VALUE-BASED PURCHASING IN MEDICARE AND MEDICAID: Areas of Intersection and Opportunities for Future Alignment

In March 2016, the National Association of Medicaid Directors published the results of a survey which described the status of value-based purchasing (VBP) efforts in Medicaid programs across the country. The report found that the majority of the 34 states that responded were engaged in activities designed to change the way Medicaid providers are paid for services, away from volume-based and towards value-based payments.

Leaders from the Centers for Medicare and Medicaid Services (CMS) have cited the importance of multi-payer alignment in the progress towards VBP. In the March report, Medicaid Directors re-iterated the importance of this alignment from the states’ perspective, and in a follow-up letter asked HHS Secretary Burwell to prioritize the engagement of state Medicaid Directors in the work of the CMS as it develops and implements new models of care in order to maximize synergy and alignment between these two major public payers.

The purpose of this issue brief – developed with the support of The Commonwealth Fund – is to highlight the importance of Medicaid state-led work in VBP, and the potential for state and federal efforts to be aligned in both the substance and the process of VBP development in order to achieve the maximum effect in improving health, improving care and lowering costs. Without an intentional effort to ensure that state-led Medicaid efforts are part of the broader VBP conversation, there is a risk that federally-led and state-led VBP strategies will diverge, leaving providers to struggle with multiple different approaches to achieving essentially the same ends. As the volume of new models and demonstrations increases, accelerating this alignment will increase the likelihood of provider engagement and support the achievement of VBP goals in publicly funded healthcare.


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What is driving Medicaid VBP efforts?

**Increases in Enrollment.** States face continuing pressure to maximize the value of their Medicaid spending, which generally constitutes about a quarter of state budgets (including the federal contribution). While per enrollee spending in Medicaid has risen more slowly than spending in the commercial market, increasing enrollment constitutes the primary driver of rising Medicaid costs. For the 30 states that have expanded their Medicaid programs under the Affordable Care Act (ACA), 2017 represents the first year that states will begin to assume some of the costs for that population. Over 16 million more individuals now receive Medicaid benefits compared to prior to ACA implementation.

**Need to reform a complex, volume-driven delivery system.** In addition to more enrollees, there is a growing recognition that fee-for-service (FFS) payment to providers (whether through direct contracts with the state or through Medicaid managed care organizations) has been responsible for the development and maintenance of a delivery system which does not adequately address the needs of the most complex Medicaid beneficiaries. The elderly, disabled, those with severe mental illness, and children with complex medical needs all constitute some of the most vulnerable and costly Medicaid members. Many of them are still served by fragmented delivery systems which are driven by the historical vestiges of siloed funding streams and a lack of financial incentives to coordinate or improve care. Hospitals, long-term care facilities, behavioral health providers, home and community-based care agencies, substance use treatment providers, and agencies serving the disabled, as well as physicians, federally qualified health centers and rural health centers are all part of a complex Medicaid delivery system that continues to be fragmented from both a delivery system and payment system perspective.

How are Medicaid Programs approaching Value-based Purchasing?

The need to address quality and efficiency in Medicaid at the state level has led to significant Medicaid-led activity in the implementation of value-based purchasing strategies. In partnership with CMS, Medicaid agencies are developing and implementing new delivery system and payment strategies aimed at providing comprehensive care coordination across the entire delivery system, accountability for the total cost of care, engaging members in their care, addressing social determinants of health, and improving the appropriateness and quality of care while lowering costs.

These goals align with those of HHS Secretary Burwell to move Medicare, Medicaid and the commercial markets to a system where payment is predominantly tied to quality and value. Congress took another significant step in this direction with the 2015 passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which gradually transitions Medicare payments to physicians to a value-based platform.

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The majority of the 34 states in the March 2016 NAMD survey reported at least some activity in the implementation of VBP strategies:

- At least 12 states are implementing programs which **provide supplemental payments to providers for infrastructure, quality measurement and reporting**. These programs most often support Health Home or Patient-centered Medical Home programs, and may include a shared savings or shared risk component.

- Seven states have either implemented or are in the process of developing **episode-based payment programs** in which accountability for quality and total cost of care for specific procedures or events (such as asthma exacerbation, childbirth or CHF) is placed on an identified provider or group of providers, with opportunities for shared savings predicated on quality performance.

- At least nine states have implemented **population-based payment models**, which establish a targeted expenditure based on Total Cost of Care for an identified population, and hold providers responsible for quality and cost and usually include a shared savings component.

Significant qualitative findings from the survey included:

- States are highly engaged and interested in implementing VBP models but are challenged by finding the appropriate skills and resources to do so in the current environment in which Medicaid agencies function.

- High quality data for providers on cost, quality and utilization is a critical component of successful VBP implementation; and aligning such data across payers is highly desirable.

