁷⁸

⁷³ [Iowa Medicaid ACO Program Outcomes, Iowa Department of Human Services, 2016.](#)

⁷⁴ [3M™ Value Index Score \(VIS\) Domains & Measures: Action Plans for Quality Improvement. Iowa Department of Human Services.](#)

⁷⁵ [Value-Based Payment \(VBP\) Models Definition & Qualifying Criteria for Determining Eligible Models. Iowa Department of Human Services, December 2015.](#)

⁷⁶ [State Innovation Models Initiative: Model Test Awards Round Two. Centers for Medicare & Medicaid Services.](#)

⁷⁷ [Primary Driver Diagram: Payment Reform. Align Payers in VBP. Iowa Department of Human Services.](#)

⁷⁸ [Medicaid Modernization Transition Fact Sheet: Iowa Medicaid Managed Care Transition for ACOs. Iowa Department of Human Services, October 15, 2015.](#)

Kansas

While there are a number of commercial and Medicare value-based payment initiatives underway in Kansas, the state does not have a coordinated, statewide strategy to implement value-based payment reform. The state has done some limited work to implement PCMH in primary care practices and has also implemented a voluntary P4P strategy for nursing homes in the Medicaid program.⁷⁹ Kansas was approved to participate in the DSRIP program through 2017 after the approval of its 1115 Demonstration Waiver. The program focused on two public hospitals to address sepsis and to encourage access through PCMHs.⁸⁰ Finally, the Greater Kansas City area (in both Kansas and Missouri) is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.⁸¹

⁷⁹ [Promoting Excellent Alternatives in Kansas Nursing Homes \(PEAK\). Kansas Department for Aging & Disability Services.](#)

⁸⁰ [Center for Health Care Strategies Delivery System Reform Incentive Payment \(DSRIP\): State Program Tracking.](#)

⁸¹ [CMS Innovation site on CPC+.](#)

Kentucky

While there are several private and federal initiatives occurring in Kentucky, the state does not have a coordinated, statewide strategy to implement payment reform. Kentucky received a SIM Design grant from CMMI, which the state used to complete a State Health System Innovation Plan (SHSIP), submitted to CMS in December 2015.⁸²

The SHSIP lays out a four-pronged strategy:

- 1) expanding the state's PCMH initiative to improve primary care;
- 2) implementing a multi-payer ACO strategy;
- 3) launching EOC; and
- 4) developing a Community Innovation Consortium to share best practices.

The plan has not been implemented, possibly because a new governor took office shortly after the SIM plan was submitted to CMS. Additionally, Kentucky participated in one pilot program under the CMS Medicaid Innovation Accelerator Program (IAP), as one of seven states in the High Intensity Learning Collaborative track of the IAP to reform payment and healthcare delivery models for Substance Use Disorders. The program ran from January 2015 through January 2016.⁸³ Finally, Northern Kentucky (the Greater Cincinnati area) is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.⁸⁴

⁸² State Health System Innovation Plan (SHSIP), State Innovation Model (SIM) Model Design Grant, Commonwealth of Kentucky, December 2015. No longer available online

⁸³ [Evaluation of the Medicaid Innovation Accelerator Program \(IAP\): Interim Report, March 2018.](#)

⁸⁴ [CMS Innovation site on CPC+.](#)

Louisiana

Louisiana has no statewide coordinated strategy to transition to a value-based reimbursement model. However, in March 2016, the legislature passed a law (HCR 77) asking the state's Department of Health to report on the feasibility of using ACOs in the Healthy Louisiana (Medicaid) program. In response to this, the state issued a request for information (RFI) to solicit feedback regarding the possibility of moving toward a system whereby the state would contract directly with ACOs at a PMPM rate to provide care to Medicaid patients. Per the RFI, this would be done as part of a planned re-procurement of Medicaid in 2019, and ACOs would supplement rather than replace MCOs.⁸⁵ Finally, Louisiana is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.⁸⁶

⁸⁵ [Louisiana Department of Health, Request for Information, Provider-Led Accountable Care Organizations, 11/4/2016.](#)

⁸⁶ [CMS Innovation site on CPC+.](#)

Maine

Maine launched a statewide value-based purchasing strategy in 2011 within the state Medicaid program, known as MaineCare.⁸⁷ As part of this strategy, Maine has invested in three value-based payment models: (1) Health Homes; (2) Behavioral Health Homes; and (3) Accountable Communities, a form of ACO. The Accountable Communities Initiative offers shared savings for MaineCare provider organizations. In the third year of the program, which concluded in July 2017, four regional ACOs participated, serving 55,000 MaineCare beneficiaries.⁸⁸

In 2013, Maine was awarded a \$33 million SIM Test grant from CMMI to implement its State Innovation Plan.⁸⁹ The payment reform goals in the SIM include support for quality improvement in behavioral health, a statewide quality dashboard, and a multi-stakeholder payment reform workgroup to help transition the state to value-based payment. Maine's payment reform work is managed by the Maine Health Management Coalition, which is working to engage stakeholders in the process to move the Maine healthcare system to one that is value-based.

Maine's chronic condition Health Home programs have operated since 2013, and the state later added two more programs: Behavioral Health Homes (BHH) and Opioid Health Homes.^{90, 91} During 2018, the Maine Department of Health and Human Services implemented a P4P provision for BHH providers, placing 1% of total BHH payments at risk pending performance on a quality measure. The current quality measure is: of the MaineCare members assigned to the BHH provider who had two or more fills of anti-psychotic medication, the percentage of members who had at least one HbA1c or fasting blood glucose test.⁹²

⁸⁷ [MaineCare Services, Maine Department of Health & Human Services, Value Based Purchasing Strategy.](#)

⁸⁸ [Maine Department of Health & Human Services, Accountable Communities Providers and Number of Members, 2017.](#)

⁸⁹ [State Innovation Models Initiative: Test Awards Round One. Centers for Medicare & Medicaid Services.](#)

⁹⁰ [Behavioral Health Homes, MaineCare Services, Maine Department of Health & Human Services.](#)

⁹¹ [Opioid Health Homes, MaineCare Services, Maine Department of Health & Human Services.](#)

⁹² [Behavioral Health Homes, MaineCare Services, Maine Department of Health & Human Services.](#)

Maryland

For decades, Maryland has had a unique all-payer model for hospital payments, made possible through a waiver with CMS, which allows the state to set all-payer rates for hospital payments. Under this agreement, Medicare, Medicaid, and all third-party payers agree to pay the same rates as established by the Maryland Health Services Cost Review Commission.⁹³ In 2009, Maryland agreed to incorporate quality measures into the payment system and to make other adjustments to the payment system. This program evolved in 2017 into the Care Redesign Program (CRP), which added performance goals focused on coordination of care, improved quality, and cost control. In 2018, all hospitals in the state were placed on global budgets and in 2019 they were also moved to a scaled adjustment based on total cost of care.⁹⁴

In January of 2019, Maryland transitioned from the CRP, implementing its Total Cost of Care (TCOC) Model. The multi-payer program seeks to limit hospital cost growth and requires participating providers to participate in: coordinated care programs, including hospital settings; performance payments based on patient outcomes; and chronic condition specific programs.⁹⁵ The TCOC Model is identified as an Other Payer Option by CMS in the All-Payer Advanced APM program through two of its components: the Care Redesign Program, and the Maryland Primary Care Program (MDPCP).⁹⁶ Providers participating in the Care Redesign Program are incentivized to use EOC models and to manage chronic care. The MDPCP is modeled on the CPC+ medical home program and is focused on delivering advanced primary care services to decrease hospitalization. Both programs seek to limit hospital cost growth to 3.58% per capita annually.

