APM.02 APM Quarterly Update Template

Instructions: Fill in the cells that are shaded yellow in this worksheet and in the APM reporting template. For questions on terms see the Definitions tab.

MCO Name & Contact Person/e-mail for questions on APM Report (note reporting time period and if you are using an incurred/date of service approach)		
Contract Year ("CY") Time Period for Reporting		

Alternative Payment Models are health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper (https://hcp-lan.org/groups/apm-refresh-white-paper/). See 'refreshed' APM Framework tab for a summary graphic.

Types of APMs (Subcategories)

Question	LAN APM Category	APM Types - Subcategories Select all that apply by putting an X in column C in each applicable row		APM Identifier Name and #: Please assign each APM an identifier # including a descriptive name and identifying number, e.g., Primary Care Medical Home, NHHF APM PCP 1	For each APM in this category, provide a brief description of type of providers/services involved (e.g. primary care, hospitals, maternity providers, etc.). May include additional APM detail such as noting provider payment arrangements that include multiple APMs or shared savings approaches that have not yet been reconciled.
Which types of APM payment models were in effect during any portion of the payment period.	2A		Foundational payments for infrastructure and operations		
	2B		Pay for Reporting		
	2C		Pay for Performance		
	3A		APMs with Shared Savings		
	3B		APMs with Shared Savings and Downside Risk		
	4A		Condition-specific population-based payment		
	4B		Comprehensive population-based payment		
	4C		Integrated Finance & Delivery System		

APM.02 MCO Quarterly APM Reporting Template

MCO Name:

TIMEFRAME FOR REPORTING (#Q, YR):

Instructions:

APM #	APM Name	APM LAN Category	Additional Description of Qualifying APM Type, e.g., total cost of care, PCMH, small provider, traditional capitation	Type of provider paid under APM	Define the type and # of attributed members served by this APM	Number of Providers Covered under APM (% of all)	Please describe in detail the APM formula for savings and how it is tied to quality/performance (use attachment if necessary)	Experience (months/years payment strategy in place)	Identify total performance-based payments made to providers during specified term under APM

* Please include specific payment metrics, including amounts and incentives on a separate sheet if necessary.

Identify quantitative clinical outcomes achieved during specified term under APM	What State Priority Does this APM impact and how?

APM.02
Quarterly APM Update Standard Template

First report due 7/31/2020 for data period 3/1/20 - 3/31/20

Row 5;	
Column A: "APM Number."	APM Number is the identifier assigned by the MCO to each APM model and can include letters and numbers but should be no longer than 12 symbols. This APM Number should be used consistently by the MCO as an identifier when reporting about the APM.
Column B: "APM Name."	The APM Name is the identifying descriptive name given by the MCO to the APM used consistently in communications with DHHS and providers.
Column C: "APM Category"	Enter one of the following categories: Fee for Service (FFS) (non-qualifying), 2A Foundational payments for infrastructure and operations (non-qualifying), 2B Pay for Reporting (non-qualifying), 2C Pay for Performance: Rewards Participating Providers, 3A APMS with Shared Savings, 3B APMs with Shared Savings and Downside Risk, 4A Condition Specific population based payment or Bundled Payment, 4B Comprehensive population-based payment, Traditional Capitation, Total Cost of Care, or Other APM (Describe). Categories are consistent with national published HCP-LAN framework.
Column D: "Additional Description of Qualifying APM Type"	Include further descriptive details regarding the type of APM model, e.g., total cost of care, PCMH, small provider, traditional capitation, CMHC case rate, bundled SUD treatment episode, etc.
Column E: "Type of provider paid under APM"	Describe the type of provider paid through the APM, e.g., primary care, specialty care, hospital, other facility, other provider, other ancillary services, or FQHCs, hospital emergency departments, etc. Please be detailed.
Column F: "Define the population and # of members served by this APM"	Describe the Medicaid population whose health or behavioral health services are paid through the APM (e.g., prenatal and pregnant women, children, etc) as well as the number of members attributed to the providers participating in the APM if applicable.
Column G: "Number of Providers Covered under APM (% of all)"	Detail the number of credentialled providers (and their groupings if practical) participating in the APM and the percentage these providers are of the total number of similarly situated credentialled providers in the MCO's network.
Column H: "Please describe in detail the APM formula for savings and how it is tied to quality/performance"	Detail the formula for determining risk and shared risk. Please also detail and identify cost and quality performance targets and their relationship to provider payments including earned incentives or disincentives, as well as the schedule for reconcilliation and incentive payment. Please include links or reference to how these formulas are communicated to providers if not provided in MCO APM Plan.
Column I: "Experience (months/years payment strategy in place)"	Identify for how many months the APM has been in place as a payment model.
Column J: "Results - identify $$ saved and $$ paid to providers including dates (i.e. shared savings/bonus payments/etc"	Quantify and detail the earned incentives or disincentives and amounts paid or recouped to or from providers in the APM as well as the time frame associated with such amounts.
Column K: "Results: quantitative clinical outcomes achieved"	Detail the results of quality outcomes associated with APMs
Column L: "What State Priority Does this APM achieve and how? "	Please use the "Reference State Priorities" tab as a guide.

