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State Requirements for Managed Care Organizations to Implement VBP Models with Providers

A Guidehouse analysis reveals that more states are requiring the use of value-based payment contracts between Medicaid managed care organizations (MCOs) and providers. Learn what this means for MCOs, providers, and states.

The Medicaid managed care landscape is catching up with leading payers and providers in the shift from fee-for-service to value-based payment (VBP), according to a Guidehouse analysis. The findings show that more states are requiring the use of VBP or alternative payment models in contracts between Medicaid managed care organizations (MCOs) and providers. However, the required approaches to these models vary across states.

Guidehouse analyzed the most recent publicly available managed care contracts between states and their MCOs, as well as current or recently released state requests for proposals (RFPs) from all states with Medicaid managed care programs.

All contracts spanned from 2017 to 2022, with the majority being agreements executed in 2020 or more recently. Identified contracts/RFPs were evaluated for sections on quality management/improvement, provider incentives, and/or provider payments, to ascertain and catalog the existence of any VBP requirements.

For the purposes of this analysis, VBP is defined as the full continuum of evolving payment arrangements outlined in the Health Care Payment Learning & Action Network (HCPLAN) framework, including pay for performance, bundled payments, shared savings, and capitation. Additionally, many states operate multiple Medicaid managed care programs. This analysis focused on Medicaid managed care programs that serve the Temporary Assistance for Needy Families (TANF) populations.[1]

State Requirements for MCOs to Implement VBP Contracts with Providers

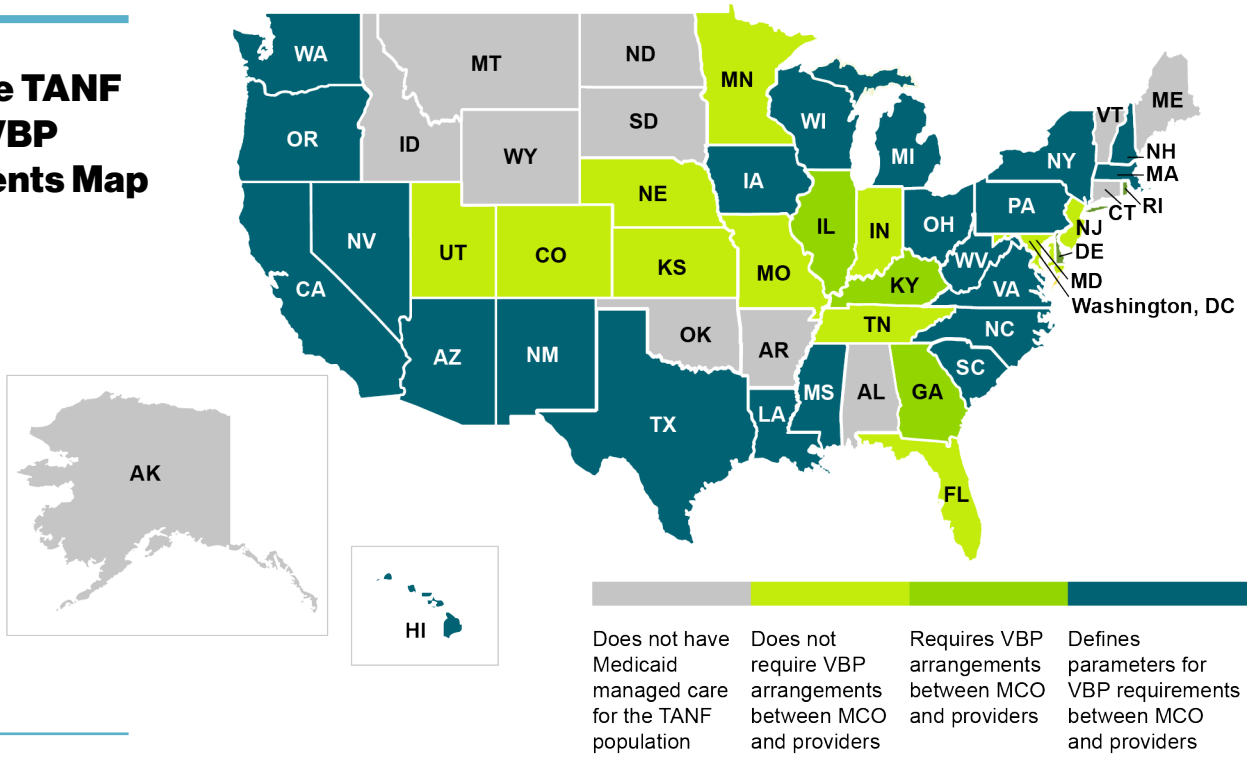
The analysis of the states that have Medicaid managed care (39 states and Washington, DC) shows:

- 29 (73%) require MCOs to implement VBP models with providers.
- 26 (65%) define the types of VBP models that MCOs must implement.