- Stakeholder engagement in the process is a critical component of success.

- Misalignment of or lack of coordination between state and federal efforts could impede successful implementation of Medicaid VBP efforts

- States have found a number of tools and supports from CMS to be helpful in VBP implementation. In particular, Delivery System Reform Incentive Program 1115 waivers, and the State Innovation Model Test funding have both been instrumental in providing the infrastructure for a number of states to develop and implement VBP in Medicaid.

### Medicaid VBP Efforts in the Context of Federally-led Models

CMS is currently piloting and implementing a large number of payment and delivery system innovations. These innovations are discussed below.

- **Medicare Value-Based Programs**. Existing Medicare value-based Programs include the Hospital Value-Based Purchasing Program, Hospital Readmission Reduction Program, Value Modifier Program (also called the Physician Value-Based Modifier or PVBM) and Hospital Acquired Conditions Program.

- **Provisions of the Medicare Access and CHIP Reauthorization Act (MACRA)**. MACRA replaces Medicare’s sustainable growth rate formula and establishes two paths for provider payment: the budget-neutral
Merit-Based Incentive Payment System (MIPS) program or the Advanced Alternative Payment Model (APM) program. MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on Quality, Resource use, Clinical practice improvement and Meaningful use of certified EHR technology.

Rather than participate in MIPS, some providers may be eligible for participation in the Advanced APM program. The Advanced APM program provides Medicare incentives for providers who have a certain percentage of their patients or payments through Advanced APMs. Models will be considered Advanced APMs if they meet certain criteria, including linking payment to quality measures, requiring providers to bear risk, and requiring use of certified EHR technology. Qualifying APM Participants (QPs) receive a 5 percent bonus payment in payment years 2019-2024, and then receive higher fee schedule updates starting in 2026. The Advanced APM program also includes a multi-payer component. Beginning in 2021, participation in Other Payer Advanced APMs, including Medicaid Advanced APMs, will help a provider achieve a Medicare bonus under the Advanced APM program.

- Models being Tested through the Center for Medicare and Medicaid Innovation (CMMI). CMMI is testing 69 programs in seven different categories. These seven categories are:
  1. Accountable Care.
  2. Episode-based Payment Initiatives.
  3. Primary Care Transformation.
  4. Six Initiatives Focused on the Medicaid and CHIP Population (one which allows Medicaid FFS to pay for services in an institution for mental disease, one which provides enhanced FMAP for Preventive Services, one technical assistance program to states, and three grant programs to improve birth outcomes).
  5. Three Initiatives Focused on the Medicare-Medicaid Enrollees (one payment demonstration for dually eligible individuals, two nursing home avoidable hospitalizations).
  7. Initiatives to Speed the Adoption of Best Practices.

To address the alignment of these initiatives with the broader commercial and Medicaid VBP work, CMS has convened a public-private partnership called the Healthcare Payment Learning and Action Network (LAN). The Healthcare Payment Learning and Action Network was convened...

"To help achieve better care, smarter spending, and healthier people, the Department of Health and Human Services (HHS) is working in concert with our partners in the private, public, and non-profit sectors to transform the nation's health system to emphasize value over volume[...] To support these efforts, HHS has launched the Health Care Payment Learning and Action Network to help advance the
work being done across sectors to increase the adoption of value-based payments and alternative payment models.”

**Figure 1:** LAN Framework for Alternative Payment Models

In January 2016, the LAN finalized its Framework of Alternative Payment Methodologies (APMs) (Figure 1). The LAN Framework provides an opportunity to crosswalk the Medicaid VBP efforts with the framework for APMs being promoted by CMS. Comparing the findings of the NAMD survey with the Draft Framework published by the LAN, Table 1 shows how the Medicaid approaches to VBP compare to those described in the framework.

**Table 1:** Medicaid VBP Efforts and the LAN Framework

<table>
<thead>
<tr>
<th>Medicaid Strategy</th>
<th>LAN Framework Category</th>
<th>LAN Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Payments to support PCMH and Health Home models</td>
<td>Category 2 and 3</td>
<td>FFS – Link to Quality and Value APMs Built on FFS Architecture</td>
</tr>
<tr>
<td>Episode payments</td>
<td>Category 3</td>
<td>APMs Built on FFS Architecture</td>
</tr>
<tr>
<td>Population-based payments</td>
<td>Category 3 and 4</td>
<td>APMs Built on FFS Architecture Population-Based Payment</td>
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Moving forward with Alignment: Key Considerations

While the types of VBP efforts being implemented in Medicaid broadly conform to the framework described nationally for the LAN, a critically important consideration is the alignment of the components of the models that are being used to implement them, and the delivery systems they target. With the publication of a number of whitepapers, the LAN has begun to address alignment of several of these. Some components for consideration in the Medicaid alignment discussion include:

- The types and characteristics of providers targeted by the model.
- The populations targeted by the model.
- Quality measures.
- Data collection and feedback strategies and portals.
- Member attribution strategies.
- Total cost of care calculations and financial benchmarking.
- Risk adjustment strategies for payment and quality measures, including risk adjustments for socioeconomic status.
- Episode parameters.

