An Introduction to Alternative Payment Models

June, 2016

Agenda

- Survey of Alternative Payment Contracting Models
- Policy Catalysts for APMs
- Examples of State-based Medicaid APM Requirements
- New Hampshire's DSRIP Waiver and APMs
- Appendix: APMs and Required Provider Competencies

Survey of Alternative Payment Contracting Models

What is an Alternative Payment Model (APM)?

The definition of an APM is evolving…

- Definitions vary across individual providers, payers, and regulatory bodies
- Generally refers to paying providers based on improving outcomes through effective prevention, treatment, and care coordination—not based on volume

… but most share some key elements

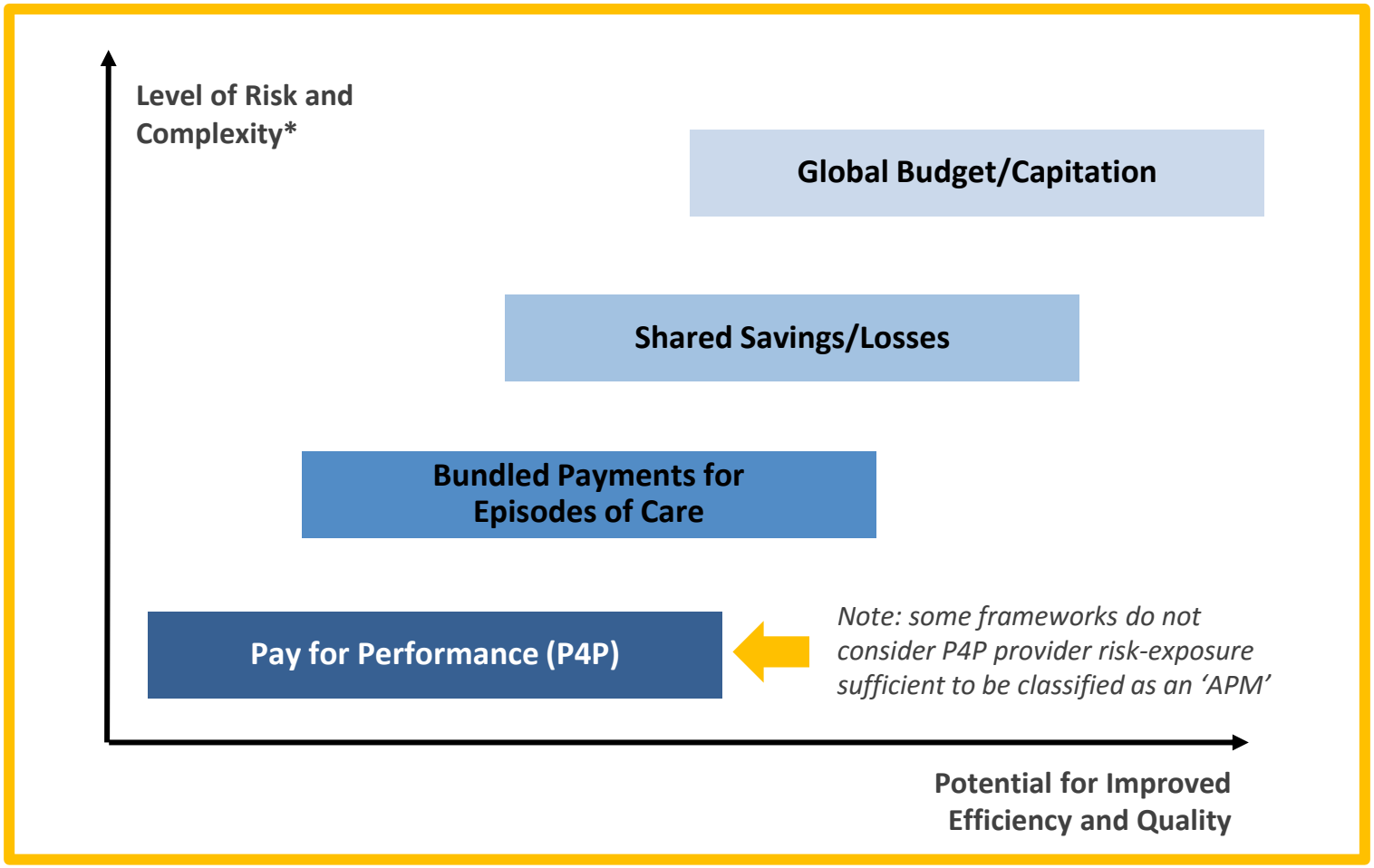
1. Use of risk-sharing to create provider incentives to contain costs
2. Robust quality metrics to ensure high-quality care
3. Re-investment of saved funds to areas of need

