


 The logo features two overlapping circles: an orange one on the left and a teal one on the right. The text 'Medi-Cal' is inside the orange circle, 'Explained' is inside the teal circle, and 'FACT SHEET' is to the right of the teal circle.

Medi-Cal Explained FACT SHEET

Medi-Cal Explained: What Are Alternative Payment Models?

Authors: Athena Chapman and Samantha Pellón

Introduction

OVER THE PAST DECADE, the Centers for Medicare & Medicaid Services (CMS) has increasingly used health care provider payment reforms that encourage better value in the health care system. These payment reforms are known as alternative payment models (APMs) and are defined as a provider payment method that uses financial incentives for the provision of care that is high-quality, cost-efficient, or both.¹ This issue brief explores how Medi-Cal, California's Medicaid program, has been developing APMs to align with these federal initiatives and state financial and policy goals.

Overview of Alternative Payment Models

APMs represent a departure from the fee-for-service (FFS) payment model, which pays a hospital, medical group, or individual health care provider for each service rendered, thereby incentivizing a higher volume of services irrespective of health care cost, utilization, and patient outcomes. In 2021, the National Academies of Science, Engineering, and Medicine issued a report that recommended payers, including Medicare and Medicaid, shift away from FFS to payment methods that reward improved quality and outcomes over volume of services provided.² APMs are designed to create a financial responsibility for the provider to be accountable for the provision of optimal, evidence-based care for their patients and incentivizes an efficient use of health care dollars. Additionally, by promoting

payment for services that improve outcomes and reduce unnecessary use of high-cost services, the total cost of care should be reduced over time using APMs.

APMs include a continuum of value-based payment (VBP) options, and these two terms are often used interchangeably. VBP models are an approach used by a state or other payer to align financial incentives and reduce overutilization and inefficiencies in the health care system. APMs are the specific mechanism by which those approaches are implemented, which range from FFS payments that include quality or bonus payments for improving outcomes or quality scores, to full risk-based capitation payments in which a provider is responsible for offering an agreed-upon set of covered services to a patient for a single monthly payment (known as capitation). For the purposes of this issue brief, APM is considered inclusive of the various VBP approaches. See [Appendix A](#) for more detail on the various VBP options that could inform APM structures in Medi-Cal.

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.



For more information, visit www.chcf.org.

California Quality Collaborative: Facilitating APM Implementation

In December 2021, CMS announced that California is one of four states selected to participate in the Health Care Payment Learning and Action Network (HCP-LAN) state-based initiative, the State Transformation Collaboratives. The California Department of Health Care Services (DHCS), CalPERS (California Public Employees' Retirement System), Covered California, and Purchaser Business Group on Health, through its California Quality Collaborative, will participate in a new partnership to improve health care quality, access, and outcomes through value-based care. Additional details are emerging as the partnership develops, but the goal will be to facilitate the movement toward APMs through state-level alignment on key elements of health care delivery model design and implementation.³

Prevalence of APMs in Medicaid

The growth of APMs in state Medicaid programs, including Medi-Cal, has been influenced by payment reforms launched at the federal level by CMS in the Medicare program. Passage of the Medicare Access and CHIP [Children's Health Insurance Plan] Reauthorization Act of 2015 (MACRA) changed the way that Medicare pays providers under the Part B Physician Fee Schedule. MACRA established the Medicare Quality Payment Program, which offers financial incentives for Medicare Part B providers to participate in risk-bearing APM arrangements.

Over the years, CMS has funded the implementation and expansion of two major types of APMs, population-based models (e.g., accountable care organizations) and episode-based models (e.g., bundled payments). A 2020 survey of public and private payers and purchasers suggested that approximately 58% and 43% of Medicare Advantage and traditional Medicare payments, respectively, qualified as an APM, leading all lines of business. But the survey also found that Medicaid programs had one of the largest year-over-year growth rates in APM spending since 2018. Despite this recent growth in APM among state Medicaid programs, out of all surveyed plans and markets, Medicaid

still had the largest share of its provider payments linked to volume rather than value.