Please Answer the Following Questions in approximately 500 words or less:	
What material changes in models, outcomes or results have occurred since the last quarterly reports? Why?	
What APM Models not currently part of your NH program are you interested in exploring in NH?	
What lessons have you learned from your NH APMs about what works and what doesn't in NH Medicaid?	
What models would you like to try in NH that you have explored in other states?	
What percentage of your overall revenue is linked to alternative payment models?	
What percentage of members are receiving care from a provider who is paid based on value, not volume?	
Can you demonstrate that the providers paid through this APM understand and are engaged in the outcomes?	

Definitions

Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper and the graphic included on the 'refreshed' APM Framework tab. https://hcp-lan.org/groups/apm-refresh-white-paper/
Category 2 APM (must be linked to quality)	Fee-for-service linked to quality. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics. Examples are described in more detail in other definitions and include: 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems 2C: Rewards and Penalties for Performance: Bonus payments/rewards and/or penalties for quality performance on specified measures, including those in DRG systems.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	Alternative payment methods (APMs) built on **fee-for-service architecture** while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are **based on cost performance against a target**, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are retrospectively eligible for shared savings, and those that do not may be held financially accountable. Examples include: 3A: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); Oncology COE with retrospective shared savings (no shared risk). 3B: APMs with upside gain sharing and downside risk: retrospective bundled payments with up and downside risk, retrospective episode-based payments with shared savings and losses; PCMH with retrospective shared savings and losses; Oncology COE with retrospective shared savings and losses.
Category 4 APM (excludes capitated payment models that are NOT linked to quality)	**Prospective population-based payment**. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Examples include: 4A: Condition-specific population-based payments, e.g. via an ACO, PCMH or Center of Excellence (COE), partial population-based payments for primary care, and episode-based payments for clinical conditions such as diabetes. 4B: Comprehensive population-based payments - full or % of premium population-based payment, e.g. via an ACO, PCMH or Center of Excellence (COE), integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care. 4C: Integrated Finance & Delivery Systems - global budgets or full/percent of premium payments in integrated systems
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A**]
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**]
Foundational spending	Includes but is not limited to payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category **2A**]
HCP-LAN APM Framework	Health Care Payment Learning and Action Network APM framework. http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf. Only APMs in LAN Categories 2C-4 are "qualifying APMs" but understanding the MCO glidepath and implementation of other APMs is included in the reporting obligation.
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B** if there is a link to quality**]**
Linked to quality	Payments that are set or adjusted based on evidence that providers meet a quality standard(s) or improve care or clinical services, including for providers who report quality data, or providers who meet thresholds on cost and quality metrics.
Pay for performance	The use of financial incentives to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. [APM Framework Category **2C** if there is a link to quality].
Payment Period	The twelve month period, applicable to the specified MCO reporting requirements.
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period including inpatient care and facility fees. [APM Framework Category **4A** if there is a link to quality].
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B** if there is a link to quality].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
Provider	For the purposes of this report, provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH/FCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.
Shared risk/losses	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
State Priorities	See "Reference State Priorities Tab"
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period including behavioral health and *excluding* directed payments.