Rationale for APMs: Changing Focus from Volume to Value

Volume	Value
Payment linked to *volume* of care	Payment linked to provider *performance* and patient *outcomes*
Providing and paying for interventions that address an *individual's* medical needs	Paying for outcomes, including prevention and wellness of *populations* in addition to care of individuals
Creates incentives for duplicative capacity and unnecessary care	Rewards efficiency
Gatekeeper model leads to denied claims and denied or delayed care as utilization management tool	Incentivizes improved access, use of evidence based practices and performance against quality metrics that generate cost savings and improved patient outcomes
Pits payers and providers as adversaries	Aligns payer and provider partners

Range of APM Contracting Models

APM approaches tend to differ based on the level of risk providers assume and the structure of payments



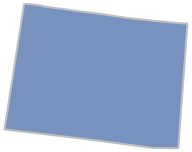
Note: actual level of risk can vary depending on specific arrangement; e.g., a bundled payment program with upside and downside risk-sharing may have potential for greater losses than a limited shared-savings program.

APM Example: Pay for Performance

Simplified Example

- Primary care provider receives a 1% bonus on total paid claims if 95% of patients receive recommended immunizations

APM in Action: Colorado Medicaid Accountable Care Collaborative (ACC)



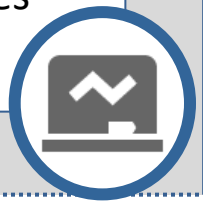
- Primary care providers participate through Regional Care Collaborative Organizations (RCCOs).
- RCCOs receive a per-member-per-month (PMPM) care coordination fee and can receive incentive payments for meeting quality metrics.
- Quality metrics include reductions in ED visits and hospital readmissions, well child visits, and postpartum care.
- Program saved more than $37 million in FY 2014-15.
- For more information, see 2015 ACC Annual Report

Sources: "Medicaid Accountable Care Organization Programs: State Profiles," Center for Health Care Strategies, October 2015; "Accountable Care Collaborative: 2015 Annual Report," Colorado Department of Health Care Policy & Financing," 2015.

APM Example: Bundled Payments

Simplified Example

- Payer sets pre-set price of $5,000 for maternity care from pregnancy to 6 months after delivery.
- Bundle includes services provided by hospital, physician/midwife, home care agency, nutritionist, and other providers.
- If the total cost for maternity episodes over a year is < $5,000, the contracting provider shares in the savings; if average cost is > $5,000, the provider shares in the losses
- Payment reduced by $500 if quality scores not attained.



APM in Action: Arkansas Health Care Payment Improvement Initiative

- Arkansas Medicaid and commercial health plans established 12 “episodes of care,” which include chronic (e.g. asthma, ADHD) and acute episodes (e.g. heart failure).
- Providers continue to be reimbursed on FFS basis. At end of year, individual provider spending per episode is compared to average spending per episode. Provider shares in savings or losses if spending is far above or below average.
- Provider must also meet quality benchmarks to share in savings.
- For more information, see the Health Care Payment Improvement Initiative website.

APM Example: Shared Savings

Simplified Example

- Target cost for population of all attributed patients is $100 PMPM.
- End of year tabulation indicates actual FFS claims were $96 PMPM.
- Savings are split 50/50 between payer and provider. Payer sends $2 PMPM bonus to provider. Bonus reduced by $0.50 PMPM if quality scores are not attained.

APM in Action: Medicare Shared Savings Program

Medicare.gov

- Providers form ACOs to control costs and improve quality of attributed Medicare patients.
- Providers can share in savings only or share in savings and risk, depending on the model.
- Percentage of savings provider receives is also dependent on quality scores.
- For more information, see the CMS Shared Savings Program website.

APM Example: Global Budget/Capitation

Simplified Example

- Provider group receives $100 PMPM for care of an attributed population in a calendar year.
- Payment is reduced to $98 PMPM if quality scores not are attained.