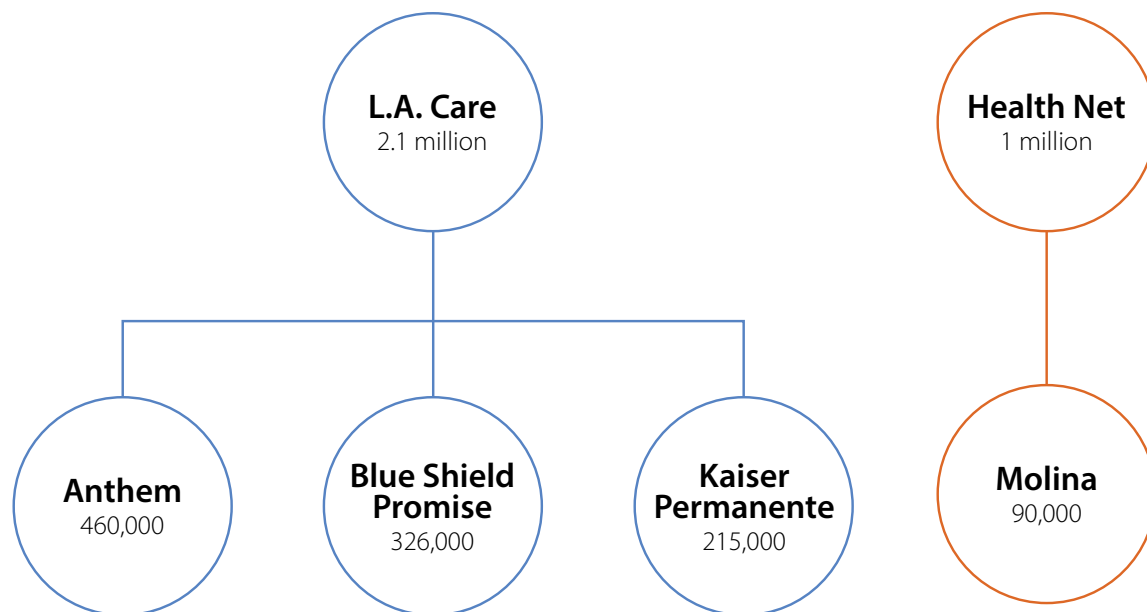
In California, and within the Medi-Cal program itself, the movement toward value-based payment has not been uniformly tracked: Experts interviewed for this brief suggested anywhere between 20% and 80% of provider payments in Medi-Cal are currently considered "value-based."

Medi-Cal Managed Care APMs

California has increasingly used its Medi-Cal managed care plan (MCP) contracts to facilitate the spread of APMs among health care providers. Approximately 83% of Medi-Cal enrollees are covered by managed care plans, which are paid a per-member per-month amount for all Medi-Cal services covered in the contract.

MCPs often "delegate" the inherent financial risk they carry to defined groups of health care providers through the use of APMs. Delegated models occur when the MCP assigns administrative functions, including downstream claims payment of other providers, credentialing, network management, and grievance functions, to contracted providers or provider groups. California's capitated model is unique in its dependence on delegated model arrangements between MCPs and with providers.

Los Angeles County's Medi-Cal managed care arrangements (see Figure 1) demonstrate how delegation currently occurs between the MCPs. In addition to the delegation between the MCPs, there is often an additional layer of delegation to the providers. For example, Health Net and L.A. Care have delegation arrangements with medical groups and independent physician associations (IPAs) as well as engage in global capitation payments to the Los Angeles County Department of Health Services to provide care for assigned Medi-Cal patients. An IPA is an entity owned and organized by one or more physicians, medical groups, or Federally Qualified Health Centers (FQHCs) and receives

Figure 1. Los Angeles County Delegation Model by Medi-Cal Managed Care Organization and Enrollee Volume

Source: Jill Yegian and Katrina Connolly, *Los Angeles: Vast and Varied Health Care Market Inches Toward Consolidation*, 2020, CHCF, January 2021.

delegation through “upstream” contracts with MCPs and “downstream” contracts with independent physicians and other local providers.

