Rural

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Value-based payment strategies used by Medicaid Managed Care Organizations

Rural Health Value Brief

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Summary

As of the end of 2024, 41 state Medicaid programs contracted with Managed Care Organizations (MCOs) to manage acute care services. Given the role that MCOs play in delivery of and direct payment for health care services, their impact on the design of value-based payment (VBP) arrangements with healthcare organizations can influence the spread of VBP in rural communities. This document uses reviews of state Medicaid websites to summarize VBP strategies used by MCOs in 36 states and the implications for rural healthcare organizations.

Purpose and Background

Medicaid provides health coverage to millions of low-income Americans. It is a joint federal-state program that is administered by the Centers for Medicare & Medicaid Services (CMS) at the federal level. The program served approximately 72.9 million beneficiaries (over 20 percent of the nation's population) in June, 2024.[1] It serves as a critical safety net for vulnerable Americans and comprises a significant portion of healthcare spending. Medicaid spending in 2022 (the most recently reported year) amounted to over $805 billion, which is 18 percent of national health expenditures for the year.[2]

Medicaid programs are administered by individual states, and payment and care models are approved by CMS. There are multiple federal authorities that states can use to contract with managed care organizations. Section 1115 Medicaid demonstration waivers offer states the ability to individually test new strategies within the Medicaid program. Waivers that are "comprehensive" allow states to make large changes within their Medicaid programs, including payment methodology such as VBP programs. Section 1915 waivers offer individual states additional flexibility in Medicaid services. Section 1915(b) waivers allow states to implement service delivery models, like MCOs, that restrict individuals' choice of providers as well as waive other state Medicaid requirements. These waivers can be used to provide managed care in limited geographic areas and provide additional benefits outside of Medicaid's original scope to those enrolled in managed care.

This *Policy Brief* presents findings from a review of state Medicaid program websites that include descriptions of value-based payment (VBP) strategies deployed by Managed Care Organizations (MCO) under contract with the states. Our purpose is to develop a knowledge base of how MCOs approach VBP, and implications for rural healthcare organizations. A paper published by investigators at Georgetown University in January 2025 found that there were 41 state Medicaid programs contracting with MCOs.[3] This brief describes themes discerned from reviewing the 36 state Medicaid websites providing information on MCO contracts

Methods

Information detailing actions of MCOs to implement VBP strategies was collected from multiple sources. Reports from KFF[4] and Guidehouse[5] were used to identify state interest in VBP based on use of MCOs or insurance plans managing particular Medicaid subpopulations (e.g., North Dakota using VBP through Blue Cross/Blue Shield to pay for services to an expansion

population). Those KFF and Guidehouse sources contained limited information regarding details of MCO payment strategies by state. We conducted a search of websites of state agencies responsible for the Medicaid program (e.g., state health department (specific agencies are identified in endnotes for each of the 36 states in the Appendix)). In some states one more step was required – using the website of the MCO (e.g., Highmark Health in Delaware). We were able to collect sufficient detail to describe payment designs of MCOs in 36 states. We omitted 5 states with MCOs that did not have sufficient detail.

The table below describes our findings from 36 states that use VBP language in the context of payment designs of MCOs. VBP language is identified if talk of VBP is included by the state when describing payment designs in their MCO. Instructions for provider payment is checked if the state requires a glidepath or timeline for meeting saturation targets for VBP implementation. Finally, no instructions provided is checked if states require VBP arrangements between Medicaid MCOs and providers but do not provide specific requirements or parameters.

