

Is Medicaid Managed Care the New Value-Based Care Frontier?

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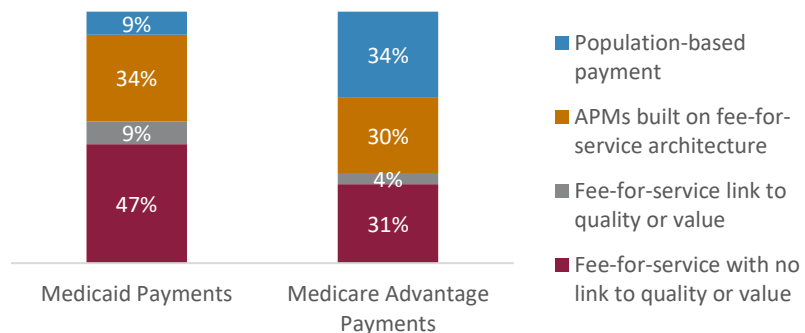
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Penetration of value-based care (VBC) initiatives in Medicaid, particularly those that are risk-based, has historically lagged the more significant growth in VBC within the Medicare Advantage (MA) population¹. However, as Medicaid Managed Care plans (MCOs) and states face cost pressures while aiming to improve outcomes and increase access, there has been an increasing shift away from fee-for-service reimbursement models tied to volume and towards alternative payment models (APMs) that more closely tie reimbursement to outcomes and align incentives by gradually encouraging providers to take on more risk. As a result, there is growing interest among a diverse group of stakeholders including investors, providers, MCOs, and healthcare technology companies in pursuing new revenue opportunities within Medicaid VBC. Programs that effectively realign incentives to prioritize outcomes and value can generate savings for states and MCOs and lead to improvement in the overall quality of care for patients. Herein we address opportunities for VBC for the Medicaid population, identify major challenges facing stakeholders, and examine differences between states that may facilitate greater adoption and success.

Figure 1: 2023 Comparison Of VBC Penetration For Medicaid Versus Medicare Advantage



¹ Health Care Payment Learning & Action Network; APM Measurement Progress of alternative Payment Models: 2024 APM Measurement Methodology Report

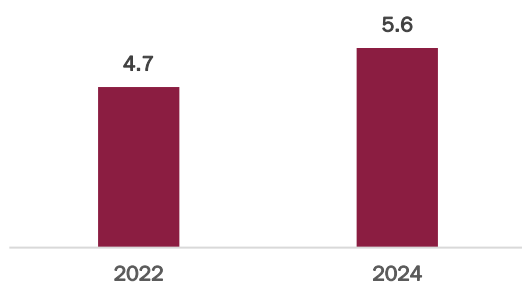
I. MCO and Policy Drivers of Value Based Care (VBC) In Medicaid

VBC within the Medicaid population is driven by several factors and stakeholders, including Medicaid Managed Care Organizations (MCOs), state and federal policy, providers, and technology solutions.

MCOs are one of the largest drivers in the shift towards VBC. For MCOs, value-based payment models offer a way to reduce costs and improve outcomes while reducing health disparities and improving access. VBC is a priority for most large MCOs, and this has only increased as a result of the recent cost pressures that many MCOs are currently facing due to increased utilization and cost pressures associated with a misalignment in the capitated rates the plans receive from states².

Figure 2: Degree To Which Plans Are Encouraging Risk-Based Arrangements In Medicaid: 2022 Versus 2024

Average ranking on a scale of 1-7, where 7=strongly encouraging



Source: Marwood MCO Surveys, 2022 and 2024

Historically, there have also been policy initiatives at the state and federal level that have encouraged VBC, and looking forward over the next few years, political priorities and likely Medicaid policy initiatives of the incoming administration will drive further adoption.

Many states have implemented VBC payment targets in their contracts with MCOs, which can lead to greater adoption of VBC models. In some states, a portion of the payment may be withheld from MCOs based on their performance on quality measures. This withholding can incentivize MCOs to pursue contracts with providers that prioritize performance on these measures, further promoting the adoption of VBC initiatives.

