Value-Based Payment Toolkit

bailit health

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Table of Contents

Welcome!

Welcome to the ACAP Toolkit for Implementing Value-Based Payment (VBP). This toolkit is tailored specifically to ACAP-member plans interested in implementing value-based payment models with their contracted providers to improve health care quality and reduce overall costs.

Across the country, plans and providers are moving away from the traditional fee-for-service system in recognition that the fee-for-service reimbursement model has been a major contributor to the increasing costs of the US health care system. Fee-for-service rewards volume of highly priced services, does not incentivize coordination across providers, does not promote whole-person care, does not reward quality and in fact, can actually reward *poor* quality. Value-based payment is the global term that refers to any payment model that is not strictly fee-for-service and which rewards providers for delivering high-value care that is patient-centered, clinically-and cost-effective.

This toolkit is designed to guide Medicaid plans with step-by-step instructions, resources, examples, and considerations for implementing a VBP model with its contracted providers. It walks plans through getting ready to implement a VBP program, choosing a VBP model, implementing it with providers, and overcoming specific challenges to operating VBP in Medicaid programs. This toolkit was informed by interviews with health plans and providers who have implemented or attempted to implement many different value-based payment models, in addition to the authors' experience in consulting with plans and purchasers in the design and implementation of value-based payment models.

Instructions for the Toolkit

The main body of this toolkit is organized into four sections essential for designing and implementing a successful VBP program. Each section includes several action items and steps required to complete those action items.

This toolkit is designed so that plans can jump from one section to another to focus on action items that are of most interest, depending on where you are in VBP development. Click on items that are **underlined in blue font** to move to another section of the document with additional information on that defined term or subject.

While this toolkit presents information in a sequential order, the process of building a VBP program may be iterative. It is not necessary to complete every step to implement a VBP program (though, some are required, like provider contracting) and it is not necessary to complete the steps in the order in which they appear in this toolkit.

Throughout this document, the following icons are used to indicate key parts of this toolkit.

- Checkboxes indicate action items. Once you've completed the task, you can click on the box to mark it complete.

- This icon indicates a cautionary note that plans should carefully consider when building their VBP program.

- This icon indicates a best practice or a suggested approach.

- Last, a list of resources and a glossary of definitions is provided. Terms that are appear **like this** are defined in the glossary.

As a supplement to this toolkit, four previously-recorded VBP webinars are available for review and cover the material included in this toolkit. They can be accessed **here**.

Glossary of Terms

Attribution: Attribution is the statistical or administrative methodology and process of assigning members to providers for the purposes of calculating health care costs and quality of care measures for that population.

Capitation: Capitation is when one or more providers receives a lump sum payment at the beginning of a set period of time for a specific set of services of an attributed population.

Episode-based Payment: Episode-based payment is a fixed dollar budget target (or payment amount) that covers a set of services for a defined period of time. There are generally two types of episode-based payments:

- acute care episodes or events, which include services related to a condition or procedure (e.g., joint replacement, URI, colonoscopy, pregnancy & delivery), and
- chronic condition episodes, which include services for a fixed amount of time related to a chronic condition (e.g., one year's worth of care for a diabetic member).

Gate: Performance benchmark(s) that a provider must meet or exceed for the provider to receive a specific incentive payment.

Ladder: Provider incentives that vary in a step-wise fashion (either up or down) based on performance against multiple levels of established performance benchmarks. Ladders can be set to establish percentages of supplemental payments distributed, pay-for-performance incentives distributed, portion of shared savings distributed, or portion of shared risk a provider must bear.

Pay-for-Performance: Pay-for-performance (P4P) payment models offer providers a financial bonus for attaining pre-established targets of performance excellence or improvement on specific measures (e.g., access, quality, efficiency). In some cases, pay-for-performance programs include financial disincentives (e.g., eliminating payments for negative consequences of care or reducing payments for poor performance on specific measures).