In addition to the TCOC Model, Maryland has a value-based purchasing strategy within its Medicaid program that sets performance targets, based on encounter-based and Healthcare Effectiveness Data and Information Set (HEDIS®) measures, for contracted MCOs. At the end of a program year, each MCO either receives an incentive payment, a disincentive assessment, or no change in payment depending on performance.⁹⁷

HEDIS is a registered trademark of the National Committee for Quality Assurance

⁹³ [Maryland All-Payer Model, Centers for Medicare & Medicaid Services Innovation Center.](#)

⁹⁴ [Maryland All-Payer Model's Care Redesign Program, June 21, 2018.](#)

⁹⁵ [Maryland Total Cost of Care Model, The Maryland Health Services Cost Review Commission.](#)

⁹⁶ [Maryland Department of Health. Maryland Primary Care Program.](#)

⁹⁷ [Medicaid & You: Measuring Medicaid Impact. Maryland Department of Health & Mental Hygiene, 2016.](#)

Massachusetts

In 2014, the Massachusetts legislature passed a massive health system overhaul, known as Chapter 224, to contain healthcare costs in the state. The law requires the state to adopt alternative payment models across state programs, establishes an all-payer claims database, and empowers the state's Health Policy Commission to set a global cap on the state's health costs. With funding from a \$44 million federal SIM Test grant, Massachusetts expanded its use of PCMH with shared savings across multiple payers. This was combined with Primary Care Payment Reform in Medicaid featuring three payment methodologies: a risk-adjusted PMPM payment, a quality-incentive payment, and a shared savings/risk payment.⁹⁸

Massachusetts applied for a 1115 Demonstration Waiver from CMS and received approval in November 2016 to implement an ACO-based reform initiative.⁹⁹ In December 2016, Massachusetts launched its Medicaid ACO initiative, with a one-year pilot program.¹⁰⁰ After the pilot, the state planned to contract with 18 ACOs across the state to provide care for 900,000 Medicaid beneficiaries.¹⁰¹ According to the state waiver, ACOs will be expected to provide integrated behavioral health, LTSS and social supports, as well as traditional medical care for a capitated, PMPM payment. Some ACOs will partner with MCOs (e.g., Tufts Health Plan, Fallon Health), while others will contract directly with the State Office of Medicaid.

The Division of Medical Assistance adopted rule amendments in December 2017 to implement MassHealth's policy to begin contracting with ACOs on March 1, 2018.¹⁰² In 2018, the Massachusetts Accountable Care Partnership Plan was approved as an Other Payer Option by CMS through the All-Payer Advanced APM program. The Accountable Care Partnership network is a multi-payer program that integrates ACO primary care practices into managed care plans statewide.¹⁰³

⁹⁸ [Commonwealth of Massachusetts, Executive Office of Health & Human Services, State Innovation Model Operational Plan, August 1, 2013.](#)

⁹⁹ [Press Release, Office of Governor Charlie Baker, Baker-Polito Administration, Centers for Medicare & Medicaid Services Announce Five Year, \\$52.4 billion Deal for MassHealth Restructuring. November 4, 2016.](#)

¹⁰⁰ [Massachusetts Office of Medicaid, MassHealth Partners with Six Health Care Organizations to Improve Member Care. 11/29/2017.](#)

¹⁰¹ [Massachusetts Insurance Market Reform, Affordability & MassHealth Sustainability. Executive Office of Health & Human Services, January 26, 2017.](#)

¹⁰² [Text of 130 CMR 508.000, MassHealth: Managed Care Requirements.](#)

¹⁰³ [Massachusetts Accountable Care Partnership Plan.](#)

Michigan

Michigan received a SIM Test grant from CMMI in February 2015 totaling \$70 million to implement the state's innovation plan. In that plan, Michigan proposed to roll out state-led multi-payer delivery and payment reforms that support patient-centered care. The components of the SIM include: (1) PCMH, launched January 2017 and covering 350,000 beneficiaries; (2) build-out of the state's health information exchange (HIE); and (3) Community Health Innovation Regions (CHIRs), an effort to create links between clinical and community resources, and to work more collaboratively on regional population health.¹⁰⁴ In the coming years, the state will be setting measurable value-based payment goals for MCOs to achieve as part of the state's new managed care contracts.¹⁰⁵

The state is also working on a "multi-payer payment and service delivery model, including a formal partnership with CMS for Medicare alignment."¹⁰⁶ Michigan submitted a plan for its fourth and final year of SIM funding in December 2018. The Department summarizes its plans as focusing "heavily on efforts to sustain the initiative, including working with CHIRs to identify long-term funding sources; bolstering the SIM PCMH Initiative by supporting the execution and refinement of clinical community linkages while encouraging practice transformation efforts focused on population health management; and working with Medicaid health plans to increase the amount of Medicaid spending in advanced, value-based payment methodologies."¹⁰⁷

In October 2018, CMS approved an SPA for Michigan to add a third Health Home program to its existing Severe Mental Illness Health Home model and chronic conditions Health Home model—an opioid treatment Health Home model operating in 21 counties.¹⁰⁸ Finally, Michigan is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁰⁹

¹⁰⁴ [Michigan Department of Health & Human Services, Policy Planning & Legislative Affairs Administration Report, FY2018.](#)

¹⁰⁵ [State Innovation Model Newsletter, Michigan Department of Health & Human Services, June 2017.](#)

¹⁰⁶ [State Innovation Model Initiative Summary, Michigan Department of Health & Human Services, April 2017.](#)

¹⁰⁷ [SIM Initiative News Letter, Michigan Department of Health & Human Services, December 2018.](#)

¹⁰⁸ [State Plan Amendment \(SPA\) #:18-1500-Opioid Health Home.](#)

¹⁰⁹ [CMS Innovation site on CPC+.](#)

Minnesota

Minnesota was among the first states in the country to consider payment reform as part of an overall approach to reforming the state health system. As part of a 2008 Health Reform Law, the legislature directed the Minnesota Health Department to develop a “basket of care” initiative, which, similar to EOC payments, would define a “basket” of services related to a particular disease state.¹¹⁰ In response, the state developed seven baskets of care, including those for both chronic conditions as well as surgical procedures. Another law, in 2010, directed the state to implement delivery system reform and led to the creation of the Integrated Health Partnership (IHP) demonstration, a shared-risk ACO program for the Medicaid population.¹¹¹

Minnesota received a SIM Test grant of \$45 million in February 2013 to implement its State Innovation Plan. The grant period ended in December 2017. Minnesota’s innovation model builds on the state’s IHP demonstration, which currently includes 21 providers and serves 465,000 Medicaid recipients.¹¹² The SIM plan expands this model to include other payers in the state. Using SIM resources, the state will invest in its information-sharing platform (HIE), data analytics tools for providers, and technical assistance in value-based payment arrangements.¹¹³ In addition, Minnesota aims to use about 15% of its funds to establish up to 15 Accountable Communities for Health (ACH) across the state that will work collaboratively to improve outcomes by increasing coordination, connecting community/clinical organizations, and focusing on the social determinants of health.

¹¹⁰ [Minnesota Health Reform Initiatives, Minnesota Department of Health.](#)

¹¹¹ [Integrated Health Partnerships \(IHP\) Overview, Minnesota Department of Health.](#)

¹¹² Ibid.