Few providers currently have the advanced capabilities to manage risk under full capitation

APM in Action: Nationwide Children's Hospital (Columbus, Ohio)

- Nationwide Children's Hospital in Columbus, Ohio sponsors Partners for Kids , a physician hospital organization that operates as a pediatric ACO
- The ACO manages full risk for over 300,000 low-income children through subcontracts with Ohio's five Medcaid MCOs through a risk-adjusted PMPM capitation payment.
- While the MCOs retain a percentage of the Medicaid premium for claims processing and other administrative functions, Partners for Kids carries the business risk for clinical and financial outcomes

Recap: Summary of APM Contracting Models

Less Risk → **More Risk**

Pay for Performance

- Bonus/withhold tied to performance on defined quality metrics or care coordination standards
- Bonus/withhold generally a percentage of existing payment (either capitation or FFS)

Bundled Payments

- Fixed budget or target for specific episode of care (*e.g.*, maternity care)
- Bonus (or penalty) tied to overall spending for the episode of care. including spending for services delivered by other providers

Shared Savings/Losses

- Existing payment structure (*e.g.*, FFS) remains in place
- Bonus (or penalty) tied to overall spending for a defined population, including spending for services provided or arranged for by other providers

Global Budget/Capitation

- Fixed budget for a defined population across a range of services
- Existing payment structure may remain in place with year-end reconciliation or providers may choose PMPM capitated payments

Payments may vary based on quality scores

Policy Catalysts for Alternative Payment Models

Alternative Payment Models (APMs) are at the Center of Federal Payment and Delivery System Reform

CMS has led the way and set an aggressive timeline for shifting reimbursement from volume to value

"Today, for the first time, we are setting clear goals – and establishing a clear timeline – for moving from volume to value in Medicare payments.

*Our first goal is for **30% of all Medicare provider payments to be in alternative payment models** that are tied to how well providers care for their patients, instead of how much care they provide – and to do it **by 2016**. Our goal would then be to get to **50% by 2018**.*

*Our second goal is for virtually all Medicare fee-for-service payments to be **tied to quality and value**; at least **85% in 2016 and 90% in 2018**."*

-- HHS Secretary Sylvia Burwell, January 26, 2015

Examples of CMS APM Catalysts

- Medicare Shared Savings Program, Next Gen ACO, and bundled payment initiatives continue to foster the testing and deployment APMs
- Medicare and CHIP Reauthorization Act (MACRA) further sharpens the focus on APMs by tying Medicare physician payments to performance
- Health Care Payment Learning & Action Network (LAN) launched as a public-private partnership to drive multi-payer payment reform alignment
- APM requirements increasingly required as part of State Medicaid 1115 waivers
- Finalized Medicaid Managed Care rules reinforce States' ability to drive APMs

Source: http://www.hhs.gov/blog/2015/01/26/progress-towards-better-care-smarter-spending-healthier-people.html

At the State-level, Medicaid APMs are Widely Discussed but Only Beginning to Gain Traction

- Majority of states now incorporating or planning to incorporate APMs into their Medicaid programs
- Depth, level of risk sharing, and scale of APMs vary widely across states
- Most APMs still at the early stages of development and deployment

DSRIP Waivers (7 states)

Examples

- California
- New Hampshire
- New York
- Massachusetts
- Texas

Medicaid ACOs (17 states)

Examples

- Iowa
- Illinois
- Maryland
- Minnesota
- Oregon

Bundled Payment (7 states)

Examples

- Arkansas
- Connecticut
- Ohio
- Oklahoma
- Tennessee

APMs Required in MCO Contracts (15 states)

Examples

- Arizona
- New Jersey
- Pennsylvania
- South Carolina
- Virginia

Recently Finalized Medicaid Managed Care Rules Reinforce States' Ability to Require that Plans Implement APMs

States may leverage managed care contracts to direct provider payments in order to advance delivery system/payment reform and performance improvement goals

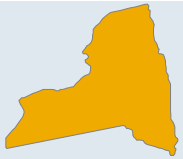
States may:

- Require plans to implement value based purchasing models (e.g., P4P, bundled payments)
- Require plans to participate in multi-payer delivery system reform or performance improvement initiative (e.g., PCMH, EHR incentive payments for otherwise ineligible providers)
- Require plans to set higher reimbursement standards for particular provider types or services (e.g., PCP enhancement)