Fee for Service (FFS)	Payment for unbundled and separate services. (non-qualifying)
Traditional Capitation	A set amount payment for each enrolled person assigned to them, per period of time, whether or not that person seeks care, regardless of quality of care delivered.
Total Cost of Care	A risk-adjusted payment that captures all costs of care for a defined population, including all professional, pharmacy, hospital, and ancillary care.

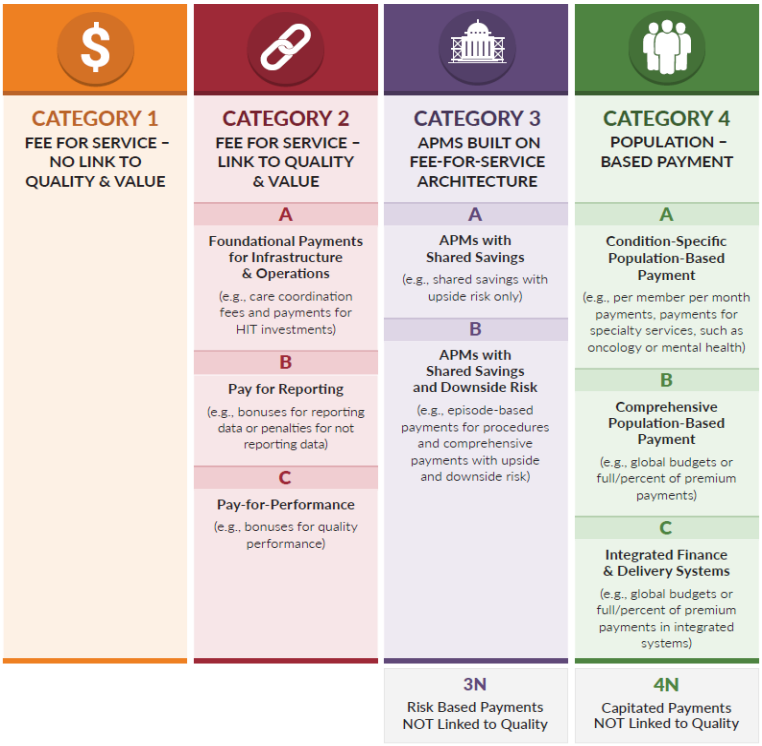
State Priorities
Opportunities to decrease unnecessary service utilization, particularly as related to use of the hospital Emergency Department (ED), especially for Members with behavioral health needs and among low-income children
Reduce preventable admissions and thirty (30)-day hospital readmissions for all causes
Improve the timeliness of prenatal care and other efforts that support the reduction of births of babies affected by prenatal drug or fetal alcohol exposure (including Neonatal Abstinence Syndrome)
Better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with Integrated Delivery Networks (IDNs) to advance the goals of the Building Capacity for Transformation waiver
Better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts to promote effective utilization, particularly reducing potential harm from polypharmacy, as described in Section 4.2.5 (Medication Management) of the MCO Contracts
Enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of the MCO Contracts)
Address social determinants of health
Address the needs of patients who are boarded in hospital emergency departments waiting for placements or services and reduce "ED boarding"
Address emerging public health trends identified by DHHS

Alternative Payment Models

THE APM FRAMEWORK

HCP LAN
Health Care Payment Learning & Action Network

This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.



hcp-lan.org *Refreshed 2017*