While there is regional variation in value-based payment structures, several of the experts interviewed suggested that the most prevalent APM arrangements between MCPs and FQHCs included some form of capitation, particularly among health centers that also belong to IPAs. In these models, contracted primary care networks receive capitation payments through delegation assignments from MCPs. However, specialty care is typically excluded from these arrangements and still operates in the FFS model.

In some instances, IPAs with FQHC networks have upside-only shared-risk arrangements with local hospitals to seek alignment in patient outcomes and quality metrics, but several of the experts agreed that these relationships are challenging to navigate when the patient seeks care from

out-of-network providers, as it is difficult to control utilization and meet metrics. Several MCPs have also implemented pay-for-performance incentive structures that include public report card monitoring and upside-risk contracts with performance and quality measures tied to access to care, submission of encounter data, utilization measures, and Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems scores.

Hospital-Based Medi-Cal APM Models

Examples of other APMs implemented in Medi-Cal in recent years have been focused on reforms within the state’s public hospital system. Established in 2015 under the state’s Medi-Cal 2020 Section 1115 waiver, the Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME) required public hospitals and managed care plans to have 60% of patients assigned to a contracted APM by the end of 2020.

PRIME included several options with corresponding clinical project areas tied to performance metrics that determine each public hospital's PRIME funding for that year. PRIME made \$3.26 billion in federal incentive payment funds available to California's public health care systems over five years. Between \$535 million and \$700 million in funding was made available each year for entities that met the predefined benchmarks.

PRIME Project Example: Integration of Physical and Behavioral Health

Goal: To strengthen the public hospital system's ability to deliver coordinated and patient-centered care to patients with both physical and behavioral health needs.

Key activities:

- Implement a physical-behavioral health integration program that utilizes a nationally recognized model
- Implement a behavioral health integration assessment tool
- Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families
- Ensure systems are in place to support patient linkage to appropriate specialty physical, mental, and substance use disorder services

Metrics:

- Alcohol and drug misuse
- Care coordinator assignment
- Comprehensive diabetes care: HbA1c poor control (>9.0%)
- Depression remission at 12 months: CMS159v4
- Screening for clinical depression, and follow-up
- Tobacco assessment and counseling

In the first year of PRIME, all participants reported baseline data for each of these metrics. In each

subsequent year, participating public hospitals were required to improve performance in these metrics to receive associated PRIME funding.

Outcomes: Some of the improvements related to these metrics include the following:

- An additional 185,000 patients were screened for depression between 2015 and 2018
- Tobacco screening and counseling was provided to an additional 83,600 patients
- 3,600 patients have better diabetes control

Additional information on the impact of PRIME APMs can be found at the DHCS website.

All APM payments are measured against established quality benchmarks and performance metrics to determine how much PRIME funding eligible hospitals may receive. Another Medi-Cal reform, the Quality Incentive Pool program, created a pay-for-performance program intended to

Figure 2. Impacts of APM Across the Delivery System**Patients:**

- Provides better patient experience and improves health outcomes through person-centered care approaches
- Increases access to different provider types including specialist and nonlicensed providers such as social workers
- Improves coordination across the continuum of care to reduce complexity for patients and to help them navigate their care
- Addresses whole-person care and social needs by connecting the medical system with community-based providers and social supports, such as housing, nutrition, and employment services

**Providers:**

- Increases flexibility to provide the services in settings and formats that meet patient needs and improve outcomes
- Makes revenue stream consistent and not subject to sudden or unexpected changes in utilization
- Provides opportunity to innovate and generate cost savings that can be used to increase capacity or improve infrastructure

**Health plans:**

- Reduces financial risk and incentivizes cost-effective care delivery within networks
- Increases capacity with innovative provider reimbursement strategies that reward quality and the use of nonlicensed and cost-effective providers
- Reduces administrative burden and holds providers accountable

**California Department of Health Care Services:**

- Simplifies administrative processes associated with current reconciliation process
- Incentivizes quality (rather than volume)
- Promotes a population health-based model of care aligned with Medi-Cal reforms and goals to improve quality, increase access, and reduce costs
- Creates incentives and flexibility for providers to assess and address social determinants of health

Chapman Consulting, APM Key Stakeholder Interviews, March 2022

complement and over time replace PRIME by converting funding from supplemental payments into a value-based structure.