Examples of State-based Medicaid APM Requirements

Medicaid APM Requirements in Other States: New York

New York

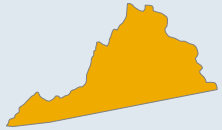


- Under DSRIP, NY's goal is to reimburse 80-90% of managed care payments to providers via value-based methodologies by the end of demonstration year 5
- Based on NY's 'VBP Roadmap,' APM arrangements can only be developed between 'VBP contractors' and MCOs. VBP Contractors are limited to the following types of organizations (note: a DSRIP Performing Provider System cannot serve as a VBP contractor unless it creates or leverages one of these entity types):
  - An Accountable Care Organization (ACO)
  - An Independent Practice Association (IPA)
  - An Individual Provider who assumes all responsibility and risk, or who subcontracts with other providers
- NY's VBP Roadmap outlines a range of implementation options for VBP contractors to consider. Providers and MCOs should select VBP arrangements that best fit their capabilities.
  1. *Total Care for General Population*: VBP contractor responsible for all care for the general population
  2. *Integrated Primary Care*: MCO contracts with PCMHs and rewards them based on savings and quality outcomes
  3. *Selected Care Bundles*: VBP contractor responsible for outcomes and costs related to an episode of care; bundles prioritize Maternity Care and Chronic Care, including the 14 most prevalent chronic conditions
  4. *Total Care for Special Needs Subpopulations:* capitated model; subpopulations include: HIV/AIDS, SMI, Managed Long Term Care, and Care for the Developmentally Disabled
- Contracting options may be implemented at varying levels of risk based on contractor capabilities, ranging from 'Level 1' (upside only) to 'Level 2' (upside *and* downside risk sharing) to 'Level 3' (capitated payments)

Medicaid APM Requirements in Other States: Virginia and Ohio

Virginia

- Virginia's Medicaid MCOs are contractually required to enter into at least two contractual arrangements with providers or health systems that include gain- and/or risk-sharing, performance-based incentives, and other incentive reforms tied to quality metrics and financial performance indicators identified by the State.
- These arrangements, called Medallion Care System Partnerships (MCSP), must be designed to integrate primary, acute, and complex health services in order to improve enrollee outcomes; examples of MCSP arrangements include medical homes or health homes.
- The model contract includes a table of MCSP model options and payment types.



Ohio

- Similarly, Ohio's model contract stipulates that MCOs must "implement payment strategies that tie payment to value or reduce waste, as those terms are defined herein. In doing so, MCO shall, on or before July 1, 2013, provide the State with its strategy to make 20% of aggregate net payments to providers value-oriented by 2020."
- Example strategies provided in the contract include:
  - Payment based on provider performance;
  - Reducing unwarranted payment variation; and
  - Payments designed to encourage adherence to clinical guidelines, including early elective deliveries.

Medicaid APM Requirements in Other States: Arizona and Tennessee

Arizona

- In 2013, Arizona began requiring MCOs to identify how to improve integration of care with identified cost reductions. MCOs are required to have a % of provider payments in value-based arrangements and become eligible for a quality distribution once they meet the VBP requirement.
- The State also added a requirement for MCOs to enter into shared-savings agreements with their providers (equal to at least 10% of their contracted medical spend), with incentive payments paid to MCOs and providers that demonstrate improved health outcomes and reduced costs.
- Other payment modernization initiatives involve development of a limited set of bundled payment structures to establish greater reimbursement consistency for episodes of care and further development of the State's patient centered care models.

Tennessee

- In 2013, the Governor launched the Tennessee Health Care Innovation Initiative, which has three strategic focuses: episodes of care, primary care transformation, and LTSS. The episodes of care initiative was modeled after Arkansas' Health Care Payment Improvement Initiative.
- In May 2014, the episodes of care initiative launched 3 episodes of care: acute asthma exacerbation, perinatal, and total joint replacement. Over 500 providers received quarterly reports from TennCare and commercial payers. Providers are to be rewarded/penalized based on performance for CY2015 for TennCare and CoverKids members.
- Under the episodes of care initiative, participating insurers (including TennCare plans) add additional episode every year with the goal of implementing 75 episodes by the end of 2019.
- For more information about the episodes of care initiative, see the following links: http://www.tn.gov/hcfa/topic/episodes-of-care, and http://www.tha.com/files/tenncare/payment-reform/20131105-tenncare-payment-reform-webinar.pdf