Population-based Payment: Population-based payment (PBP) involves defining a budget / target on a *per-capita* basis for a broad population of patients for whom the provider assumes clinical and financial responsibility.

Shared Risk: A risk arrangement that allows providers to share in a portion of any realized net savings they generate in a given time period compared to a spending target and requires providers to share in a portion of expenses when exceeding spending targets.

Shared Savings: A risk arrangement that allows providers to share in a portion of any realized net savings they generate in a given time period compared to a spending target.

Supplemental Payment: A payment model that involves additional per member per month (PMPM) payments to qualifying providers to support specified activities, including: non-reimbursed services (e.g., high-risk patient care management); infrastructure development (e.g., electronic medical record (EMR)), and operations (e.g., quality measurement and reporting).

Total Cost of Care (TCOC): Total spending on services from which shared savings and shared risk rates are based. TCOC benchmarks approximate the costs and resources used to treat identified populations for a defined set of health care services, such as all professional, pharmacy, hospital, ancillary care and administrative payments. TCOC does not always include all services, as some plans may carve out high-cost services or rarely used services to protect providers from costs they may not be able to control.

Section I.

Getting Ready for VBP

As the market shifts toward value-based payments, health plans must be ready to design, negotiate, and implement these complex reimbursement models. Health plans will require strong leadership to support change management, staff with new skills, and the tools to support the plan and its staff with value-based payment.

Summary of Action Items in Section I

- ☐ **Identify and Engage Senior-level VBP Champion(s)**
- ☐ **Identify and Engage Your VBP Team**
- ☐ **Define Your Plan's Value Objectives**
- ☐ **Consider Market Forces and Your Ability to Negotiate Alternative Payments**
- ☐ **Stay Abreast of Federal and State VBP Requirements**
- ☐ **Develop Robust Data Analytical Capability**
- ☐ **Understand your Budget Constraints**

Action Item 1: Identify and Engage Senior-Level VBP Champion(s)

Leadership is a critical element of success for health plans engaging in value-based payment. Leaders with strong vision and ability to manage change both internally and externally are required. Plans that have successfully negotiated value-based payment arrangements have made it a top priority within the executive suite. Community Health Choice, for example, has the Executive Vice President and COO leading its **episode-based payment** program pilot. This is important for trust-building with providers and an important component in managing the change in operations within the plan.

> ***"Value-based payment is not a drill."***
>
> – Medicaid health plan representative

Plan leadership needs to ensure that the value-based payment strategy is employed in a supportive manner across all internal business functions. Carefully consider who will participate in the development of the VBP model and how and when they will participate, including:

a) internal staff (clinical quality, data, provider contracting, finance, project management), and
b) external provider representatives, provider champions, and members.

Action Item 2: Identify and Engage Your VBP Team

Plans should form a multidisciplinary team responsible for managing the implementation of a VBP, the ongoing operations, and for engaging providers in value-based payment.

The VBP team might consist of:

- senior leaders who have decision-making responsibilities;
- provider relations staff who have "on the ground" knowledge of the providers;
- contracting staff who will negotiate the final details of a contract;
- clinical staff, particularly for payment models that are clinically-focused such as PCMH and **episode-based payment** models;
- quality management staff who help develop a quality strategy and discuss issues surrounding quality measurement with providers;
- analytical and/or financial staff who can interpret any data the plan might share with providers;
- business, finance, and project management staff who can manage the internal operations of implementing and operating a VBP, including monitoring the fiscal impact to the plan and providers, and
- any staff able to articulate responses to questions regarding the methodology of the payment model being proposed.

When this team, or a subset of this team, meets with providers, it is important that the plan ask providers how the value-based payment methodology being proposed might impact providers' operations, including clinical and administrative operations. The plan should be willing to work to identify solutions to provider challenges that might arise.

For more ideas on employee functions in a VBP context, **see this Alternative Payment Business Leader job description** from CareOregon.