¹¹³ ["E-Health" of the Minnesota Accountable Health Model, Minnesota Department of Health.](#)

Mississippi

While there are various value-based payment programs occurring in Mississippi through Medicare or commercial payers, Mississippi does not have a coordinated statewide strategy to implement value-based payment programs in its healthcare system. Mississippi's Coordinated Access Network, (MississippiCAN) is a Medicaid Coordinated Care Organization (CCO) program which began in 2014 and was re-bid in 2017.¹¹⁴ The state selected three contractors (Magnolia Health, United Healthcare, and Molina Healthcare), to act as CCOs for most Medicaid covered services (excluding long-term care and waiver services). It is mandatory for certain populations to participate.¹¹⁵ Most recently, MississippiCAN added Psychiatric Residential Treatment Facility services to the CCO contracts via a Medicaid SPA, effective October 1, 2018.¹¹⁶

¹¹⁴ [MississippiCAN Enrollment, Mississippi Division of Medicaid.](#)

¹¹⁵ [Who Qualifies for MississippiCAN, Mississippi Division of Medicaid.](#)

¹¹⁶ [2017 RFP For Contracted Health Plans \(CCOs\).](#)

Missouri

Missouri has a limited strategy to better manage its state Medicaid program through value-based payment strategies. Prior to 2017, about half of the state's Medicaid population was covered through at-risk contracts with MCOs, while the remaining members were covered through a state-run fee-for-service program.¹¹⁷ Missouri has implemented two Health Home SPAs since 2011. One SPA covers individuals with a serious and persistent mental illness, mental health or substance abuse disorder plus a chronic condition, and mental health or substance abuse disorder plus tobacco use.¹¹⁸ The other SPA covers individuals with at least two of the following chronic conditions: asthma, cardiovascular disease, diabetes, developmental disabilities, and obesity, or with one of the previous chronic conditions and who are at risk of developing another.¹¹⁹

Effective May 1, 2017, the state completed a significant expansion of the MCO program, which now includes coverage of the entire state and excludes only the elderly and disabled population. The new MCO program will provide coverage for more than 700,000 individuals. Finally, the Greater Kansas City area (in both Kansas and Missouri) is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹²⁰

¹¹⁷ [Missouri Medicaid Basics. Missouri Foundation For Health, Spring 2017.](#)

¹¹⁸ [SPMI Health Home SPA.](#)

¹¹⁹ [Chronic Conditions Health Home SPA \(2016 SPA replaces 2011 SPA\).](#)

¹²⁰ [CMS Innovation site on CPC+.](#)

Montana

Montana has implemented a PCMH program across multiple payers in the state. The program pays a PMPM participation fee as well as a PMPM fee to support disease management. Some payers also offer a shared savings bonus to providers.¹²¹ In 2015, Montana won a SIM Design grant from CMMI to complete a State Health Care Innovation Plan. The resulting plan, completed and submitted to CMS in 2016, includes value-based payment reform as a key strategy in the effort to transform Montana's healthcare system.¹²² The plan refers to a strategy wherein the state will gradually move along the continuum to value-based payment but does not necessarily recommend a starting point or concrete next steps. Finally, Montana is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹²³

¹²¹ [Montana State Innovation Model Design, Presentation to the Governor's Council, March 8, 2016.](#)

¹²² [Montana Innovation Plan, Governor Steve Bullock's Council on Health Care Innovation & Reform, June 2016.](#)

¹²³ [CMS Innovation site on CPC+.](#)

Nebraska

In 2014, the Nebraska Legislature initiated a voluntary, multi-payer PCMH program that required participating health plans to contract with PCMH clinics and agree to use the same quality measures.¹²⁴ Payment details were left to the individual payers to determine. In 2017, Nebraska expanded its Medicaid Managed Care program, Heritage Health, to cover all Nebraska Medicaid enrollees (about 230,000 residents). Newly contracted MCOs were required to enter into value-based contracts with providers and to continue to support the state's PCMH initiative.¹²⁵ Finally, Nebraska is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹²⁶

¹²⁴ [Nebraska Medicaid Multi-Payer Medical Home Pilot Program, Patient-Centered Primary Care Collaborative, March 2015.](#)

¹²⁵ [Nebraska Medicaid's New Integrated Managed Care Program: Heritage Health. Nebraska Department of Health & Human Services. Presentation before the Health & Human Services Committee, October 19, 2016.](#)

¹²⁶ [CMS Innovation site on CPC+.](#)

Nevada

Nevada received a SIM Design grant in 2015 to create its State Innovation Plan, which was submitted to CMS in 2016.¹²⁷ According to the plan, the state will base its payment and delivery system reforms on three elements: PCMH, Medicaid Health Homes, and a program that focuses on high utilizers. The PCMH initiative will proceed in four phases of implementation that range from incentivizing participation, to paying for reporting and outcomes, and finally to a shared-savings model. The Health Home participants will be paid a risk-adjusted PMPM payment as well as an outcomes-based incentive payment. After this initial value-based reimbursement implementation phase, “consideration of bundled or episode-based payments will follow” as the state moves to more complex models with upside and then downside risk.¹²⁸

¹²⁷ [Nevada State Innovation Model, Nevada Department of Health & Human Services, January 29, 2016.](#)

¹²⁸ Ibid.

New Hampshire

In 2013 and 2015, New Hampshire received two rounds of SIM Design grants from CMMI to create a State Innovation Plan.¹²⁹ The plan outlined two tracks for reform in the state: reform of services for the Long Term Supports and Services (LTSS) population, and improvements in population health. The plan's focus is on adopting the Medicaid Health Home model for complex patients and a move toward a global budget for LTSS patients. As part of the LTSS reform, the state will also create a "Triple Aim Incentive Pool," which will be paid out to providers that achieve certain cost savings and quality targets.

In 2015, after the state received a second SIM Design grant, the New Hampshire Insurance Department contracted with a University of Massachusetts consulting firm to evaluate opportunities for the state to utilize value-based reimbursement strategies to lower health care spending in the state.¹³⁰ The UMass report echoed much of what was already in the state plan, but added the suggestion that the state provide technical assistance to private parties—i.e., a model contract and public reporting of quality data—to help ease the transition to value-based payment.

In 2015, New Hampshire submitted a 1115 Demonstration Waiver for DSRIP program approval to CMS that creates a system of seven regional Integrated Delivery Networks (IDNs) and commits to move at least 50% of payments to Medicaid providers to APMs by 2020. The seven IDNs, like ACOs, will coordinate behavioral and social support services as well as provide physical health services to Medicaid beneficiaries in their regions, which account for about 13% of New Hampshire's total population. The state's APM Roadmap calls for the creation of an APM Workgroup comprised of IDN and MCO stakeholders so that all parties have clear guidance as to what constitutes an APM and how the program will intersect with other existing value-based payment initiatives.¹³¹ IDNs reported to the state on their participation in existing state, federal, and commercial APM programs, and MCOs were required to submit information on their APM activity by the end of September 2017.¹³²

¹²⁹ [State Health Care Innovation Plan, New Hampshire Department of Health & Human Services, December 2013.](#)

¹³⁰ [Highland JP, et al. Health Care Payment Reform: Options & Recommendations. UMass Medical School Commonwealth Medicine. April 20, 2015.](#)

¹³¹ [New Hampshire's Building Capacity for Transformation Section 1115\(a\) Medicaid Research & Demonstration Waiver, DSRIP Alternative Payment Models Roadmap, Year 2 \(CY2017\) and Year 3 \(CY2018\).](#)

¹³² Ibid.