Federally, there have also been initiatives that encourage focus on VBC within the Medicaid population. The Medicaid Innovation Accelerator Program (IAP), administered by CMS from July 2014 to September 2020, provided technical assistance and support to 44 participating state agencies to facilitate adoption of VBC and APMs for various Medicaid subpopulations, including maternal and infant health and children's oral health³. More recently, CMS's Making Primary Care First model launched in July 2024, which aims to encourage gradual participation in risk-based payments through a multi-payer approach that emphasizes care coordination, care management, and social determinants of health. This program has partnered with state Medicaid

² <https://www.elevancehealth.com/newsroom/ely-quarterly-earnings-q3-2024>

³ <https://www.medicaid.gov/resources-for-states/medicaid-innovation-accelerator-program/index.html>

agencies in eight states and targets primary care providers that have not participated in previous VBC models⁴.

As the incoming administration takes office with Republican control of the House and Senate, the primary political goal for Republicans in 2025 is to extend and increase the expiring Tax Cuts and Jobs Act tax cuts. While many Republicans believe that Congress does not need to use budgetary offsets for tax cut extensions because the cuts are already built into the baseline, there are likely to be discussions around reductions in mandatory spending to help pay for the tax cuts, and Medicaid is likely to be included in the pay for discussions. In addition to this potential headwind, it appears that Republicans will look to offset a \$1.5 trillion increase in the debt limit with \$2.5 trillion in mandatory spending cuts. This is not a realistic number, and it is unlikely that Republicans will be able to agree on cuts approaching that level, but in any event, Medicaid is likely to be discussed as a source of deficit reductions throughout 2025.

While the range of potential cuts include reducing the federal matching rate for the Medicaid expansion population, imposing per capita caps or block grants on Medicaid funding, and imposing work requirements nationwide, Congress is likely to only be able to pass more modest reforms. For example, Congress could pass a state option for both work requirements and per capita caps. This would allow states to receive waiver approval for work requirements (typically for the Medicaid

expansion population) or for per capita caps without concerns that courts will reject those waivers, as occurred in the prior administration.

For Medicaid VBC, the potential Medicaid changes present an opportunity. The risks to Medicaid enrollment and funding are primarily in the expansion population, with few changes to aged, disabled, and pediatric populations. These are populations where VBC providers can provide outsized value, and Medicaid managed care plans are likely to look to gain additional savings among those populations if enrollment declines in the typically healthier expansion population. With regard to the expansion population, VBC providers can provide additional value in providing more frequent outreach and attention to enrollees, helping to maintain enrollment for those beneficiaries who satisfy the work requirements but may struggle with the administrative side of the requirements.

One additional regulatory risk is that the incoming administration could make it more difficult for states to use typical strategies for accumulating the nonfederal share of the Medicaid matching rate. In that case, there could be a modest reduction in Medicaid funding for states, which would increase the interest in cost savings. This focus on cost savings could advantage Medicaid VBC providers.

The incoming administration is expected to be friendlier to MA than the Biden administration, but there are likely to be limitations on that generosity. For example,

⁴ <https://www.cms.gov/blog/cms-innovation-centers-strategy-support-high-quality-primary-care>

the V28 risk adjustment changes that have pressured plan revenue and hurt VBC providers in MA are not likely to be unwound under the incoming administration. Instead, it is more likely that the model could be tweaked slightly, adding back diagnosis codes or increasing certain Hierarchical Condition Category (HCC) coefficients. This will not ameliorate all of the pressure on MA plans and VBC providers, but is likely to improve the overall outlook, especially as MA annual growth rates recover as well. This will make MA more attractive to VBC providers while also rewarding a more diversified approach that includes Medicaid.

One of the primary challenges in increasing VBC penetration is provider willingness to engage and assume risk, making provider buy-in particularly important. Providers may choose to participate in VBC initiatives for several reasons. In some cases, VBC participation can be a way for the providers to generate additional revenue since Medicaid fee-for-service payments are generally low. Providers who perform well on quality metrics may be eligible for bonuses and those who effectively manage their population under risk-based models can achieve higher margins compared to the fee-for-service model. Additionally, providers with experience in managing risk for MA and dual eligibles may seek additional growth opportunities in the Medicaid population. This is particularly true as bearing risk within MA has become less profitable for many large and experienced providers due to the roll-out of the V28 risk adjustment changes.