New Hampshire's DSRIP Waiver and APMs

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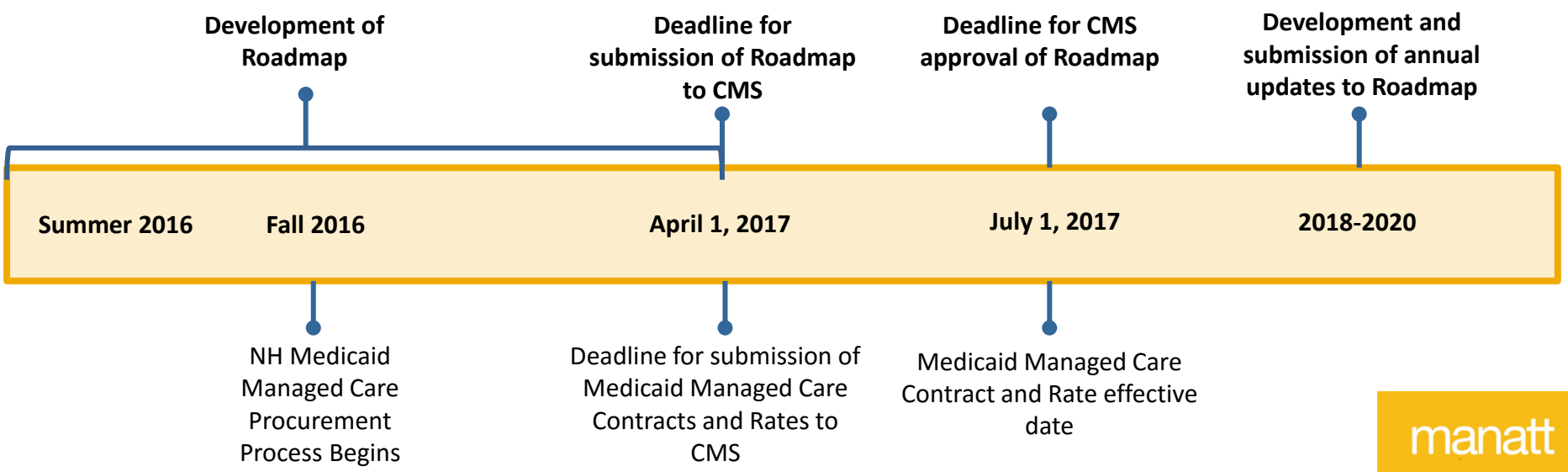
New Hampshire's DSRIP Medicaid Waiver and the Transition to Alternative Payment Models

Goals and Requirements: NH's APM Roadmap

- Under DSRIP, New Hampshire's **funding model** will shift from planning support to performance payments to **long-term sustainability**.
- The Special Terms and Conditions of the waiver require that the state develop a plan, or **Roadmap** for:
  - **Sustaining the DSRIP investments beyond the life of the waiver**, including how it will modify its Medicaid managed care contracts to reflect the impact of the waiver and the state's APM goals
  - **Moving at least 50 % of payments to Medicaid providers into alternative payment models**

APM Roadmap: Important Dates



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STC Spotlight: Roadmap Requirements

STC Language re: MCO and Medicaid Service Delivery Contracting Plan, aka, the Roadmap

Purpose

In recognition that the **IDN investments** represented in this demonstration must be **recognized and supported by the state's MCO and Medicaid service delivery contracts** as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries with diagnosed or emerging behavioral health issues through comprehensive payment reform, strengthened provider networks and care coordination, **the state must take steps to plan for and reflect the impact of IDN in Medicaid provider contracts and rate-setting approaches.**

Process

Recognizing the need to formulate this plan to align with the stages of IDN, this should be a **multi-year plan developed in consultation with managed care plans and other stakeholders, and necessarily be flexible to properly reflect future IDN progress and accomplishments**.

2017 Deadlines

Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017 [i.e., **prior to April 1, 2017**], the **state must submit a roadmap for how it will amend contract terms and reflect new provider capacities and efficiencies in Medicaid provider rate-setting**.

This plan must be **approved by CMS** before the state may claim FFP for Medicaid provider contracts for the 2018 state fiscal year [i.e., **by July 1, 2017**].

Annual Updates

The state shall **update and submit** the MCO and Medicaid service delivery contracting plan **annually** on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the MCO and Medicaid service delivery contracting plan will also be included in the **quarterly demonstration report**.