New Jersey

New Jersey has implemented a PCMH pilot project to manage high-need seniors and an ACO demonstration project (2015 legislation) within its Medicaid program. It was also one of the first states to incorporate LTSS supports into the Medicaid managed-care program. In 2015, the Rutgers Center for State Health Policy was awarded a \$3 million SIM Design grant for the state of New Jersey. The SIM project produced several reports, including an in-depth analysis of the outcomes of the state's ACO demonstration.¹³³

In March 2017, the New Jersey Health Quality Institute released a report titled "Medicaid 2.0: A Blueprint for the Future," which makes several recommendations to the state regarding improvements that should be made to ensure Medicaid's long-term solvency.¹³⁴ On APMs, the report recommends that the state require Medicaid MCOs to test three to five EOC models, beginning with bundles for maternity care, cardiac care, and total joint replacement. The report also recommends implementation of a statewide PCMH program. Finally, New Jersey is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹³⁵

¹³³ [Thompson FJ and Cantor JC. The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process. Rutgers Center for State Health Policy, May 2016.](#)

¹³⁴ [Medicaid 2.0: Blueprint for the Future. New Jersey Healthcare Quality Institute & the Nicholson Foundation. March 2017.](#)

¹³⁵ [CMS Innovation site on CPC+.](#)

New Mexico

In 2013, New Mexico received final approval for its 1115 Demonstration Waiver for Centennial Care, the state Medicaid program. In the waiver, the state planned to require MCOs, by contract, to implement value-based payment pilot programs. These MCO contracts require plans to (1) subject a certain percentage (16% by 2017) of provider payments to value-based payment arrangements and (2) “step up” the intensity of the value-based payment agreements from level one (withhold/incentive for quality) to level two (shared savings and bundled payments) to level three (some or full-risk capitation).

In 2015, state-contracted MCOs launched 10 value-based payment pilot programs, representing a range of models, including PCMH, shared savings, and EOC.¹³⁶ MCOs are required to have 16% of provider payments subject to value-based payment arrangements by 2017. The state is currently in the process of revising the original plan and proposes to increase percentage of payments that are tied to value in MCO contracts.¹³⁷

¹³⁶ [Centennial Care Value-Based Purchasing Brief](#). New Mexico Human Services Department, January 2017.

¹³⁷ [Centennial Care 2.0: Section 1115 Demonstration Waiver Renewal Concept Paper](#), New Mexico Human Services Department, May 2017.

New York

New York received a \$100 million Round Two SIM Test grant in 2015 and in the same year received approval for its 1115 Demonstration Waiver and DSRIP program from CMS.¹³⁸ The goals in both plans are similar: In the SIM, the state committed to 80% of all payments in value-based payment by 2021, and in the waiver, the state committed to achieving 90% value-based payment in Medicaid by 2021. The state's DSRIP waiver creates 25 Performing Provider Systems (PPS), which will be responsible for providing care for five million Medicaid beneficiaries in the state, moving PPS providers from a P4P payment model. The state's waiver update from 2016 notes that the state has "extensive experience with what [is] described as Level 0 Value Based Payments, fee-for-service with quality bonus payments" used in the PCMH and medical home demonstrations that have taken place across the state.¹³⁹

In 2016, less than 25% of the state's Medicaid spending was in a Level 1 or higher value-based payment program.¹⁴⁰ For this reason, the state seeks to push MCOs and providers along the continuum to Level 1, 2, and 3 risk-sharing arrangements, or the MCOs will face penalties. While the state is prepared to provide technical assistance, a standardized quality measure set, and other guidance, it leaves the MCOs and providers to determine the details of their individual value-based payment contracts.¹⁴¹

As of 2016, the state hoped to launch approximately 15 value-based payment pilots with a focus on:

- 1) total care for the general population;
- 2) integrated primary care;
- 3) maternity care;
- 4) HIV/AIDS; and
- 5) health and recovery plans.

The state does note that Prometheus is the bundling methodology of choice for the maternity and (eventually) chronic care bundles.¹⁴² Experience with these pilots through 2019 will be used to inform the future direction of Medicaid payment reform. Implementation of the SIM plan, which extends to 2020, is following a parallel path, with a focus on moving to value-based payment in the commercial market in addition to Medicaid. The centerpiece of the SIM plan is the development of Advanced Primary Care (similar to PCMH) in the state with a common set of measures and payments tied to aiding this transition. The PPS (ACOs) created by DSRIP are expected to conform with the APC program so that all payers can align payment around a common set of measures.¹⁴³ New York has contracted with the Northeast Business Group on Health to provide outreach to employers and self-insured stakeholders and engage them in the state's overall strategy to transition to value-based payment.¹⁴⁴ Finally, the Albany and Buffalo areas are two of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁴⁵

¹³⁸ [State Innovation Models Initiative: Model Test Awards Round Two](#). Centers for Medicare & Medicaid Services.

¹³⁹ [A Path Toward Value Based Payment: Annual Update](#). New York State Roadmap for Medicaid Payment Reform. NY State Department of Health Medicaid Redesign Team, June 2016. (p. 9).

¹⁴⁰ [Jason Helgeson, New York State Medical Director, Presentation to the New York State Innovation Council, November 29, 2016](#).

¹⁴¹ [A Path toward Value Based Payment: Annual Update](#). New York State Roadmap for Medicaid Payment Reform. New York State Department of Health Medicaid Redesign Team, June 2016.

¹⁴² [List of Prioritized VBP Arrangements](#). New York State Department of Health. 2016.

¹⁴³ [New York State SIM Year 2 Operational Plan](#), New York State Department of Health, June 2016.

¹⁴⁴ *Ibid.*

¹⁴⁵ [CMS Innovation site on CPC+](#).

North Carolina

Two separate pieces of legislation (in 2015 and 2016) authorized the state’s Department of Health and Human Services to undertake Medicaid transformation, including payment reform. The state began a process and submitted a waiver application to CMS in June 2016.¹⁴⁶ CMS approved a Section 1115 Demonstration Waiver to support transitioning North Carolina’s Medicaid program from fee-for-service to Managed Care. North Carolina originally submitted the waiver application in 2016, then amended and resubmitted it in November 2017. CMS approved the waiver October 19, 2018, for the performance period January 1, 2019 through October 31, 2024. The waiver includes tailored plans for Medicaid beneficiaries with behavioral health or intellectual and developmental disability diagnoses, as well as authority to implement a “Healthy Opportunities” pilot program to identify the most cost-effective value-based payment models for managed care plans.¹⁴⁷

In August 2017, the state’s new administration released an updated vision for Medicaid Managed Care, posted for public comment, which provides more detail regarding the plan for implementation of Medicaid reform.¹⁴⁸ In the area of value-based payment, the state notes that it will include VBP language in the RFP for Medicaid Prepaid Health Plans and will reward those that help to advance the state’s value-based payment goals.

¹⁴⁶ [North Carolina Medicaid & NC Health Choice Section 1115 Demonstration Waiver Application. North Carolina Department of Health & Human Services. June 1, 2016.](#)

¹⁴⁷ [CMS 1115 Demonstration Waiver Approval Letter.](#)

¹⁴⁸ [North Carolina’s Proposed Program Design for Medicaid Managed Care, August 2017.](#)

North Dakota

While there are value-based payment initiatives operated by CMS and commercial payers in the state, North Dakota does not have a coordinated statewide strategy to achieve payment reform. Specifically, North Dakota is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁴⁹

¹⁴⁹ [CMS Innovation site on CPC+](#).

