March 24, 2016

Dear Colleagues:

Medicaid is responsible for a complex and growing population, serving 72 million of the country’s most vulnerable individuals, while facing the constant pressure of cost growth in the U.S. health care system. This is driving Medicaid Directors to design and implement payment and delivery system innovations that maximize the quality of care and value purchased with every Medicaid dollar. Facing similar pressures, Medicare is also pursuing value-based models. Earlier this year, it achieved its initial goal of having 30 percent of its fee-for-service payments in “value-based” arrangements, and is working to have 50 percent of payments in these arrangements by 2018. At this critical juncture for both payers, NAMD is releasing this first of its kind report to begin to describe Medicaid’s critical work to design and implement value-based purchasing models in the U.S. health care system.

This analysis, which was made possible with the support of The Commonwealth Fund and through the partnership of Bailit Health Purchasing, offers insight into successful value-based purchasing strategies at the provider level and creates a baseline to track progress in Medicaid over time. Similarly, it gives federal policymakers an on-the-ground look at Medicaid’s work to transform provider payment in a way that rewards value. As the report reveals, there is a broad movement in Medicaid to transform payment at the provider level away from the traditional fee-for-service (FFS) system, which rewards volume, into alternative models that reward value. States are driving these provider-level payment changes through their contracts directly with providers or through managed care arrangements. While states are tailoring these models to reflect the needs of their local marketplace, the report finds that these models generally fall into three broad categories:

- **Additional payments that support delivery system reform**: Providers (typically primary care providers) receive a per member per month (PMPM) payment to be used for a wide variety of purposes, including care management, care coordination, quality measurement and infrastructure development, in exchange for meeting performance expectations. These models may include a shared savings component.

- **Episode-based payments**: One provider is held accountable for the costs and quality of a defined, and discrete set of services for a defined period of time. Examples include asthma exacerbation, tonsillectomy, attention deficit hyperactivity disorder, among many others.

- **Population-based payments**: One or more providers is held accountable for the cost of care that cover the vast majority of health care services to be delivered to an attributed population. These approaches include both shared savings and “downside” financial risk for providers.
In describing Medicaid value-based purchasing, this report offers a starting point for identifying opportunities for greater alignment across Medicaid efforts and federal models in Medicare and through the Centers for Medicare and Medicaid Innovation. This alignment is important as it reduces duplication and confusion for providers engaged with multiple payers and for the consumers they serve. It also expands the reach of payment methodologies and quality improvement strategies. Such alignment across Medicare and Medicaid can be achieved by identifying the common tools and mechanisms that can mutually support both payers’ objective of value, such as aligned quality metrics and common outcome goals.

NAMD began this conversation on multi-payer alignment with states and federal policymakers prior to our release of this report. In this dialogue there was clear agreement: value-based purchasing represents a fundamental change in the healthcare system, and the importance of thoughtful alignment across payers cannot be overstated. Misalignment has the potential to cause disruption in the healthcare system; but alignment across payers can multiply the success of Medicare and Medicaid alternative payment models aimed at achieving better health, better care, and at lower cost. Recognizing this importance, Medicaid Directors and federal policymakers identified the need for a mechanism to support the ongoing exchange of knowledge on value-based purchasing, which can prevent missteps and enhance the success of these models.

Therefore, we are pleased to release this report as a first step toward: 1.) building the baseline knowledge of Medicaid value-based purchasing to track progress over time, and 2.) enhancing the federal and state dialogue on value-based purchasing. NAMD will continue to serve as a conduit of vital information to support cross-payer alignment, and serve as a resource for Medicaid Directors as they design, implement, and continually improve models that reward value.

Finally, we want to acknowledge the individuals and organizations that made this first of its kind examination of Medicaid value-based purchasing possible. We want to thank The Commonwealth Fund for their generous support of this work, without which this analysis would not be possible. We also want to recognize the Medicaid Directors and their staff who took the time to share their value-based purchasing experience to inform the report. Finally, we appreciate Bailit Health Purchasing for their partnership and taking on the daunting task of identifying, capturing and distilling this complex information into a coherent framework.

We hope that each of you find this report informative, and it serves as a springboard for our ongoing dialogue on Medicaid’s critical role in delivering value in the health care system.

Sincerely,

Matt Salo
Executive Director