The LAN framework proposes an eventual transition away from Category 1 payments and towards those in Categories 3 and 4. To enhance and accelerate progress along this continuum and alignment of these models, Medicaid leaders are calling for an intentional effort to ensure that state-led Medicaid efforts are included in the broader federal VBP conversation and that considerations of Medicaid populations, delivery systems, quality measures and administrative considerations are integral to the development and implementation of future federally-designed programs.

A few recent examples of programs being developed in parallel in Medicaid and Medicare illustrate the missed opportunities of a VBP implementation process for publicly funded payers that is not strategically aligned. These examples are explored in the sections that follow.

The Comprehensive Primary Care Practice Initiative (CPCI)

CPCI is an innovative CMMI demonstration (from 2013-2016) which brings multiple payers together in a state or region to implement a Patient-centered Medical Home (PCMH) program in primary care. The program’s intent was to include both public and private payers. While the NAMD survey shows that payment to support PCMH implementation is a predominant Medicaid strategy for VBP, a CPCI enrollment snapshot in mid-year 2015 documents 2.7 million participating members in this multi-payer medical home initiative, but only 78,000 Medicaid beneficiaries participating. The reasons for the low Medicaid enrollment are likely complex and diverse, but a more intentional effort at the outset of the program to target and engage Medicaid payers and providers and to align with existing Medicaid efforts may have allowed for more robust enrollment. Better alignment would also

Key alignment considerations:
- Data collection/feedback
- Member attribution
- Population
- Providers
- Quality measures
enable CMS and states to understand the impact of a multi-payer PCMH approach on quality, cost and member experience of care. In fact, in the recently announced next round of CPCI, CMMI has reached out specifically to Medicaid programs to better understand the programmatic considerations and encourage participation. Continuing and making routine this type of consultation would be welcomed by Medicaid Directors.

**The Core Quality Measure Collaborative**

Aligning quality measure sets across Medicare, Medicaid and commercial payers is a tangible opportunity for multi-payer coordination in VBP. It can reduce duplication of effort for providers without necessitating that the payment model or other operational elements of VBP models be identical. In March 2016, CMS – in partnership with America’s Health Insurance Plans (AHIP) and other stakeholders – published seven core measure sets designed to support multi-payer VBP efforts in Medicare, Medicaid and commercial insurance. The topics and content of these sets are minimally aligned with CMS’s existing Adult and Child Core Sets for Medicaid. In total, of the 78 measures included in the Core Quality Measures Collaborative sets, there are 14 which address the same topic as the Medicaid and Child Core Sets. It is unclear how these two bodies of work can or should harmonize to support Medicaid VBP in the future (Table 2). At the time this issue brief was written, CMS and AHIP were also in the process of developing an eighth core measure set focused on pediatrics, which is not reflected in Table 2 below.

These seven – and soon to be eight – core measure sets have caused some confusion as to where they fit in with other federally-sponsored measure alignment strategies. Quality measure alignment is a major focus for many of the 20 State Innovation Model (SIM) Test award programs, and states and their local partners have been engaged in that process for some time. Existing multi-payer Medical Home programs, in which several Medicaid programs participate, have developed their own aligned measure sets. CMS and states have invested heavily in the capacity to collect and report the Medicaid Adult and Child core measure sets, and to implement programs to work with providers to improve performance on these measures. Given the resource constraints most state Medicaid agencies face, revising programs, contracts and provider interventions to adjust to these changing measure sets places a strain on Medicaid agencies and is confusing to providers.

Key alignment considerations:
- Populations
- Providers
- Quality measures
### Table 2: Alignment of Measure Content between CMS/AHIP Core Measures and Medicaid Core Measures