II. The Importance of Technology

Effective use of Healthcare Technology (“Healthtech”) solutions can be critical in terms of increasing penetration of VBC models and increasing the success of providers under VBC models, particularly those that are risk-based. Lack of technology capabilities is a major barrier to greater adoption of VBC, especially risk-based models.

Solutions that enable providers to perform well and report upon KPIs, create workflow efficiencies, and enable interoperability typically have the most success in terms of increasing VBC penetration. KPIs and quality metrics vary depending on the population but typically include low preventable ED visits, low readmission rates and inpatient stays, focus on addressing behavioral health conditions, hitting goals for preventative care and annual visits, adherence to care pathways or treatment protocols, medication adherence, screening and identifying social determinants of health (SDOH), ensuring utilization of cost-effective medications, and patient satisfaction related metrics such as waiting time and customer service.

Medicaid-specific solutions can be a significant differentiator as many risk-bearing healthcare technology companies focus on the MA population and concentrate on solutions such as MA-specific risk adjustment, that are not as valuable for Medicaid population. As an example, Astrana Health is differentiated within the VBC enablement space by having a greater focus on the Medicaid population. From an MCO perspective, this

has spurred growth in risk-based Medicaid contracts outside of the California market by providing a full suite of tech-enabled services that have led to a greater migration of providers from fee-for-service to VBC contracts than would otherwise be possible. VBC enablement companies that take on risk through an aggregation model must be able to provide tools to providers that focus on care coordination and population health management. Furthermore, tools that would typically be considered to be more payor focused, like claims adjudication and prior authorization, can lead to more successful cost containment, and less provider abrasion.

Population health solutions that are able to pull information from payors, providers, Health Information Exchanges, and other sources to create a 360-degree view of the patient, can enhance EHR capabilities and help to facilitate better care management and interventions with patients that are managed under risk-bearing arrangements.

For example, the goal of Pediatric Associates' recent partnership with Innovaccer, is that better patient data will help providers ensure that members are receiving the necessary preventative care and immunizations, and that risk is being properly identified to prevent more unnecessary high-cost care, such as ED visits. The platform is also expected to lead to better care coordination and communication across care teams, and the reporting capabilities will likely help the

provider report quality and outcomes metrics back to their payor partners⁵. In addition to providers, MCOs may also partner with population health solutions, for example, the GuidingCare tool from HealthEdge has a pediatric specific module targeted at payors to help track and report Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements in Medicaid and additional state requirements and quality metrics.

Below are several key examples of VBC tools that risk-bearing providers may engage with, and their corresponding impact in terms of driving greater adoption of VBC within Medicaid.



⁵ <https://www.hcinnovationgroup.com/policy-value-based-care/article/55056398/qa-amanda-furr-md-on-scaling-up-for-value-based-care-in-pediatrics>

Figure 3: Overview of Medicaid VBC Technology Solutions

	Point Solutions for SDOH or Member Engagement	VBC Focused-EHR Providers	Population Health Tools	Tech-enabled Risk Bearing Primary Care Groups and VBC Enablement Companies
Core Solutions	- AI-driven member engagement solutions - Solutions may focus on addressing loneliness or social isolation	- Modules that focus on VBC provider needs in addition to core EHR capabilities, such as clinical pathways and decision support - PACE specific solutions often focus on specific program reporting requirements	- Data aggregation across multiple sources for 360-degree patient view - Patient risk stratification and predictive analytics - Care coordination - Screening and preventative services tracking - Reporting on state-specific requirements	Proprietary tech-stack may include provider-focused solutions such as care coordination and management, preventative care alerts, risk stratification and predictive analytics, network and specialist/referral management, but may also include tools more focused on payor-related tasks such as eligibility, prior authorization, claims adjudication
Customers or Revenue Source	- Traditionally more payor/MCO focused - Smaller focus on VBC providers	- VBC providers - PACE organizations	- VBC providers - Payor and Life Sciences	Payors/MCOs
Considerations For VBC Adoption	- Core customers are currently payors as opposed to VBC providers - Solutions can include Medicaid beneficiaries, but may not be Medicaid-specific, which can lead to challenges in member engagement success	- Larger EHR platforms like Athena have VBC offerings, but they are generally not specific to Medicaid - PACE-specific solutions are unique and focused on VBC needs around care coordination and case management, but the overall PACE TAM is limited (though growing)	Interoperability is key in terms of these solutions' ability to drive value; ROI can be significantly eroded if solutions cannot deliver on the promise of interoperability and the ability to create efficiencies in provider workflow	- Most players in the VBC enablement and tech-enabled risk bearing provider space have focused on Medicare Advantage - Those focusing on Medicaid specifically are more unique and differentiated - Tech stacks that perform payor-related functions in addition to offering population health tools for providers to use, can be more effective at controlling costs
Select Companies	  	   	  	   