Ohio

In 2013, Ohio received a SIM Design grant to develop its State Innovation Plan¹⁵⁰ and a follow-up \$75 million Test grant in 2015 to implement its plan,¹⁵¹ which aims to tie 80-90% of payments in the state to value-based payment by 2019. To achieve this, Ohio will implement two strategies: (1) expand the PCMH model with the goal of statewide coverage by 2018; and (2) implement a multi-payer EOC model.¹⁵² Ohio has secured participation from its largest commercial payers as well as its Medicaid health plans, which collectively account for 90% of the state population.¹⁵³

Under the episode-based strategy, patients are assigned to a Principal Accountable Provider (PAP) for each episode, who is responsible for coordinating care. PAPs are assessed against the cost of an average episode and either receive shared savings or a negative incentive based on their performance. The episode-based strategy began rolling out in 2015 with six episodes. Seven more were developed in 2016 and an additional 20 launched in 2017.¹⁵⁴ Behavioral health bundles are contemplated for the fourth wave, slated to begin in 2018. By the end of 2018, the state hoped to have 50+ episodes defined and launched across payers, but as of March 2019, the state has defined 43 episodes.¹⁵⁵

In 2018, Ohio's Episode-based Payments Model was approved as an Other Payer Option by CMS through the All-Payer Advanced APM program. Ohio Medicaid is using the federal funding in this program to continue its EOC-based, value-based payment policy.¹⁵⁶ Finally, Ohio is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁵⁷

¹⁵⁰ [State Innovation Models Initiative: Model Design Awards Round One](#). Centers for Medicare & Medicaid Services.

¹⁵¹ [State Innovation Models Initiative: Model Test Awards Round Two](#). Centers for Medicare & Medicaid Services.

¹⁵² [Introduction to the Ohio Episode-Based Payment Model](#), Governor's Office of Health Transformation, December 2015.

¹⁵³ [Ohio Governor's Office of Health Transformation. State Innovation Models Round 2 Model Test: Ohio Operational Plan, Updated December 16, 2015.](#)

¹⁵⁴ [Ohio Governor's Office of Health Transformation. Introduction to the Ohio Episode-Based Payment Model. December 2015.](#)

¹⁵⁵ Ibid. at page 6.

¹⁵⁶ [Medicaid Innovation Accelerator Program: Aligning State Medicaid Value-Based Payment Approaches with MACRA Policies & Measures.](#)

¹⁵⁷ [CMS Innovation site on CPC+.](#)

Oklahoma

In 2015, Oklahoma received a SIM Design grant to complete a State Innovation Plan. The State Health System Innovation Plan was submitted to CMS in March 2016.¹⁵⁸ The plan proposes to shift to a Regional Care Organization (RCO) model for all state-purchased care, including Medicaid and state employees. RCOs will receive a risk-adjusted capitated PMPM payment for each attributed member and will also be eligible for incentive payments based on quality measures. To participate, RCOs must agree to: (1) have 80% of their payments to providers be value-based by 2020; (2) participate in the multi-payer EOC program; and (3) use one additional APM.¹⁵⁹

In addition to RCOs, Oklahoma proposes to implement an EOC program that will focus on Medicaid and eventually be expanded to all payers. The state is proposing an initial group of episodes but plans to expand the list once the program is up and running. Finally, Oklahoma is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁶⁰

¹⁵⁸ [Oklahoma State Health System Innovation Plan, State Innovation Model Design Grant. Oklahoma State Department of Health. March 31, 2016.](#)

¹⁵⁹ Ibid.

¹⁶⁰ [CMS Innovation site on CPC+.](#)

Oregon

Oregon's health reform initiative began with the launch of Patient Centered Primary Care Homes in 2010 and CCOs in 2012. In 2013, Oregon received a SIM Test grant in the amount of \$45 million to implement the State Innovation Plan. The grant, which concluded in September 2016, provided funding for the state's transition to global payments for CCOs and development of a "starter set" of APMs.¹⁶¹ CCOs are networks of all types of healthcare providers that agree to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid). CCOs receive a risk-adjusted PMPM payment for each attributed member and accept financial risk for providing mental, physical, and dental care to their member population. In 2016, nearly one million Oregon residents were enrolled in Medicaid and 90% of these enrollees received care through a CCO.¹⁶²

Oregon enacted SB 934, which took effect January 1, 2018, requiring three types of payers to spend at least 12% of total medical expenditures on primary care by January 1, 2023: CCOs, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board. Further, the law also directs the Department of Consumer and Business Services to create requirements for carriers who spend less than 12% of total medical expenditures on primary care to submit a plan for increasing their primary care spending. The bill also removed the sunset provision for the Primary Care Transformation Initiative.¹⁶³

The Oregon Health Authority then adopted rules that provide the framework for CCOs to implement, administer, and oversee Health-Related Services within the Medicaid managed care integrated service delivery model. This rule outlines a framework and defines the circumstances under which a CCO or managed care entity can provide flexible services. These services are offered to individual members to supplement covered services under the Medicaid program, and community benefit initiatives that are community-level interventions focused on improving population health and healthcare quality.¹⁶⁴ Finally, Oregon is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁶⁵

¹⁶¹ [State Innovation Model Grant \(SIM\) website, Oregon Health Authority Transformation Center.](#)

¹⁶² [Oregon's Health System Transformation: Annual Update. Oregon Health Authority, September 2016.](#)

¹⁶³ [Oregon S.B. 934](#)

¹⁶⁴ [Amendments to Chapter 410 -141-3150 to implement the CCO framework.](#)

¹⁶⁵ [CMS Innovation site on CPC+.](#)

Pennsylvania

Pennsylvania received a total of about \$4.5 million in two SIM Design grants in 2013 and 2015 to develop the Health Innovation in Pennsylvania Plan, which was submitted to CMS in June 2016.¹⁶⁶ In the plan, Pennsylvania outlines three complementary strategies for achieving value-based payment reform in the state: multi-payer EOC payments for acute care; global payments for enhanced primary care through PCMHs; and a global budget for rural hospitals. In addition, in the most recent Medicaid MCO contracts, the state required MCOs to shift 30% of their payments into APMs by 2019, ramping up to those numbers beginning in 2017.¹⁶⁷

The state began a planning process in 2017 to develop the approach to EOC payments. According to the plan, the goal of these stakeholder meetings is to (1) adopt a common approach for performance measures; (2) identify regions and/or episodes where payers will shift payment to EOC; and (3) develop a roadmap for EOC implementation. In addition to this initial plan, the Office of Mental Health and Substance Abuse Services has implemented value-based payment requirements on MCOs to meet 20% value-based purchasing requirements by 2020 for behavioral health services.¹⁶⁸ Finally, the Greater Philadelphia area is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁶⁹

¹⁶⁶ [Health Innovation in Pennsylvania Plan, Pennsylvania State Health Department. June 20, 2016.](#)

¹⁶⁷ Ibid. at page 37.

¹⁶⁸ [Pennsylvania Value Based Purchasing Website.](#)

¹⁶⁹ [CMS Innovation site on CPC+.](#)

Puerto Rico

In 2015, Puerto Rico received a nearly \$2 million SIM Design grant to create a State Health Innovation Plan. The plan, which was filed with CMS in 2016, lays out a three-year roadmap for Medicaid transformation on the island.¹⁷⁰ Puerto Rico's value-based payment plan breaks down into two phases; first, the government will establish five disease-specific bundles (prenatal care, pediatric asthma, diabetes management, chronic kidney disease, and super-utilizers), followed by implementation of at least three provider-led ACOs that would contract directly with the state to provide care for Medicaid patients. Puerto Rico began implementation of the plan in 2017 and incorporated the proposed value-based payment reforms into the Medicaid program via the 2018 MCO RFP.¹⁷¹

¹⁷⁰ [Nichols D, Farrell K, Morrison M, Berkman N, & Gavin N. State Innovation Models \(SIM\) Round 2: Model Design Final Report. RTI International, August 2017.](#)

¹⁷¹ *Ibid.* at page 27.