Benefits of APMs

The potential benefits of APM across the Medi-Cal delivery system are outlined in Figure 2.

Evaluations of APMs

APMs have demonstrated positive impacts on cost and quality, though both the scale of the programs and the magnitude of measurable improvement were modest. Outside of California, one of the more well-known examples is the Alternative Quality Contract (AQC) implemented by Massachusetts in 2009. The AQC used a risk-based, global payment to participating physician groups and hospitals to cover all health care services and system

improvements and is combined with additional performance incentive payments tied to quality metrics, improved outcomes, and patient experience. An October 2014 study in the *New England Journal of Medicine* showed that the AQC has improved the quality of patient care and lowered costs in the first four years of implementation.

Within California, organizations such as Covered California, the Integrated Healthcare Association, and the Purchaser Business Group on Health have all promoted various forms of APM adoption in recent years. Health plans have also sought to implement value-based payment approaches. For example, Anthem's Enhanced Personal Health Care (EPHC) program seeks to help primary care physicians transform their practices and support flexible contracting capabilities so that providers accept more financial risk over time. EPHC

providers receive up-front compensation for work completed between office visits, and organizations that meet quality thresholds on the performance scorecard are eligible to share in cost savings. A four-year analysis (2014–17) of EPHC results in California suggests the following:

- **Increased savings.** \$1.8 billion overall cost savings, with 9.7% savings in outpatient lab services, 8.8% savings in avoidable emergency department visits, and 6.5% savings in outpatient surgery
- **Greater compliance.** Ten times faster and 3.1% improved compliance rate for diabetic A1C screenings and 2.2 times faster and 4.1% improved compliance rate for well-child visits
- **Improved outcomes.** 6.2% fewer patient admissions and 7.6% fewer avoidable ER visits

Barriers to APM Adoption

Despite the advantages to implementing APMs, barriers to adoption among providers continue to exist, including the following.

Operations and Cost

Executing practice transformation to enable the implementation of APMs can often require significant investments. For instance, providers must be able to conduct extensive data sharing and reporting to demonstrate the results of the APM, and that may require new or updated electronic health record systems, additional data tracking resources, and staff training. Additionally, managing the clinical risk requires a level of sophistication in financial modeling and investment in care management tools. For some smaller practices or providers that do not have sufficient patient volume, these activities may be cost prohibitive even with the financial incentives contained in APM

Ability to Implement Risk-Based Payments

Providers have varying capacity to take on risk-based payments. Being able to effectively manage risk requires financial modeling and data infrastructure that many (especially small and rural) Medi-Cal providers are not equipped to handle.

This concern will become more prevalent as MCPs integrate Medi-Cal's Enhanced Care Management and Community Support (see appendix) providers into provider networks, as these are often community-based organizations that lack the immediate capacity or funding to develop the knowledge and infrastructure required to handle risk-based payments.

Competitive Concerns

When providers build successful APMs that support patients in a person-centered care setting, a market dynamic may be created where one provider draws in a disproportionate share of the most complex patients. While APMs are ideally set up to provide resources for these patients, the risk mix (the number of high-cost and complex patients that providers will serve) assumes these patients will be split across payers within a system. Providers may not have the resources to adequately address the needs of a patient population significantly more complex than its competitors.

Unique Characteristics of Rural Providers

Providers in rural or traditionally medically underserved areas face unique challenges in both financing and technology that impact their ability to adopt APMs. A Government Accountability Office study of some of these barriers found that a lack of capital to finance the up-front costs of transitioning to an APM, including purchasing electronic health record technology, and challenges acquiring or conducting data analysis necessary for participation, were among the top reasons that rural providers did not adopt APMs at the same rate as their more urban counterparts.