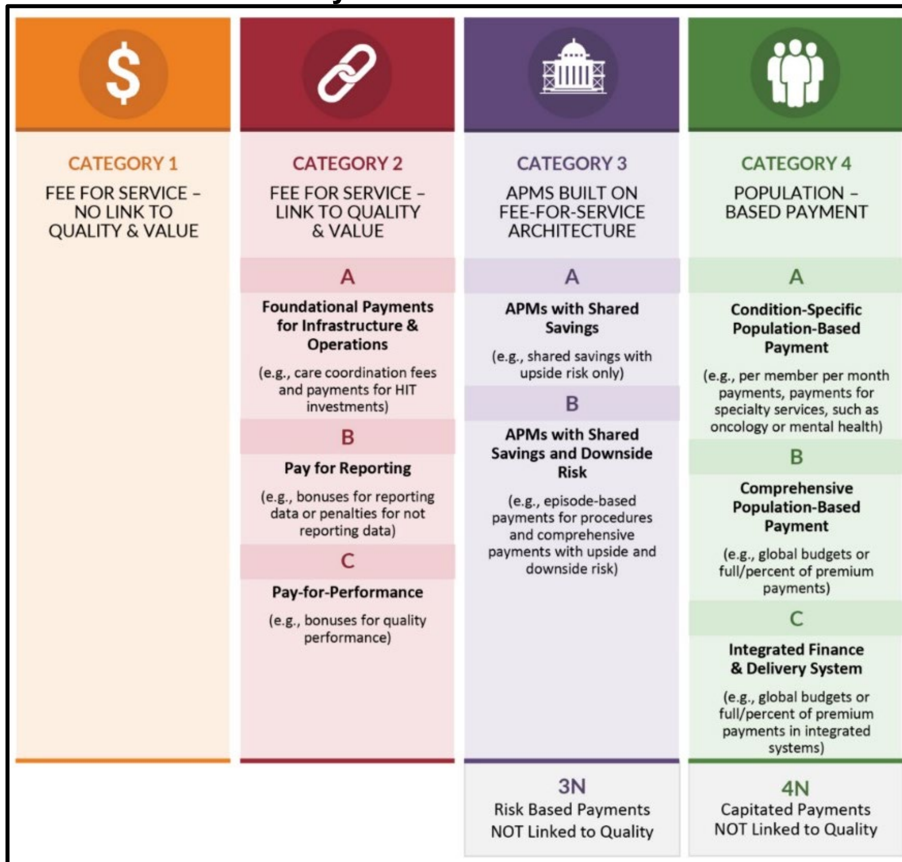
Summary of Findings from States

State	VBP Language	Instructions for Provider Payment	If no Instructions, Strategies for Provider Payment
Arizona	X	X	N/A
California	X	X	N/A
Colorado	X	X	N/A
Delaware	X	X	N/A
Florida	X	X	N/A
Georgia	X	X	N/A
Hawaii	X		
Illinois	X		X
Indiana	X		X
Iowa	X	X	N/A
Kansas	X		
Kentucky	X	X	N/A
Louisiana	X		
Maine	X		
Maryland	X	X	N/A
Massachusetts	X	X	N/A
Michigan	X	X	N/A
Mississippi	X		X
Missouri	X		
Nebraska	X		
New Hampshire	X	X	N/A
New Jersey	X		
New Mexico	X	X	N/A
New York	X	X	N/A
North Carolina	X		X
Ohio	X	X	N/A
Oklahoma	X	X	N/A

Oregon	X	X	
Pennsylvania	X	X	N/A
Rhode Island	X		X
South Carolina	X		X
Tennessee	X	X	N/A
Texas	X	X	N/A
Virginia	X		X
Washington	X	X	N/A
West Virginia	X		X

Of the 29 states that Guidehouse reported as requiring VBC in their contracts with MCOs, 17 used the Health Care Payment Learning & Action Network's (HCPLAN) APM Framework (pictured below) as a context for MCOs. The remaining 12 states did not specify which framework they use. It was noted that some of the states utilize their own framework with different definitions, but these frameworks were not described. The HCPLAN framework describes a continuum of payment approaches across four categories ranging from fee-for-service (i.e., no link to quality and value) to full capitation (i.e., population-based payment).