The map below further illustrates states that have included requirements in their most recent contract/RFP for their MCOs to use some type of VBP model in their contracts with providers.

[1] https://hcp-lan.org/apm-framework/

Nationwide TANF Medicaid VBP Requirements Map



Guidehouse categorized states based on publicly available Medicaid managed care TANF contracts and RFPs.

State-specific clarifications: Georgia has not yet implemented the VBP requirements outlined in its contract. North Dakota only has managed care for its Medicaid expansion population. Oklahoma issued a Medicaid Managed Care RFP with VBP requirements in 2021, but the procurement was cancelled.

Analyzing States with VBP Requirements

Among the 29 states that require VBP between their MCOs and network providers, 26 states define parameters for those arrangements. However, the level of specificity and sophistication of the requirements vary.

17 states specifically mention the HCPLAN Framework for defining VBP arrangements. These include: Arizona, California, Hawaii, Louisiana, Mississippi, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Virginia, and Washington.

19 states specify saturation targets (e.g., a percentage of total payments or enrollees that must be in a VBP arrangement). These include: Arizona, Delaware, Iowa, Louisiana, Massachusetts, Michigan, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington, and West Virginia.

11 states require a glidepath or timeline for meeting saturation targets for VBP implementation. These include: Arizona, Delaware, Louisiana, Massachusetts, New Mexico, New York, Ohio, Oregon, Rhode Island, Texas, and Washington.

3 states require VBP arrangements between Medicaid MCOs and providers but do not provide specific requirements or parameters. These include: Georgia, Illinois, and Kentucky.

In general, the majority of states in the analysis rely upon widely used frameworks, such as HCPLAN, to define allowable VBP arrangements. However, some states, such as New York, have developed and use their own definitions.

New York constructed its own framework for VBP arrangements for providers, which includes three levels[2]:

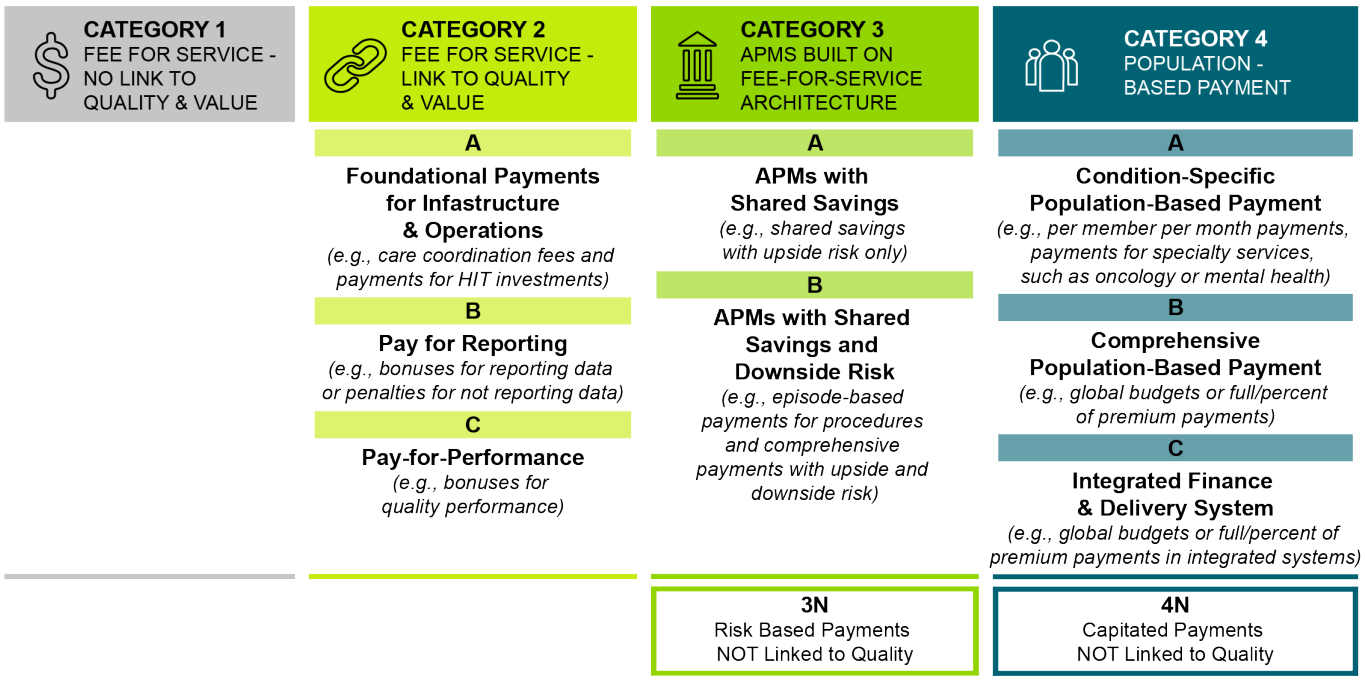
- Level 1: FFS with Retrospective Reconciliation – Upside Only
- Level 2: FFS with Retrospective Reconciliation – Upside and Downside
- Level 3: Prospective Payments (PMPM or Bundled Payments)