STC Spotlight: Roadmap Requirements

Per the STCs, the state's Roadmap must address the following areas:

1. **Payment Approaches:** What approaches service delivery providers will use to reimburse providers to encourage practices consistent with IDN objectives and metrics, including

2. **Path to 50% APM Goal:** How the state will plan and implement a goal of 50 percent of Medicaid provider payments to providers using Alternative Payment Methodologies.

3. **Impact on Providers and Alignment with IDN objectives/measures:**

    a. How alternative payment systems deployed by the state and MCO/Medicaid service delivery contracts will reward performance consistent with IDN objectives and measures.

    b. How the IDN objectives and measures will impact the administrative load for Medicaid providers, particularly insofar as plans are providing additional technical assistance and support to providers in support of IDN goals, or themselves carrying out programs or activities to further the objectives of the waiver. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with IDN funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

4. **Stakeholder Engagement:** How the state has solicited and integrated community and MCO/Medicaid service delivery contract provider organization input into the development of the plan.

Continued on following page

STC Spotlight: APM Roadmap Requirements

Per the STCs, the state's APM Roadmap must address the following areas (cont'd):

Continued from prior page

5. Managed Care Rates:

a. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by IDNs, including how up-to-date data on these matters will be incorporated into capitation rate development.

b. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with IDNs that the plans will undertake. How plans will be measured based on utilization and quality in a manner consistent with IDN objectives and measures, including incorporating IDN objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

6. Contracting Approach:

a. How the state will use IDN measures and objectives in their contracting strategy approach for MCO/Medicaid service delivery contract plans, including reform.

b. If and when plans' currents contracts will be amended to include the collection and reporting of IDN objectives and measures.

NH APM Transition Planning: Early Threshold Decisions for Consideration by the State

NH may consider several threshold decisions as it begins its APM transition planning process:

What needs to be 'paid for' in a post-DSRIP NH?

1. Which of the IDN investments being made under DSRIP will require additional long-term funding to be sustainable? (e.g., Core Competencies, services addressing social determinants of health)
2. Beyond the DSRIP waiver 's behavioral health-specific goals, what are the Departments other Medicaid delivery system reform priorities to be supported through payment reform?

How does NH define APMs?

3. NH has committed to moving *at least* 50 % of Medicaid payments to APMs, but what will the actual target threshold be and how should it be measured (e.g., % of payments to providers, % of members?)
4. What 'counts' as an APM? (e.g. do pay-for-performance models count? Upside-only models?)
5. Who can be the APM contracting entity on the provider side? (IDNs? Any provider?)
6. What is the population scope? (e.g., behavioral health population only? Physical and BH chronic population? all Medicaid beneficiaries?)
7. What can the state leverage from existing APM arrangements across the state (Medicare, Commercial)?

How prescriptive/flexible will the state be?

8. How should the Fall 2014 MCO re-procurement RFP process be used to gather information on how Plans might support the state in achieving its APM goals?
9. How prescriptive will the state be in mandating terms between MCOs and providers? E.g., will it mandate certain models be used or will the roadmap define a menu of options?
10. What role will the state play in dictating or defining quality metrics? (e.g. will the state require specific metrics, or develop a menu for plans/providers to choose from?)

Appendix: APMs and Required Provider Competencies

Why Develop an APM Strategy?

Considerations for plans and providers include:

	Advantages	Challenges
Plans	▪ FFS system has not controlled costs and contains conflicting incentives for plans and providers. VBP can align plan and provider incentives to improve outcomes and decrease costs.	▪ Requires ceding certain plan functions to providers, who may not have necessary infrastructure. ▪ Providers may not generate savings, leading to plan losses (which would vary based on the arrangement).
Providers	▪ Opportunity to gain more autonomy over patient treatment and management decisions at individual/pop levels ▪ Providers are compensated to keep patients healthy rather than on the number of billable visits. ▪ Market is shifting rapidly to VBP arrangements. Providers that build capacity now will reap rewards later.	▪ Providers must work as a part of a team to manage patient care. ▪ Requires new care management and IT capabilities. ▪ Requires financing to build new capabilities.