Solutions' Ability To Drive Greater VBC Adoption

III. Assessment of VBC Opportunities Within Medicaid Across Geographies and Models

Since MCOs and providers are the primary drivers of VBC penetration, understanding their dynamics at the local level is important for understanding the current state of VBC as well as the growth outlook. For example, large plans like Centene have national strategies aimed at increasing VBC contracting, but competitive dynamics with other MCOs within a specific state, as well as a state's Medicaid program priorities, can lead to significant variations in the penetration of VBC across different states. Providers' abilities and experience in care coordination and other activities integral to a VBC program's success are also critical factors.

Metrics for success and risks that can lead to pressure provider margins or VBC penetration can also vary significantly depending on the type of risk-based provider model, the population types included, and the details within the specific contract. For example, shared risk or Accountable Care Organization (ACO) arrangements, operating based on a benchmark estimated cost of services and utilization, may also have payments that are linked to performance across specific quality metrics. Capitated arrangements may have carve outs for certain high cost services or products that are reimbursed under fee-for-service rates, which may or may not be tied to a state set Medicaid fee schedule or Medicare rates.

It is also common for there to be limitations and variability in risk bearing arrangements in terms of the populations covered.

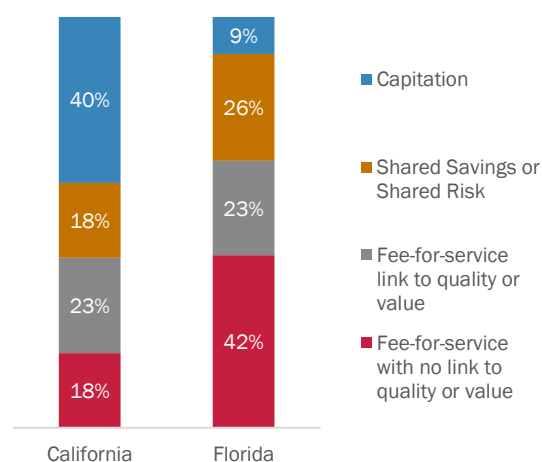
Certain populations may be favored for VBC by different stakeholders, and as previously mentioned, the regulatory and legislative outlook can vary significantly by population group. As an example, pediatric-focused models are less at risk from a funding and enrollment perspective under the incoming administration and are often favored by MCOs because of their ability to deliver on improving outcomes for a segment of the population that makes up a large portion of membership and receives a high degree of focus from state Medicaid agencies. Pediatric VBC providers' reimbursement is often at risk and tied to performance on outcomes measures that are typically centered around ensuring preventative services and immunizations are performed, and that behavioral health needs are being addressed, and are less focused on the metrics that are more prevalent for populations that typically generate more spend and have higher utilization. Effective care coordination, reporting on KPIs, and ensuring that members are receiving the preventative services they need are all important factors to pediatric-focused VBC success.

IV. Comparison of Florida and California

Penetration of risk-based models within Medicaid is region specific, with some markets like California and Florida seeing greater adoption of risk-based models. California and Florida are both states with a high degree of VBC penetration. California has historically had more penetration of global capitation than Florida. This is primarily due to providers being more willing to enter these contracts

and build the infrastructure necessary to fulfill the contracts, as well as a large population and the presence of providers with experience managing risk, starting originally with Kaiser and now expanding to many providers willing to accept global capitation arrangements.