<table>
<thead>
<tr>
<th>AHIP/CMS Core Quality Measures Collaborative Measure Sets</th>
<th>CMS Medicaid Core Sets</th>
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<tbody>
<tr>
<td></td>
<td>2016 Medicaid Adult Core Set</td>
</tr>
<tr>
<td></td>
<td>Total measures: 28</td>
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</table>
| **ACO and PCMH/Primary Care** 22 measures | **Five** common measures:  
- Controlling high blood pressure  
- Comprehensive diabetes care: HbA1c poor control  
- Comprehensive diabetes care: hemoglobin A1c testing  
- Cervical cancer screening  
- Breast cancer screening | **One** common measure:  
- Medication management for people with asthma |
| **OB/GYN** 11 measures | **Four** common measures:  
- Cervical cancer screening  
- Breast cancer screening  
- Elective delivery  
- Antenatal steroids | **Two** common measures:  
- Cesarean section  
- Frequency of ongoing prenatal care |
| **Orthopedics** 3 measures | No alignment | No alignment |
| **Cardiovascular** 31 measures | **One** common measure:  
- Controlling high blood pressure | No alignment |
| **Gastroenterology** 2 measures | No alignment | No alignment |
| **HIV/Hepatitis C** 8 measures | **One** common measure:  
- HIV viral load suppression | No alignment |
| **Medical Oncology** 14 measures | No alignment | No alignment |
**Delivery System Reform Incentive Payment (DSRIP) Waivers**

Medicaid agencies in eight states are currently using DSRIP waivers under section 1115 of the Social Security Act, and other waivers are under consideration or development. These programs are supported by a federal investment of billions of dollars and they are intended to improve the quality and value of Medicaid programs through delivery system innovations and payment reforms. In particular, many of the recent DSRIP programs are focused on the design and implementation of APMs to drive value in Medicaid. In most cases, these waiver programs represent broad and fundamental change in the Medicaid program and have far-reaching consequences for providers and beneficiaries in their states. States using the DSRIP waiver to support the infrastructure necessary to develop and spread VBP strategies cite this mechanism as a key lever for Medicaid in the implementation of payment reform. Some have also involved the SIM Model Test program as a means to enhance alignment.

Despite this impact and the federal investment involved, states have noted that there is no formal structure for collaborating on the alignment of DSRIP models and federally promulgated models to enhance the chances of success and uptake. States would like to have the opportunity to align the new payment strategies being deployed through DSRIP with other federally-developed models. Nonetheless, the lack of an explicit strategy or mechanism to discuss the intersection of these programs with the federal models being implemented...
represents a risk of divergence in strategies that could be challenging for providers and result in slowing down or impeding progress along the APM continuum.

**Next Steps: Creating a Nexus in the Development of Medicare and Medicaid VBP programs**

There is, of course, an inherent structural variation between the processes for developing and implementing VBP programs at the federal level and at the state level. While these different processes are inherent to the statutory and regulatory frameworks of the programs, there is the potential to develop a nexus between the two in the inception, design and implementation of VBP programs which could enhance the successful implementation of both.

Medicaid agencies are designing state-specific VBP programs which are often tailored to the specific market in a state, respond to a specific clinical, budgetary or programmatic issue in a state, or are facilitated by new authorities or incentives from CMCS (such as health homes or the Financial Alignment Demonstration for dually eligible individuals). States rely on their own Single State Agency resources to develop and implement new models, or they contract with Medicaid managed care organizations, using varying levels of direction and specificity, to implement the VBP model. While additional federal authorities (state plan amendments or waivers) are often required when a Medicaid agency implements a new payment model, there is no clear administrative pathway for engaging with CMS to explicitly work on alignment of federal and state APM strategies. As a result, some of the models described above have been generated at the federal level and targeted at Medicaid programs, but analogous state-led models have already been developed and implemented. This situation leaves state agencies and providers wondering whether to continue to invest and build on state-designed models, or switch away from a model that has often involved large investments of state time and resources to be more closely aligned with federal efforts.

While complete alignment of VBP models between Medicare and Medicaid is neither feasible nor desirable, there are some areas where the appropriate coordination could streamline the process and reduce the burden on providers and beneficiaries. NAMD members are encouraged by recent efforts to improve the understanding between state and federal partners in the implementation of VBP and are very interested in ongoing consultation between CMS leaders and state programs. The goals of this consultation would be to understand:

- The current work already underway in value-based payments and APMs in states.
- The states’ processes for and challenges with participating in a federally-led program.
- Any federal authorities that would be required for a state to participate in a federally-led program.
- The financial implications at the state level of the implementation and administration of the model.
- The process by which states can discuss with Medicare leadership how the two models can intersect when a state-led effort in VBP is being scaled up or spread.
Medicaid Directors and leaders from CMS have been discussing the importance of this issue and have begun to identify strategies for improved communication. There are encouraging signs of recognition of the importance of alignment. With support from the Commonwealth Fund, NAMD will be convening a group of Sentinel States in Medicaid Value-based Purchasing over the coming year. These states will serve as a continuing source of information for states and their federal partners about implementation of VBP models at the state level, the challenges, barriers, successes, and opportunities for federal/state alignment. The Sentinel States, and Medicaid Directors in general, are anxious to continue to engage with federal policymakers on the development, roll-out and implementation of VBP models.