Note: Entering into value-based payment contracts with providers might take a significant amount of time, so it is important to plan in advance and engage providers early. This is especially true if the providers that a plan is targeting are not experienced with value-based payment models.

Action Item 3: Define Your Plan's Value Objectives

Prior to embarking on a new VBP initiative your leadership team should consider what your objectives are for a value-based payment. For example, your value objectives might include:

- improving care coordination, including transitions of care;
- reducing overutilization, underutilization, and misuse of service by measuring and reducing unwarranted practice variation;
- specifically focusing on improving care for certain high cost, high care populations;
- improving quality by closing care gaps (difference between best practice and actual practice);
- addressing social determinants of health;
- empowering patients, and
- reducing health care cost growth.

These value objectives will help you decide which value-based payment to pursue, and how you should construct them.

Action Item 4: Consider Market Forces and Your Ability to Negotiate Alternative Payment Arrangements

Many value-based payment programs are complex where details matter. Plans need strong contracting staff with the skills required to negotiate value-based payment arrangements within the parameters of the health plan strategy.

- Some plans are designing value-based payment programs that seek consistency in all program design elements across providers to better leverage internal resources and streamline operations. As one Medicaid health plan official noted, "Everything impacts business operations." He recommended that "Plan standardize VBP rules and types of models. Plans need to consistently produce reports and make payments." This type of standardized VBP approach is a strategy works better with plans with significant market power and in cases where plans are working within state requirements for implementing specific VBP models with defined components.

- On the other hand, some plans are negotiating collaboratively with providers and making provider-specific tweaks (within a set of parameters) or pilot programs that meet providers where they are and foster relationships within its provider network. This strategy might be useful for plans that seek to strategically align with certain providers, or for those in markets where providers have more market power. For an example of how this approach has been used in **episode-based payment** programs, see the discussion of "negotiable" elements in an **episode-based payment** program, in the **ACAP Toolkit on Episode-Based Payment Programs.**

For more information on provider contracting, see the **"Contract with Providers"** action item in "Section III: Implementing VBP with Providers."

Action Item 5: Stay Abreast of Federal and State VBP Requirements

Designate staff to stay abreast of state contractual requirements and federal regulations related to VBP. The landscape of value-based payment is changing rapidly and both the Center for Medicare and Medicaid Services (CMS) and state governments are taking a closer look at strategies they can employ to encourage the movement away from traditional fee-for-service payment. It is important for plans to stay abreast of any new or proposed state requirements that require Medicaid MCOs to implement value-based payments.

- In areas where state government is more active, some states require that a percentage of health plan medical expenses (or members, or contracted providers) are associated with some sort of value-based payment. Some states specifically define payment models that plans must operationalize, while others provide some or no guidance to plans on the types of payment models to be implemented. **"Appendix A: Summary of Medicaid MCO VBP Requirements in ACAP-Member States"** includes a summary of states where ACAP plans operate and their Medicaid MCO VBP requirements as of mid-2016.

- Likewise, providers and plans are closely watching **MACRA**[1] regulations unfold. Whether or not a health plan has a Medicare line of business, Medicare has generally set the tone for health care reimbursement and the MACRA definitions of value-based payment (or "qualifying alternative payment models") might set the course in providers seeking alignment across different payment models. **Click here for more information on CMS VBP initiatives and requirements**.

Action Item 6: Develop Robust Analytical Capability

It is critical for a health plan to think strategically about its analytical capabilities and ensure that it has tools to manage "big data" to support the operations of the plan and providers engaged in value-based payment. Without sophisticated data analytics, neither providers nor payers can effectively assess—or successfully operate under—a value-based payment program.

> *"The value of a health plan is providing sophistication in terms of tools, data and transparency."*
>
> – Medicaid health plan representative

[1] The *Medicare Access and CHIP Reauthorization Act of 2015*.

☐ Step 1: Model Scenarios to Support Plan Strategy.