In addition to its VBP requirement, New York implemented a voluntary program that uses Medicaid managed care to meet population health goals. The Innovator Program supports experienced VBP contractors prepared to participate in VBP Level 2 (full risk or near full risk) or Level 3 Total Care for General Population and/or Subpopulation arrangements.

17 states specifically mention the HCPLAN Framework for defining VBP arrangements

The HCPLAN framework is the product of a public-private partnership aimed at spurring payment innovation in the healthcare system and provides a ready-to-use framework for VBP arrangements of varying risk[3]. Of these 17 states, 10 specify the categories the MCO should use for its VBP program, usually HCPLAN Category 2C or higher.

HCPLAN APM Framework



[2] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

[3] http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

Louisiana's VBP Models in 2021 RFP[4]

Louisiana's most recent RFP for Medicaid managed care services explicitly referenced the HCPLAN framework to guide VBP efforts. The state requires bidding MCOs to propose a VBP strategic plan that meets a glidepath of saturation targets and includes at least one network provider agreement with HCPLAN category 3A, 3B, or 4 no later than December 2023. Further, the state required that the strategy include plans for pushing providers along the VBP continuum to assume greater risk over time, and how the MCO would evolve those models over the contract period.

While not every state that defines acceptable VBP arrangements for their MCO explicitly uses HCPLAN, most of the other states use definitions that align with or overlap across HCPLAN categories. For example, Michigan's Medicaid managed care contract, while not directing MCOs to use HCPLAN, defines value-based models as including bundled payments and total/limited capitation models, which correlate to HCPLAN categories 3 and 4, respectively.

19 states have set required minimum saturation targets for VBP implementation

These states define minimum targets in one of two ways:

- Three states set targets based on the *percentage of members attributed to providers in VBP arrangements:* Iowa, Massachusetts, and West Virginia.
  - Saturation targets range from minimums of 10% to 60%, depending on the state and contract year.
- 16 states require a minimum *percentage of total expenditures or payments to be made as part of VBP arrangements:* Arizona, Delaware, Louisiana, Michigan, New Mexico, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington.
  - Saturation targets range from minimums of 20% to 80%, depending on the state, contract year, and type of VBP arrangement.

11 states require a glidepath or timeline for meeting saturation targets for VBP implementation