Role of APMs in Future Medi-Cal Reform Initiatives

The CalAIM (California Advancing and Innovating Medi-Cal) initiative and other Medi-Cal reforms will result in broad delivery system, program, and payment improvements to expand the capacity for value-based care models by Medi-Cal providers, MCPs, and county behavioral health plans. As part of these reforms, DHCS has outlined a vision for the

Medi-Cal program that is driven by a value-based payment road map that it intends to implement in the coming years to improve quality and patient-centered care among its contracted MCPs and Medi-Cal providers. This vision and road map will be supported through the Medi-Cal procurement and contracting process that will impose new requirements for all MCPs effective January 1, 2024, with a focus on equity, quality, access, accountability, and transparency. For example, in counties with more than one MCP, Medi-Cal enrollees that do not actively choose a health plan are placed into the default enrollment process (auto-assignment). To incentivize quality, preference is given to MCPs with higher scores on specific metrics, and DHCS will revise its existing auto-assignment algorithm to include health equity outcomes in 2023. For examples of specific Medi-Cal initiatives that will utilize APM models, see the appendix.

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.

Appendix A. Value-Based Payment Approaches

Pay for Performance

Definition. Provider payments are tied directly to specific performance metrics that indicate quality or efficiency.

Benefits. Providers receive a bonus payment for achieving quality goals, patient satisfaction, and process or infrastructure achievements that will improve outcomes and reduce costs.

Disadvantage. These payments may be limited to specific providers and may not impact VBP care over time and across multiple providers.

Shared-Savings and Shared-Risk Models

Definition. Providers that keep costs below a benchmark may share in the savings (i.e., upside risk). If the benchmark targets are not achieved, providers in a contracted arrangement that shares in potential losses (i.e., downside risk) may have funding recouped. Two-sided risk refers to both upside- and downside-risk contracts.

Benefits. Incentivizes coordination and care management across all services within a provider organization and may address unnecessary costs and utilization.

Disadvantage. The predominant model in these arrangements tends to be one-sided upside-risk contracts, which reward providers that perform well but do not address poor performing providers that don't meet benchmarks. Access to cost and claims data and infrastructure investments may help boost provider participation in two-sided risk arrangements.

Bundled Payments or Episode-Based Payments

Definition. A bundled prospective payment that reflects a set of services that occur over time and across clinical settings, procedures, or a specific condition.

Benefits. Providers are incentivized to coordinate care across the spectrum of providers over a complete set of related services or for a specific procedure.

Disadvantage. Some items of care may not be covered in the bundled payment structure, such as operational challenges related to indirect costs and billing systems and distribution of funds across providers.

Global Payments / Capitation

Definition. Provider bears full financial risk for services covered under a contract. Often occurs in highly integrated delivery organizations.

Benefits. Allows for innovative payment and delivery structures that are flexible to patient needs and optimal care.

Disadvantage. May result in market consolidation because it requires significant volume to engage in effective risk management, which can impact consumer choice and price over time.

Alternative Payment Model, APM Framework, Health Care Payment Learning and Action Network (HCP-LAN), 2017