HCPLAN Alternative Payment Model Framework



Nineteen states specify saturation targets referencing this framework for VBP arrangements, including minimum percentages of payments or expenditures. Some states also require or mandate a glidepath or timeline for meeting the targets.[10]

In 17 states the MCOs, either because of the state contract or by their own decision, use a capitation withhold program as their VBP strategy. Capitation withholds range from 1-4 percent and are paid to providers when they reach, or move toward, state-predetermined key performance measures. Other VBP strategies include:

- **Pay for Performance** – a reimbursement model where healthcare providers are financially incentivized to deliver high-quality care and achieve specific performance targets.
- **Directed Payments** – financial incentive provided by payers, such as governmental programs or insurers, to healthcare providers to encourage specific actions or outcomes.
- **Differential Adjusted Payments** – payments that vary based on a healthcare provider performance, with higher reimbursements awarded to those who achieve better outcomes or meet specific quality metrics.
- **Total Cost of Care Model** – holds healthcare providers accountable for the overall cost of a patient care across all services and settings, incentivizing the delivery of more efficient and coordinated care to improve outcomes and reduce unnecessary expenses.

There is considerable diversity of VBP strategies across the states. Arizona uses a combination of Differential Adjusted Payments, Directed Payments, and Performance-Based Payments.[6] California incorporated incentive programs, performance improvement projects, and a quality withhold and incentive program.[7,8] Colorado set goals tying Medicaid payments to VBP plans using several alternative payment models (APMs).[9]

Payment methods are detailed in 29 of the state contracts, often for payment to the MCOs. Contracts may also include details pertaining to providers, although provider compensation details are not often publicly available. Provider buy-in is essential for the successful adoption of any VBC model; therefore, additional reimbursement, education, or some other incentive is usually required. Georgia, Illinois, Kentucky, and Ohio mandate VBP arrangements between MCOs and providers with varying guidelines.[10]

Implications for Rural HCOs

MCOs and VBP models present opportunities and challenges for rural healthcare organizations. Payment redesign can result in more predictable revenues (e.g., capitation, global budgeting) and opportunities for health care services redesign. While these reforms are designed to improve the overall quality of care provided to patients and mitigate the rising costs of healthcare services in each state, applying programs to universally include both urban and rural providers can present new challenges in rural populations. Small population size, limited access to health and social service providers, constrained workforce, and lower operating margins in rural communities can challenge MCOs and VBP programs.

Financial Stability and Predictability

VBP models can have a significant impact on rural healthcare organizations' financial stability. Capitated payment to providers helps create more predictable funding and a dependable financial plan compared to traditional fee for service (FFS). Assuming total revenue is at least

equal to the sum of FFS payments, this predictability allows providers to invest in preventative care, manage fluctuating patient volumes, and invest in technology, workforce development, and infrastructure to enhance both care quality and patient access.

Variability in State-Level Implementation

Variations across state populations can make it difficult to ensure all populations receive the care they need. Additionally, there is variation in how this is addressed across states. VBP models are tailored to address specific health priorities including maternal care and homelessness. While these may be significant statewide issues, they may not be representative of rural communities' needs.[6,7,11] As states such as Arizona, New York, Oregon, and Pennsylvania, consider renewing MCO contracts, however, they may consider expanding the reach of VBP models to affect all Medicaid recipients, including those in rural communities.

Regulatory Flexibility and Waivers

Reporting burdens associated with VBP often disproportionately affect rural providers that may lack the administrative capacity to comply with complex reporting requirements or quality measures. Two policy adjustments could be helpful: 1) minimizing the burden by streamlining measures and focusing on measures most relevant to services provided by rural healthcare organizations; and, 2) direct assistance to implement any new measures and reporting requirements.

Workforce Challenges

Rural healthcare organizations face significant workforce recruitment and retention challenges. VBP models frequently tie payment to staff quality requirements and increased measurement and reporting participation. Some VBP models incentivize alternate care models to mitigate workforce shortages. For example, the Washington VBP model integrates telehealth programs allowing rural providers to expand their reach and improve care.[12]

Conclusion

Medicaid MCO contracts may create opportunities to monitor impacts of VBP on rural healthcare providers and residents. Medicaid MCOs and VBP strategies have characteristics that can benefit rural healthcare providers if carefully adapted to address the unique needs of the rural communities. More predictable funding, and the ability to address broader upstream drivers have the potential to improve the health of rural residents and communities.

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