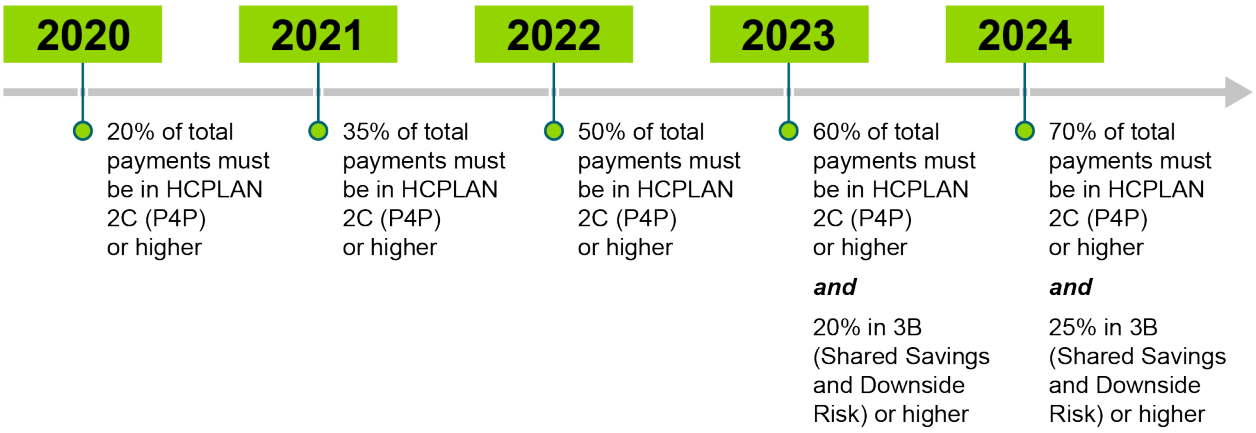
Glidepaths are typically based on saturation targets for the percentage of payments or enrollees that must be in VBP arrangements and usually increase over time. The glidepaths are structured around the contract length and can span three to five years.

[4] https://hcp-lan.org/apm-framework/

Spotlight on Oregon's Glidepath to Increased VBP[56]

Oregon began implementing VBP requirements in its Medicaid managed care program in 2020, using a glidepath that starts with 20% of all payments needing to be in at least HCPLAN Category 2C or higher in year 1. Each year thereafter, that minimum percentage increases. Starting in 2023, MCOs must also have 20% of payments in models that are at least HCPLAN category 3B (Shared Savings + Downside Risk) or higher.

Oregon Medicaid VBP Glidepath



The trend toward VBP in Medicaid managed care has critical implications for states, MCOs, and providers.

State Implications

- With no single standard approach to VBP implementation in Medicaid managed care, states new to VBP can learn from other states' experiences to proactively design effective programs.
- States with existing VBP programs should continue to review the effectiveness of their VBP programs in improving health outcomes and promoting value. They can also consider new approaches and metrics, such as incorporating health equity and social determinants of health measures into VBP arrangements.
- States should work with MCOs and providers to establish safeguards to ensure VBP arrangements do not inadvertently widen health disparities and access to care for underserved communities. For example, programs should account for variations in patient-mix and resources (large academic medical centers, rural hospitals, critical access hospitals, federally qualified health centers, etc.).

[5] https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf

[6] https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OR-VBP-Roadmap-CCO-Baseline-Evaluation-Report-July-2021.pdf

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MCO Implications

- Medicaid MCOs should have VBP models and frameworks that they can deploy with their provider networks. More states are likely to adopt VBP requirements in the coming years and/or strengthen existing requirements. MCOs should also proactively develop VBP strategies and capabilities to prepare for this future.
- Given the lack of standardization in approaches toward VBP implementation, states are still trying to understand how to successfully implement VBP requirements, thus making them unlikely to dictate VBP contractual terms without MCO input and buy-in. MCOs should consider how they can best partner with states to create a shared understanding of VBP and the reasonable targets and pathways required for states, MCOs, and providers to succeed and improve patient care.
- In a continued shift from volume to value, MCO VBP operating models should also include provider enablement solutions that vary based on the level of risk being assumed by a given provider and the provider's underlying capabilities to be successful at assuming risk.

Provider Implications

- As more states move toward VBP requirements, providers, especially those with a large population of Medicaid patients, should expect and prepare for alternative payment models to affect their reimbursement.
- For states that already require VBP arrangements, providers should expect those requirements to become even greater (a more significant percentage of reimbursement) and place providers at greater risk (downside shared savings, capitation, etc.).
- Providers should seek to align Medicaid VBP requirements with other lines of business (i.e., Medicare, commercial) to improve the impact of performance improvements and reduce administrative burden.

With nearly 70% of state Medicaid enrollees under MCOs, and the continued trend toward risk-based payment and whole-person care, it's important for MCOs, providers, and states to understand the implications of these models and learn from each other for future success.

Contact

healthcare@guidehouse.com

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