Rhode Island

Rhode Island received a \$20 million SIM Test grant from CMMI in 2015 to implement payment and delivery system reform in the state.¹⁷² In the State Innovation Plan, the state committed to achieving 50% of commercial and Medicaid payments subject to APM in 2018 and 80% of payments linked to value.¹⁷³ To achieve this, the state is pursuing parallel strategies in the Medicaid and commercial markets. The Medicaid strategy focuses on PCMH and Behavioral Health initiatives. It also includes the creation of Medicaid Accountable Entities (AEs) that will be certified by the state to provide comprehensive care to Medicaid patients via contracts with MCOs.¹⁷⁴ By 2022, the state aims to have a third of eligible Medicaid patients attributed to an AE that is receiving a TCOC payment or other approved APM through participating MCOs.¹⁷⁵

On the commercial side, the state promulgated regulations in February 2015 that require commercial payers with 10,000 or more covered lives in the state to “significantly reduce the use of fee-for-service payment as a payment methodology, to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies.”¹⁷⁶ For calendar year 2017, plans had to demonstrate that 40% of medical payments were made through an APM and this target increased to 50% in calendar year 2018.

Approved APMs include:

- 1) total-cost-of-care budget models;
- 2) limited scope of service budget models;
- 3) episode-based payments; and
- 4) infrastructure payments and P4P (2016-2017 only).¹⁷⁷

Finally, Rhode Island is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁷⁸

¹⁷² [Rhode Island Health Department. Rhode Island State Innovation Model \(SIM\) Test Grant Fact Sheet.](#) .

¹⁷³ [Rhode Island Health Department. Rhode Island State Innovation Model \(SIM\) Test Grant Operational Plan, May 9, 2017.](#)

¹⁷⁴ [Medicaid Program Accountable Entity Roadmap Document, Rhode Island Executive Office of Health & Human Services \(EOHHS\), April 13, 2017.](#)

¹⁷⁵ Ibid.

¹⁷⁶ [Office of the Health Insurance Commissioner. Regulation 2, Section 10\(d\)\(2\).](#)

¹⁷⁷ [Rhode Island 2017-2018 Alternative Payment Methodology Plan. Rhode Island Office of the Health Commissioner, January 27, 2017.](#)

¹⁷⁸ [CMS Innovation site on CPC+.](#)

South Carolina

South Carolina has moved forward with a few limited strategies to implement value-based reimbursement. First, in its Medicaid program, South Carolina provides a capitated PMPM payment to PCMHs that provide care to 25% of the state's Medicaid population.¹⁷⁹ In its contracts with Medicaid MCOs, South Carolina requires adoption of value-based purchasing—in 2017, the state required 20% of payments to be covered by value-based payment. The state provides some technical assistance but does not prescribe which type of value-based payment should be used.

In addition, from the results of two recent surveys—one by the Center for Healthcare Studies and one by Bailit Health—the state has indicated that it is also considering implementing EOC in the coming years.¹⁸⁰ The value-based payment requirements, and a formula to determine the percentage of payments made through an APM, were reiterated in the 2018 Policy and Procedure Guide for Managed Care Organizations.¹⁸¹

¹⁷⁹ [The Role of State Medicaid Programs in Improving the Value of the Health Care System. Bailit Health & the National Association of Medicaid Directors. March 22, 2016.](#)

¹⁸⁰ [Leddy T, McGinnis T, Howe G. Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches. Center for Health Care Strategies, Inc. February 2016.](#)

¹⁸¹ [Policy and Procedure Guide for Managed Care Organizations, South Carolina Healthy Connections Medicaid, July 1, 2018.](#)

South Dakota

South Dakota does not have a coordinated statewide strategy to move toward value-based care, but has moved forward with implementation of the Health Homes model within the Medicaid program, which serves patients with two or more chronic conditions.¹⁸² Under this program the state pays providers a PMPM payment for six services.

¹⁸² [Patient-Centered Primary Care Collaborative. South Dakota Health Homes.](#)

Tennessee

Tennessee received a SIM Design grant in 2013 to develop a State Innovation Plan. In 2015, the state received a \$65 million SIM Test grant to begin implementation of the innovation plan.¹⁸³ Tennessee requires all contracted TennCare (Tennessee Medicaid) and employee health plans in the state to participate in the state's innovation plan. The innovation plan involves a three-pronged strategy: (1) primary care transformation with PCMH, "HealthLink" care coordination for TennCare members with significant behavioral health needs, and an online care coordination tool; (2) implementation of EOC, for acute and specialist driven care; and (3) value-based payments in LTSS care settings.¹⁸⁴

As part of the plan, Tennessee set a goal of implementing 75 EOCs by 2019, in a phased, five-year rollout.¹⁸⁵ The EOC program is retrospective and based on a combination of quality and cost measurements, designed by McKinsey.¹⁸⁶ The TennCare EOC initiative began rollout in 2015 and the employee benefit plans transitioned to mandatory EOC in 2017.¹⁸⁷ After concerns were raised by Tennessee providers and provider associations, the state made the EOC a rewards-only program for the commercial market, while TennCare EOC employs both rewards and penalties.

In addition to TennCare and the state employee plans, some commercial payers are working in tandem with the state to implement their own EOC programs.¹⁸⁸ As of December 2018, eligible clinicians (ECs) may participate in Tennessee's Retrospective EOC Model, a statewide Medicaid managed care program that allows ECs to become Qualifying APM Participants through the CMS All-Payer Option. This option makes other-payer advanced APM arrangements that are similar to Advanced APMs under Medicare available to non-Medicare participants.¹⁸⁹ Finally, Tennessee is one of the 18 states/regions participating in the CPC+ program, a two-track primary care medical home model that seeks to reform care delivery and multi-payer payment.¹⁹⁰

¹⁸³ [State Innovation Models Initiative: Model Test Awards Round Two](#). Centers for Medicare & Medicaid Services.

¹⁸⁴ [Division of Health Care Finance & Administration. Introduction to Episodes of Care in Tennessee](#).

¹⁸⁵ [Introduction to Episodes of Care](#).

¹⁸⁶ [Episode Thresholds 2017](#). Tennessee Division of Health Care Finance & Administration.

¹⁸⁷ [Letter to Stakeholders from the Tennessee Department of Finance & Administration, Benefits Administration](#). March 8, 2017.

¹⁸⁸ [Tennessee Model Test Project Narrative](#). State Innovation Models Grant.

¹⁸⁹ [Tennessee Retrospective Episodes of Care Model](#), Tennessee Medical Association.

¹⁹⁰ [CMS Innovation site on CPC+](#).

Texas

In 2014, Texas implemented a statutorily-required Pay for Quality program in its Medicaid and CHIP programs, aimed at improving quality and encouraging its contracted Medicaid MCOs to engage in value-based contracting. In contracts with MCOs, the state puts 4% of the capitation payment at-risk, pending reporting by the MCOs on various quality-related outcomes.¹⁹¹ The state also explicitly requires MCOs to “develop and submit to [the state] a written plan for expansion of value-based contracting with its physician and non-physician providers that encourages innovation and collaboration, and increases quality and efficiency.”¹⁹²

According to the most recent summary report of value-based payment used by the state Medicaid MCOs (plan year 2015), the plans used a combination of:

- 1) fee-for-service with bonus payments for achieving specific measures (most common);
- 2) partial capitation with bonuses for quality and/or bundles;
- 3) medical home models; and
- 4) shared savings approaches (least common).¹⁹³

¹⁹¹ [Quality-Based Payment and Delivery Reforms in Medicaid and the Children’s Health Insurance Program, Texas Health and Human Services Commission Report, February 2016.](#)

¹⁹² [Texas Uniform Managed Care Contract.](#)

¹⁹³ [Overview of Texas Medicaid-CHIP MCO and DMO Value-Based Contracting Initiatives in 2016.Texas Health and Human Services Commission, July 13, 2016.](#)

Utah

The Utah state legislature passed a law in 2011 requiring the state's Department of Health to move to value-based reimbursement in the Medicaid program. In 2013, the state completed implementation, which resulted in the creation of four payer-led ACOs that serve 70% of the state's Medicaid population.¹⁹⁴ The ACOs receive monthly risk-adjusted capitated payments for members. There are no bonus payments for achieving quality measures, but the contracts do require providers to achieve a certain level of performance on quality.