Building a APM Strategy Requires a New Set of Capabilities

Providers may assume responsibility for some or all of the following:

Provider Network Management	Clinical and Care Management	Financial Management	Governance and Corporate Structure	Analytics and Information
• Network identification • Provider contracting • Management of non-compliant physicians • Referral protocol development	• Clinical protocol and standards development • Managing network of providers across continuum of care • Care management and coordination capabilities • Link to social determinants of health • Identification of quality targets	• Reimbursement and shared savings distribution structures • Claims processing capabilities • Managed care contracting • Financial analysis and modeling	• Performance oversight • Quality reporting • Business planning and strategy • Legal and antitrust evaluation	• Metrics development and implementation • Populations analytics • Utilization monitoring • High-risk beneficiary identification • Data portals • Data privacy and security

APM Contracting Models: Capabilities Required

APM arrangements at higher levels of risk will require increasing provider capabilities

Less Risk → More Risk

Pay for Performance	Bundled Payments	Shared Savings/Losses*	Global Budget/Capitation
Provider Network Management	Provider Network Management	Provider Network Management	Provider Network Management
Clinical and Care Management	Clinical and Care Management	Clinical and Care Management	Clinical and Care Management
Financial Management	Financial Management	Financial Management	Financial Management
Governance and Corporate Structure	Governance and Corporate Structure	Governance and Corporate Structure	Governance and Corporate Structure
Analytics and Information	Analytics and Information	Analytics and Information	Analytics and Information

Level of risk can vary depending on arrangement

Level of Capabilities Required

Low | Medium | High

Note: *Shared savings arrangements with lower levels of risk may require fewer capabilities.

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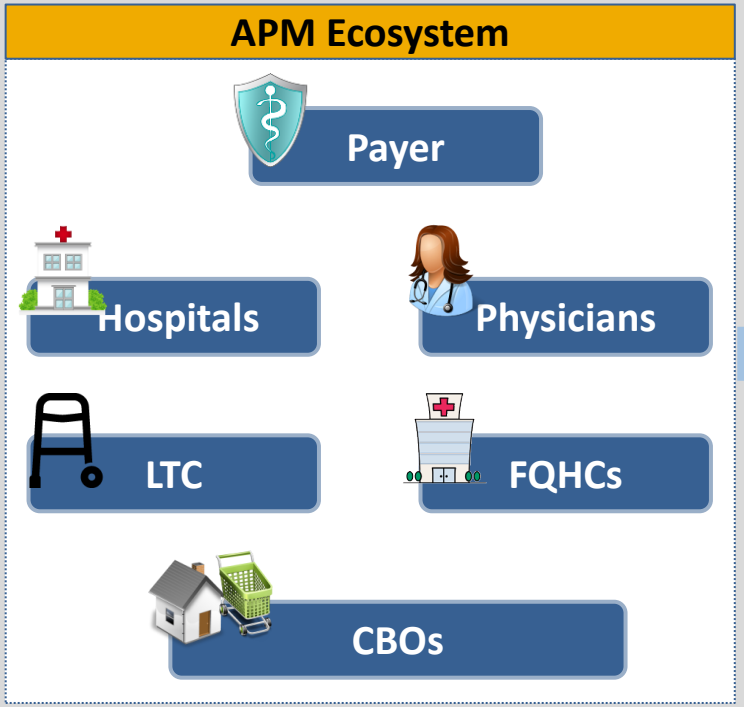
Lower-Risk APM Arrangements: Capabilities Required

APM arrangements with low levels of risk require modest upgrades of provider capabilities, which may include:

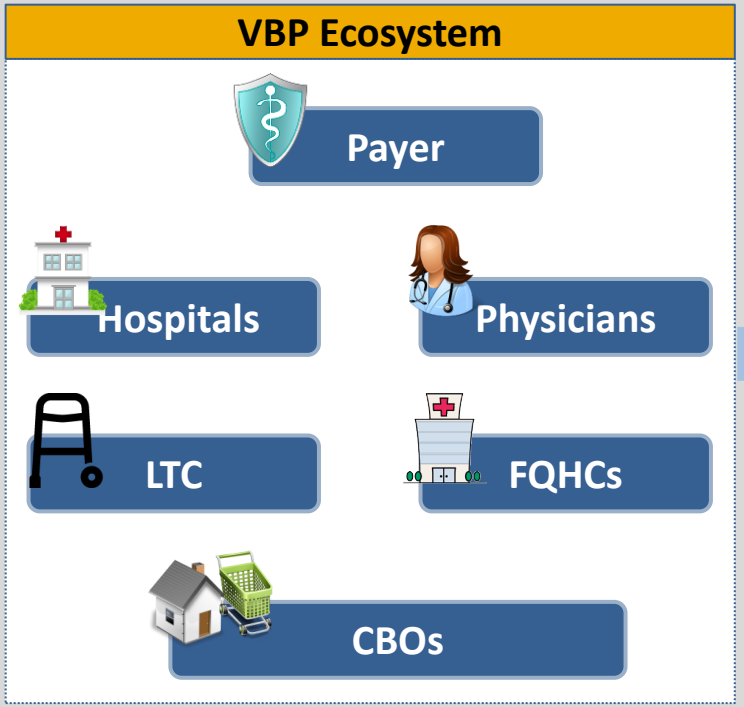


Potential Capabilities Required	
Provider Network Management	▪ Identify and manage network of providers that will participate in VBP arrangement.
Clinical and Care Management	▪ Develop care coordination protocols and processes across network. ▪ Identify shared quality targets.

Specific APM arrangements can differ widely even within the same contracting model. Required capabilities will depend on the terms of the arrangement.

Medium-Risk APM Arrangements: Capabilities Required

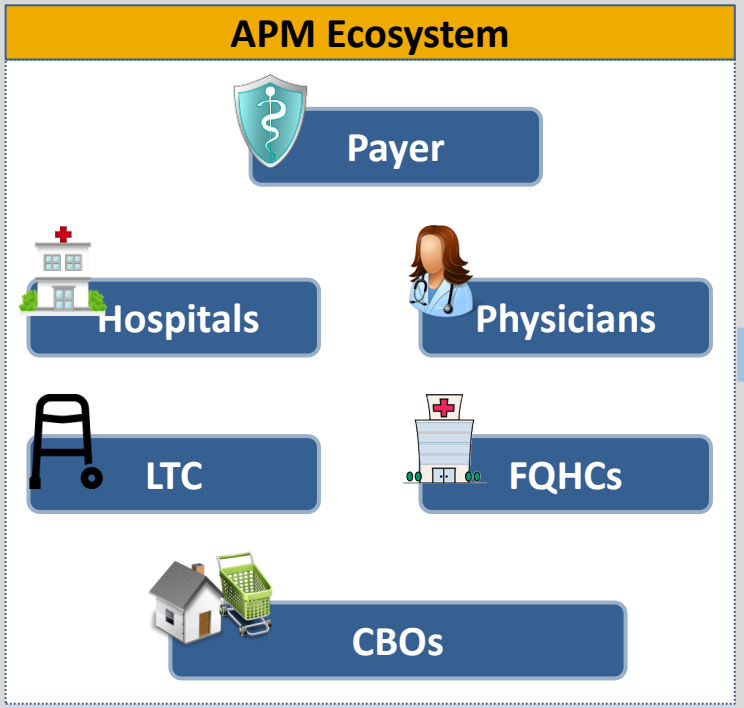
APM arrangements with medium levels of risk require substantial changes to provider capabilities, which may include:



Potential Additional Capabilities Required	
Clinical and Care Management	▪ Develop care management capabilities for highest risk patients including special needs populations. ▪ Basic ability to link to social determinants of health.
Financial Management	▪ Basic financial analysis and modeling to track spending. ▪ Ability to distribute funds across network of providers.
Analytics and Information	▪ Ability to identify and connect high-risk patients to care management and detect gaps in care
Governance and Corporate Structure	▪ Basic structure in place to perform oversight, compliance and business strategy functions.

Higher-Risk APM Arrangements: Capabilities Required

APM arrangements with higher levels of risk require major investment in provider capabilities, which may include:



Potential Additional Capabilities Required	
Clinical and Care Management	▪ Robust care management capabilities across continuum of care. ▪ Coordination with CBOs to address wide array of social determinants.
Financial Management	▪ Sophisticated financial modeling to track and project spending. ▪ Ability to pay claims (capitation only).
Analytics and Information	▪ Robust population analytics capabilities, including: ○ Systems to track utilization ○ Predictive modeling/risk scoring, ○ Geographic hot-spotting ○ Seamless provider access to care management and clinical data ○ Data security infrastructure
Governance and Corporate Structure	▪ Formal structure in place to perform oversight, compliance and business strategy functions.