Figure 4: California and Florida MCO Views on the % Of Provider Contracts Currently Under VBC Models



Source: Marwood MCO Survey 2024; averages calculated across MCOs

Florida VBC contracts in Medicaid have mostly been shared savings/shared risk arrangements, where providers are responsible for keeping the total cost of care below a benchmark. Providers then either receive additional payment or remit payment back to the plan depending on whether they are successful. Providers that are able to coordinate care and prevent emergency department visits and hospital admissions would typically be able to stay below the benchmark. In Florida, penetration has been similarly driven by a large population and a high number of MA enrollees that presented an opportunity for

risk-bearing providers, who have more recently begun to adopt VBC for the Medicaid population. While Medicaid MCOs in Florida are open to more VBC, provider willingness and capability has held back wider adoption. Changes to Florida MCO contract requirements beginning in 2025 that require a certain percentage of

payments to be under VBC may cause more capitation arrangements over the next few years; however, it's unclear how much plans are already complying with these requirements and will not need to make major changes to their contracting approach.

Figure 5: Comparison Of California and Florida VBC Dynamics		
	California	Florida
VBC Model Type and Structure	High use of VCB through global capitation contracts, in which the provider receives a per-member-per-month (PMPM) fee from the MCO that is based on a percentage of the capitation payment the MCO receives from Medicaid, and then is responsible for paying for most covered services, such as specialist and hospital services	Moderate use of VBC through primary care-only capitation with a shared savings/risk total cost of care target
Regulatory Environment	- Requires risk-bearing providers that accept global risk be licensed by the Department of Managed Health Care as Knox Keene providers - No specific MCO contract requirements for a minimum amount of payments through VBC - Detailed reporting requirements for risk-bearing providers to be used for complying with both MCO and provider MLR	- No licensure required - State approval of value-based contracts and detailed reporting of medical spend, but no provider MLR that must be met - MCO contract requirements for a minimum amount of payments through VBC, increasing annually
Market Dynamics	The presence of Kaiser has likely led to earlier adoption of VBC arrangements in the state, and these types of arrangements are now well established, particularly in the Southern part of the state, which has led to more VBC in the Medicaid population and a clinician workforce that can managed risk, operate under VBC models, do perform care coordination	- Because of its high concentration of enrollees, Florida has a history of high penetration of VBC for MA; as this is a different population with different risks and rewards it has prepared clinicians for managing risk and operating under those models - Large provider groups are still focused on MA but are also looking at Duals and Medicaid as they think about growth strategies

MCO Landscape	- California will continue to require nearly all Medicaid recipients to enroll in managed care and began new five-year MCO contracts in 2024 - California contracts with 22 MCOs, but many of these are owned and operated by the county and are the sole plan in their area. Large national plans, including Centene, Molina, and Anthem have significant market presence in Southern California - Florida will continue to require nearly all Medicaid recipients to enroll in managed care and will begin new five-year MCO contracts in 2025 with eight plans, some of which are statewide (Centene, Humana, Anthem) and others of which are regional
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Figure 5 Continued: Comparison Of California and Florida VBC Dynamics

	California	Florida
Pros of State Model	- Global capitation allows for a high degree of control through the management of referrals and downstream provider reimbursement rates; - Providers in California have many years of experience managing risk through this model,	- Shared risk/shared savings contracts can also include performance bonuses for meeting quality metrics, in addition to reducing the total cost of care, and providers that are able to meet these metrics can earn additional reimbursement - Lack of specific license and comparatively less state oversight
Cons of State Model	Greater state oversight of provider profitability and MLR	Potentially less control and ability to manage the patient, making it more difficult to meet total cost of care benchmark