Utah received almost \$3 million in two SIM Design grants,¹⁹⁵ and established a state goal of achieving 80% of payments in a value-based purchasing plan by 2018.¹⁹⁶ However, there is little publicly available information on the state's progress toward achieving this goal.

¹⁹⁴ [Lloyd J, Houston R, McGinnis T. Medicaid Accountable Care Organization Programs: State Profiles. Center for Health Care Strategies, Inc. October 2015.](#)

¹⁹⁵ [Centers for Medicare & Medicaid Services. State Innovation Models Initiative: Model Design Awards Round One.](#)
[Centers for Medicare & Medicaid Services. State Innovation Models Initiative: Model Design Awards Round Two.](#)

¹⁹⁶ [Utah Department of Health. Utah Health Innovation Plan, December 2013.](#)

Vermont

Vermont had been an active health reform state even before the passage of the Patient Protection and Affordable Care Act. In 2011, the Green Mountain Care Board was created by the Legislature to regulate the healthcare market and has been the most active healthcare entity in the state. As one of its first value-based policies, the Board developed a PCMH strategy called Blueprint for Health, which rewards advanced primary care practices for achieving quality and population health targets.¹⁹⁷

In 2013, Vermont received a \$45 million SIM Test grant from CMMI and the state used the funding to consider several APM options, including shared savings ACOs, EOC for the Medicaid population, Health Homes, and ACH.¹⁹⁸ The state abandoned its work on EOC and ACH and instead launched Medicaid and commercial shared savings ACOs in 2014 as a three-year pilot.¹⁹⁹ Three ACOs (OneCare, CHAC, Healthfirst) were formed in the state and cover about 60% of the total population. The ACO program has two tracks: (1) upside only risk or (2) upside/downside risk. In 2016, the three ACOs joined together to become the Vermont Care Organization (VCO), which is a coordinating body rather than being an ACO on its own.²⁰⁰ The consolidated organization allows providers to contract with VCO to take on varying degrees of risk.

In the beginning of 2017, CMS approved Vermont's 1115 Demonstration Waiver to implement an ambitious All-Payer ACO model in the state. Under the proposed model, commercial and government payers would align around PMPM capitated payments to ACOs for care of attributed members. The Agency of Human Services issued a new policy effective October 1, 2018 to address the Vermont Chronic Care Initiative (VCCI) by integrating that program's care management services into the state's overall strategy. The agency seeks to align VCCI with other healthcare reforms, including the Blueprint for Health and the Vermont Medicaid Next Generation ACO model. The new policy will facilitate access to the appropriate level of health services for new and non-ACO attributed Medicaid beneficiaries. Previously, eligibility for VCCI was restricted to care management for non-ACO Medicaid beneficiaries identified through claims data as being in the top 5% of beneficiaries for healthcare costs and utilization.

The Vermont All-Payer ACO Model establishes the same payment structure for Medicare, Medicaid, and commercial health payers for the majority of providers throughout the state's care delivery system, and was approved as an Other Payer Option by CMS through the All-Payer Advanced APM program. The performance period began January 1, 2017 and is scheduled to conclude December 31, 2022.²⁰¹

¹⁹⁷ [Vermont Blueprint for Health 2014 Annual Report, Department of Vermont Health Access, January 15, 2015.](#)

¹⁹⁸ [State Innovation Models Initiative: Model Test Awards Round One. Centers for Medicare & Medicaid Services.](#)

¹⁹⁹ [Vermont Health Care Innovation Project, Payment Model Design & Implementation.](#)

²⁰⁰ Value-Based Payment Reform and ACOs, Presentation before the House Health Care Committee, Vermont Care Organization, February 2017. No longer available online.

²⁰¹ [Vermont Medicare ACO Initiative \(as part of the Vermont All-Payer ACO Model\).](#)

Virginia

Virginia received a SIM Design grant in December 2014 and partnered with the non-profit Virginia Center for Health Innovation to complete a state innovation plan.²⁰² The work on the innovation plan became a part of the 1115 Demonstration Waiver that approved Virginia's inclusion in the DSRIP program .²⁰³ Now approved, the DSRIP process is expected to involve changes to the Medicaid payment system in the state beginning in 2019. This payment reform strategy will focus on the formation of Accountable Care Communities in five regions in the state, called Virginia Integrated Partners.²⁰⁴ Virginia Integrated Partners will be responsible for working with the state's MCOs to coordinate care for Medicaid enrollees. The DSRIP plan aimed to begin with the "high utilizer" population in 2018 and scale up to the full Medicaid population by 2021.²⁰⁵ Likewise, value-based payment will ramp up from incentive and care coordination payments in 2018 to TCOC payments in 2021.

²⁰² [Better Value for a Healthier Commonwealth: A Summary of Virginia's State Innovation Model Design, January 2016.](#)

²⁰³ [Virginia Department of Medical Assistance Services. Virginia Section 1115 Demonstration Waiver Application, September 19, 2018.](#)

²⁰⁴ [Virginia Center for Health Innovation. Regional Accountable Care Communities.](#)

²⁰⁵ [Op. cit.](#) (p. 14).

Washington

Washington state received a SIM Test grant in 2014 to fund the rollout of initiatives in “The Washington Way,” the state’s innovation plan.²⁰⁶ The innovation plan commits Washington state to assume the role as a “first mover” in the state by tying 80% of its state-financed healthcare payments to value-based payment by 2021.²⁰⁷ This accounts for both the state Medicaid plan, Apple Health, and the state employee health plan, which together cover two million residents.

The state-financed value-based payment strategy takes the form of two primary initiatives: (1) a primary care initiative focused on a shift to PMPM payments prospectively adjusted for quality and (2) an Accountable Care Program with integrated care for state employees.²⁰⁸ In 2017, the state employee program introduced a bundled-payment program for total joint replacements. The innovation plan also calls for commercial payers to have at least 50% of their payments in value-based payment during the same five-year timeframe through implementation of a Public/Private Transformation Action Strategy, in which the state will ask commercial stakeholders to commit to help implement the strategy.²⁰⁹ In 2019, the state aimed to have written commitments from companies that represent 60% of the current healthcare market share.²¹⁰

The Washington Health Care Authority (Authority) continues to implement its innovation plan, which calls for at least 75% of payments to be in value-based payment by 2019, 85% by 2020 and 90% by 2021. The program was approved as an Other Payer Option by CMS through the All-Payer Advanced APM program. The Authority adopted a CMS-generated framework, via HCP-LAN, to guide movement away from fee-for-service and to define payment arrangements (APMs). The Authority’s goal is to have no more than 10% of state-financed health care payments to providers in categories such as fee-for-service or lower-value APM, such as foundational payments for infrastructure and operations or pay-for-reporting.²¹¹

²⁰⁶ [Washington State Health Care Authority. The Washington Way: Washington State Health Care Innovation Plan. January 2014.](#)

²⁰⁷ [Washington State Health Care Authority website.](#)

²⁰⁸ Ibid.

²⁰⁹ [Op. cit.](#)

²¹⁰ Ibid.