Appendix B. Medi-Cal APM Initiatives

MEDI-CAL INITIATIVE	FINANCIAL RISK	ALIGNED APM FRAMEWORK
<p>Enhanced Care Management (ECM) benefit. The ECM benefit is designed to address clinical and nonclinical needs of the highest-need Medi-Cal enrollees through intensive coordination of health and health-related services. ECM is part of a broader population health system design within CalAIM, under which MCPs will systematically risk stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity.</p> <p>ECM will be implemented in a phased approach across the seven ECM target populations. Beginning January 1, 2022, ECM will be offered to specific target populations in counties with Health Homes Programs (HHP) or Whole-Person Care (WPC) Pilots. From July 1, 2022, ECM will be offered to specific target populations in counties without HHP or WPC Pilots.</p>	MCP receives capitation for ECM and holds the financial risk for providing the services.	Global payments / capitation with a bundled payment component
<p>Community Supports (CS). Community Supports are medically appropriate and cost-effective services or settings that can be used in lieu of more expensive services covered under the Medi-Cal State Plan, and per federal law these services must be optional both for MCPs to provide and for patients to utilize.</p> <p>MCPs in all counties may launch preapproved Community Supports beginning January 1, 2022.</p>	The cost of the Community Supports elected by an MCP will be built into the capitation payment.	Global payments / capitation with a bundled payment component
<p>CalAIM Incentive Payment Program. This incentive program is designed to complement and expand the Enhanced Care Management benefit and Community Support offerings by building provider capacity and MCP investment in delivery system infrastructure necessary to scale APM and achieve improvements in quality performance.</p> <p>The Incentive Payment Program is effective as of January 1, 2022.</p>	There is upside-only risk for MCPs and ECM/CS providers to utilize incentive dollars.	Pay for performance
<p>CalAIM Behavioral Health-Quality Improvement Payment Program (BH-QIP). This program supports Mental Health Plans (MHPs), Drug Medi-Cal State Plans (DMC), and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) as they implement CalAIM and prepare for payment reform, behavioral health policy changes, and bidirectional data exchange between systems of care to improve quality, behavioral health outcomes, and care coordination.</p> <p>The CalAIM BH-QIP incentives are available beginning July 1, 2021, through December 31, 2023.</p>	There is upside-only risk for MHPs and BH providers to utilize quality incentive dollars.	Pay for performance
<p>Federally Qualified Health Center (FQHC) APM 2.0 Initiative. DHCS continues to plan an APM specific to FQHCs. Enrollment is expected in 2023, and the initiative is slated to launch in 2024. For more detail on this APM initiative, please refer to Medi-Cal Explained: How Health Centers Are Paid.</p>	The FQHC holds the risk for providing all services within its scope and covered under the APM rate.	Global payments / capitation
<p>Quality Component for Capitation. Starting in 2023, DHCS will incorporate an MCP's performance on specific quality measures into adjustments that will impact capitation payment rates. The exact methodology and weighting of performance will be determined following a stakeholder engagement process later in 2022.</p>	The MCP holds upside and downside financial risk for changes in capitation related to performance benchmarks.	Global payments / capitation with a shared-risk model component

Endnotes

1. 42 C.F.R. § 414.1305 (2020).
2. Linda McCauley et al., eds., *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, National Academies Press, 2021.
3. “DHCS Stakeholder News,” communications release, California Dept. of Health Care Services (DHCS), December 17, 2021.
4. Joshua M. Liao, Amol S. Navathe, and Rachel M. Werner, “The Impact of Medicare’s Alternative Payment Models on the Value of Care,” *Annual Review of Public Health* 41 (Apr. 2020): 551–65.
5. *APM Measurement Effort* (PDF), Health Care Payment Learning and Action Network (HCP-LAN), 2021.
6. *APM Measurement Effort*, HCP-LAN.
7. Michael Engelhard, Steve Soto, and Athena Chapman, *Medi-Cal Explained: Medi-Cal Payment to Managed Care Plans — Current Process and Challenges*, California Health Care Foundation Publication (CHCF), February 2019.
8. Jill Yegian and Katrina Connolly, *Los Angeles: Vast and Varied Health Care Market Inches Toward Consolidation, 2020*, CHCF, January 2021.
9. “Public Hospital Redesign & Incentives in Medi-Cal Program,” DHCS, last modified March 23, 2021.
10. *Issue Brief: PRIME — Delivery System Transformation: Improving Care and Outcomes* (PDF), California Assn. of Public Hospitals and Health Systems (CAPH), May 2017.
11. *Delivery System Transformation*, CAPH.
12. *Improving Quality of Care Through PRIME* (PDF), CAPH, January 2019.
13. “Public Hospital Redesign & Incentives in Medi-Cal Program,” DHCS, last modified March 23, 2021.
14. “Directed Payments Quality Incentive Pool Program,” DHCS, last modified March 14, 2022.
15. Zirui Song et al., “Changes in Health Care Spending and Quality 4 Years into Global Payment,” *New England Journal of Medicine* 371, no. 18 (Oct. 30, 2014): 1704–14.
16. “Enhanced Personal Health Care: Information for California” (2014–17), Anthem.
17. *Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas* (PDF), Government Accountability Office, November 2021.
18. *Department of Health Care Services Comprehensive Quality Strategy* (PDF), DHCS, 2022.
19. *Medi-Cal Explained: How Health Centers Are Paid*, CHCF, May 2022.