V. Considerations for Key Stakeholders

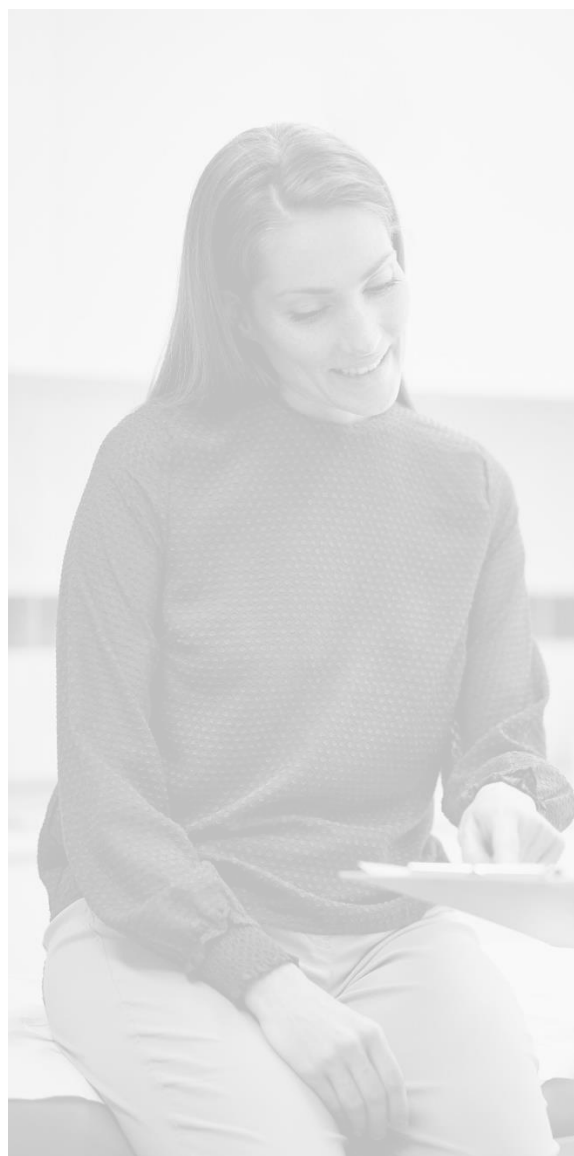
There is a significant amount of opportunity within Medicaid for VBC initiatives that can improve outcomes and reduce costs. The regulatory and policy environment over the next few years under the incoming Administration is likely to lead to further focus on VBC penetration from MCOs and states, with a particular focus on risk bearing arrangements. This creates opportunity for a variety of stakeholders.

For risk bearing providers, there will continue to be opportunities to take on risk within Medicaid and gain additional revenue through performance on quality metrics as well as efficient management and risk stratification of populations. There are still likely to be regional differences, with some states seeing greater adoption than others, and certain markets favoring specific types of risk-bearing arrangements, such as those focused on the pediatric population.

For healthcare technology companies, positive growth in VBC penetration, especially risk-based models, is likely to increase demand for business models that enable providers to coordinate care, manage referrals, stratify risk across a population, reduce unnecessary utilization, perform well across quality metrics, and share data with the MCOs. Likewise, greater availability of solutions is likely to lead to greater provider willingness and success in taking on risk. Those solutions that are able to focus on the Medicaid-specific population will likely be best positioned to grow relative to solutions that are more population agnostic or focus more on the Medicare Advantage population. Interoperability will be key achieving the highest degree of ROI, especially for population health focused-tools.

For investors, growth in Medicaid VBC creates opportunities to deliver value across stakeholders by partnering with and helping to scale technology solutions or providers, which will further accelerate the transition to VBC and improve quality and outcomes for the Medicaid population. Key to investor success within Medicaid VBC include focus on the regulatory environment and accounting for potential shifts that may occur and the corresponding impact those shifts may have on the sector. As an example, understanding that the risks to Medicaid enrollment and funding under the incoming administration are primarily in the expansion population, but that other populations like pediatrics are likely to be less impacted will be a key consideration for strategic focus. For technology solutions, ensuring that a given company can deliver on the promise of interoperability is key to achieving ROI for both payor and provider customers. A strong focus on the evolution of the

competitive landscape and understanding how solutions are differentiated is another critical factor. As an example, focusing on VBC enablement solutions that are less focused solely on the Medicare Advantage population can be a competitive differentiator and for non-EHR provider-focused technology solutions, ensuring that solutions are differentiated from EMR modules and capabilities is critical in order to achieve growth over the long term.



ABOUT THE AUTHORS

Kate Gibson joined the Marwood Group in 2013 and is responsible for overseeing due diligence and strategic engagements for healthcare corporations and investors. Ms. Gibson is also a subject matter expert on commercial, MA, and Medicaid Managed Care payor dynamics across provider and HIT sectors. Prior to joining the Marwood Group, Ms. Gibson worked at Truven Health Analytics where she worked with hospital and other large providers on various strategic engagements, with a focus on reimbursement and contracting strategies and designed models to analyze both qualitative and quantitative data for healthcare businesses. Ms. Gibson received her BA degree with honors from the University of St. Andrews.

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