²¹¹ [Washington State Health Care Authority's Value-based Roadmap, October 2018.](#)

West Virginia

West Virginia received a 2014 SIM Design grant from CMMI. The funding was used to develop the West Virginia Health System Innovation Plan, which the state filed with CMS in August 2016.²¹² The plan recommends three strategies regarding value-based payment:

- 1) set targets within the state Medicaid program requiring adoption of value-based payment by contracted plans;
- 2) encourage other payers to adopt value-based payment; and
- 3) establish regional accountable health communities.²¹³

It further sets goals of 10% value-based payment across all payers except for Medicare in 2017 and ramps up to a goal of 80% in value-based payment by 2021.²¹⁴ To shepherd this transformation process, the plan proposed the creation of a new non-profit organization, the West Virginia Health Transformation Accelerator (WVHTA). As of 2019 the WVHTA had not yet been formed.

²¹² [West Virginia Department of Health & Human Resources press release regarding West Virginia Health System Innovation Plan, July 27, 2016](#). Note that all links to the plan itself are password protected on the WV Health Innovation Collaborative website.

²¹³ Ibid. at page 96.

²¹⁴ Ibid. at page 317.

Wisconsin

In 2011, a group of 30 organizations, including large payers, providers, and state agencies, formed the Statewide Value Committee, a public-private partnership which focused on identifying common performance measures to be used in the move to value-based payment.²¹⁵ In 2014, the group, in partnership with the Wisconsin Department of Health Services, applied for a Round-2 SIM Design grant. This grant was awarded in late 2014 and the group developed a State Innovation Plan that was submitted to CMS in January 2016.²¹⁶ After an exhaustive review of value-based payment reform options, the plan recommends that the state adopt a fee-for-service model with P4P incentives and care coordination payments.

Of note, in 2009, the state Medicaid program, known as BadgerCare, began a P4P program with contracted MCOs and expanded the program in 2013 to include hospitals that were paid through the fee-for-service program. According to the plan, this experience demonstrates that the state is able to take a leadership role in promoting value-based payment and helping others move along the continuum.

²¹⁵ [Wisconsin Collaborative for Healthcare Quality. Statewide Value Committee \(SVC\).](#)

²¹⁶ [Wisconsin State Health Innovation Plan. Wisconsin Department of Health Services, 2016.](#)

Wyoming

Wyoming does not have a coordinated statewide strategy to implement value-based payment strategies. In 2015, the state Medicaid program implemented PCMH through an SPA and expanded the number of practices that participate in the PCMH program in 2016 and 2017.

Value-Based Care in America: A Table View of State-by-State Initiatives




























































Tracking Payment Innovation and the Transition to Value




Change Healthcare has conducted a review of value-based care and payment-reform initiatives in all 50 states, plus Puerto Rico and Washington, D.C. The analysis reveals a range of approaches and significant variation in the scope, leadership commitment, and resources devoted to the transition from fee-for-service to value-based reimbursement. The table below provides an aggregate look at which strategies states have adopted, whether they have chosen to set payment targets, the scope of their initiatives (Medicaid or multi-payer), and the approximate year initiatives were implemented.

Color Key: Changes to State Programs since 2017

-  No change, program in place in '17
-  Addition
-  Confirmation (moved from "Consideration" to "Live" phase)
-  Standout States

Please note CPC+ programs were not studied in our prior report and some may have been in place at that time.

State	SIM Grant	PCMH/HH	CPC+	P4P	ACO	EOC	VBP Mandates or Targets	Scope	Year
Alabama								Medicaid	2017
Alaska								Medicaid	2017
Arizona	Round 2 Design							Medicaid	2014
Arkansas	Round 1 Test							Multi-payer	2013
California	Round 1 and 2 Design							Medicaid	2015
Colorado	Round 1 Pretest, Round 2 Test							Multi-payer	2011
Connecticut	Round 1 Design, Round 2 Test							Multi-payer	2015
Delaware	Round 1 Design, Round 2 Test							Multi-payer	2015
District of Columbia	Round 2 Design							Medicaid	2016
Florida								Medicaid	2016
Georgia									
Hawaii	Round 1 and 2 Design							Medicaid	2015
Idaho	Round 1 Design, Round 2 Test							Multi-payer	2015
Illinois	Round 1 and 2 Design							Medicaid	2014
Indiana									
Iowa	Round 1 Design, Round 2 Test							Multi-payer	2014
Kansas								Medicaid	2015
Kentucky	Round 2 Design							Medicaid	2015
Louisiana								Medicaid	2016
Maine	Round 1 Test							Medicaid	2014
Maryland	Round 1 and 2 Design							Multi-payer	2011
Massachusetts	Round 1 Test							Medicaid	2014
Michigan	Round 1 Design, Round 2 Test							Multi-payer	2017

State	SIM Grant	PCMH/HH	CPC+	P4P	ACO	EOC	VBP Mandates or Targets	Scope	Year
Minnesota	Round 1 Test	✓			✓	✓		Medicaid	2008
Mississippi									
Missouri			+	+	+			Medicaid	2016
Montana	Round 2 Design	✓	+					Medicaid	2015
Nebraska		✓	+		+		✓	Medicaid	2015
Nevada	Round 2 Design	✓			+	✓		Medicaid	2016
New Hampshire	Round 1 and 2 Design	✓		✓	✓		✓	Medicaid	2015
New Jersey	Round 2 Design	✓	+		✓			Medicaid	2016
New Mexico	Round 2 Design						✓	Medicaid	2015
New York 	Round 1 Pretest, Round 2 Test	✓	+		✓	✓	✓	Multi-payer	2015
North Carolina		✓						Medicaid	2016
North Dakota			+					Medicaid	2018
Ohio	Round 1 Design, Round 2 Test	✓	+			✓	✓	Multi-payer	2014
Oklahoma	Round 2 Design	✓	+		✓		✓	Medicaid, State Employees	2016
Oregon	Round 1 Test	✓	+		✓			Medicaid	2012
Pennsylvania 	Round 1 and 2 Design	✓	+		+	✓	✓	Multi-payer	2017
Puerto Rico	Round 2 Design				✓	✓		Medicaid	2017
Rhode Island	Round 1 Design, Round 2 Test	✓	+		✓		✓	Multi-payer	2015
South Carolina		✓				✓	✓	Medicaid	2015
South Dakota		✓						Medicaid	2013
Tennessee	Round 1 Design, Round 2 Test	✓	+			✓		Medicaid; State Employees	2014
Texas	Round 1 Design	✓		✓			✓	Medicaid	2014
Utah	Round 1 and 2 Design						✓	Medicaid	2014
Vermont 	Round 1 Test	✓		+	+	+	+	Multi-payer	2013
Virginia	Round 2 Design	✓						Medicaid	2015
Washington	Round 1 Pretest, Round 2 Test	✓			✓	✓	✓	Medicaid and State Employees	2014
West Virginia	Round 2 Design							Medicaid	2017
Wisconsin	Round 2 Design			✓				Medicaid	2017
Wyoming	Round 1 and 2 Design	✓						Medicaid	2015

Key to Abbreviations

CMMI SIM: Centers for Medicare and Medicaid Innovation State Innovation Models Grant Recipient
 PCMH/HH: Patient-Centered Medical Homes, Medicaid Health Homes
 CPC+: Comprehensive Primary Care Plus
 P4P: Pay for Performance
 ACO: Accountable Care Organizations
 EOC: Episodes of Care
 VBP: Value-Based Payment

About Change Healthcare

Change Healthcare is inspiring a better healthcare system. Working alongside our customers and partners, we leverage our software and analytics, network solutions, and technology-enabled services to enable better patient care, choice, and outcomes at scale. As a key catalyst of a value-based healthcare system, we are accelerating the journey toward improved lives and healthier communities. Learn more at changehealthcare.com.