Value-based payment programs and financial arrangements between plans and providers fundamentally change the reimbursement model. Before any value-based payment is implemented, it needs to be modeled to ensure that it has the possibility of being financially viable to plans and providers. This modeling usually requires sophisticated data analysis conducted by health plan staff and/or by consultants.

☐ Step 2: Invest in Analytical Platforms and Processes to Support Provider Engagement.

Plans have pointed to analytical platforms that can produce actionable reports to assist plans in understanding the care needs of the population for which they are held accountable for under the value-based payment arrangement. For example, plans should provide:

- Provider performance information on quality indicators against benchmarks, or prior performance periods;
- Financial information on costs relevant to the payment model (e.g., total medical expense trend for **total cost of care** models, or episode-cost trend for **episode-based payment models**), and
- Reports on other key topic areas that could spur action to improve quality and reduce cost such as:
    - predictive modeling of high-risk patients;
    - avoidable Emergency Department (ED) visit opportunities, by condition;
    - medication refills, and
    - gaps-in-care reports.

In addition, plans can consider giving providers access to plan data from a web portal. These portals give providers access to important health plan data that allow providers to improve their patient care, and oftentimes, also serve as a platform for providers to transfer data for health plan use. Investing in analytical platforms need not be done when testing new payment models, but should be a consideration when seeking to sustain and expand advanced value-based payment models.

☐ Step 3: Invest in Internal Data Analytics Staff.

Plans report that value-based payment programs require skilled analytical and data support infrastructure staff that can assist plans and providers in understanding what data can be leveraged by the plan, and what data are critical for the provider to share with the plan.

Internal data analytics staff should be skilled in managing complex data sets, able to interpret and analyze clinical data, and able to develop and interpret quality and cost performance measurements at the provider level.

☐ **Step 4: Request Providers to Submit Data; Make It Easy for Them to Do So.**

It is often the case that when first starting value-based payment models, health plans may not have all of the required data to measure quality performance. Some plans include quality measures in the first year of the program that are for reporting purposes only. This allows plans time to gather the data for the purposes of setting benchmarks, and gives providers the opportunity to identify efficient ways to collect and submit the data. Plans should also consider using standardized measures to make data collection and performance measurement more likely (though not guaranteed!) to be consistent across providers' plans.

☐ **Step 5: Don't Let Perfect Be the Enemy of Good.**

Recognize that plans and providers might be experimenting with value-based payment models without perfect information. This is okay, and a critical reason why plans should be flexible, and maintain a willingness to regularly meet with providers as they gain more experience in operating under a value-based payment model. This also helps to build trust among providers, which is an essential element to health plan success.

Action Item 7: Understand Your Budget Constraints

Plans must carefully consider the cost to operating value-based payments. Some plans incur increased administrative expenses for the resources needed to design, implement and maintain one or more value-based payment arrangements with providers. One way to reduce increased expenses, to the extent plans can, is to standardize payment models with other payers in the market, or model payment models off of other proven approaches that may not be currently operating in your market. Some plans consider the administrative burden of administering payment models before choosing a model they wish to pursue.

Alternative Options to Building Internal Data Capability

Perhaps your plan is not ready to invest in home-grown data analytics in a significant way without some testing of the waters under VBP arrangements. There are several vendors that can assist plans with VBP arrangements under contract. These vendors can use their own software programs to manipulate plan data, create provider portals, and plan and provider specific reports for analysis. It is important to consider the costs of these vendors compared to the costs a plan would incur on its own.

Section II.

Choose Your VBP Model(s)

Health plans need to choose which payment model to develop and ultimately implement based on its value objectives. However, a plan should also strongly consider its own **analytical capabilities** and for which type(s) of payment models providers might be **ready**.

Regardless of which VBP model you choose:

- be realistic and clear about the process, the resources required, and your expectations;
- document your VBP approach including goals, timelines, measures, and data sources, and
- maintain a two-way dialogue with providers throughout the process.

This section describes four types of VBP models, their pros and cons and key decisions that need to be made to implement each payment model. If you already know which model you want to explore, click on the links below to go directly to the related section. If you're unsure, consider reading through all of the model descriptions.

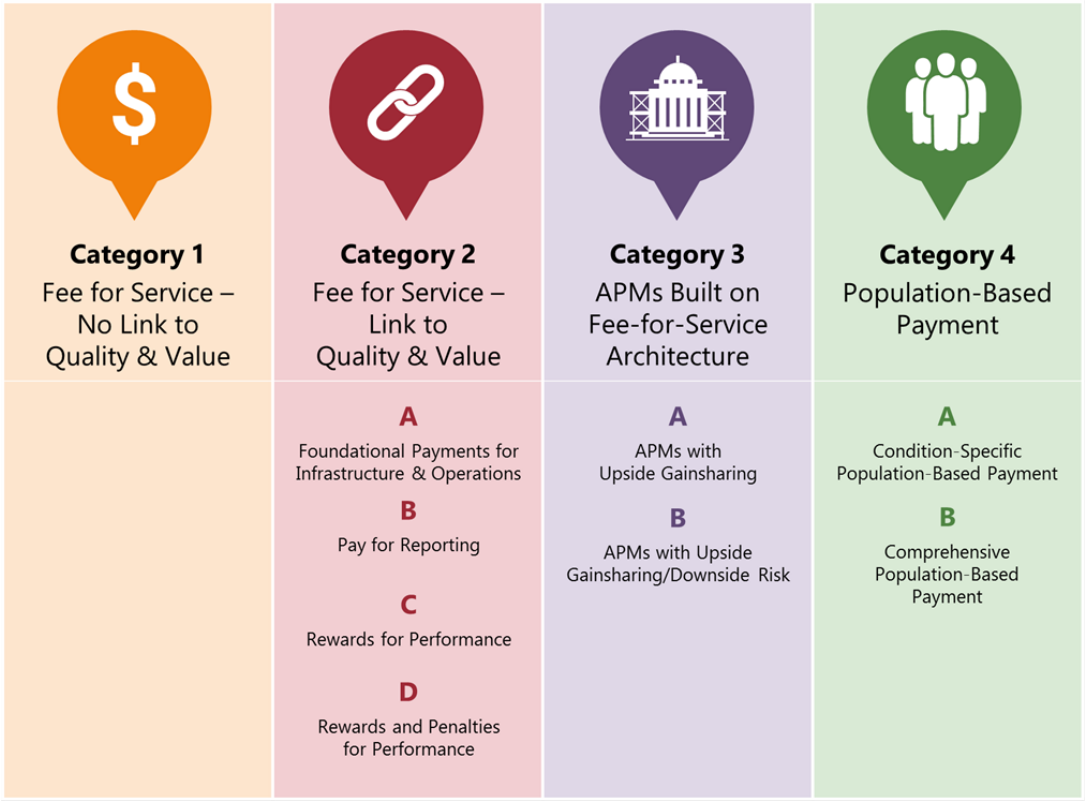
This toolkit addresses four types of VBP models:

- **Supplemental Payment Models**
- **Pay-for-Performance Models**
- **Episode-based Payment (Bundled Payment) Models**
- **Population-based Payment Models**

A wide variety of VBP initiatives are being implemented simultaneously in the public and private health care sectors, and consistent terminology remains a challenge. The Health Care Payment-Learning Action Network (LAN) was launched by the U.S. Department of Health and Human Services as a public-private partnership to advance the work being done across sectors to increase the adoption of value-based payments. The LAN has established a framework that identifies categories of value-based payment models. Additional information is available in a 2016 **LAN APM Framework white paper**.

As of the summer of 2016, a number of states are considering or requiring Medicaid MCOs to report on their use of VBP using the LAN framework, or a modified version of the framework. In addition, in mid-2016, ACAP encouraged its member plans to participate in the LAN's first national VBP data collection effort. Therefore, throughout this toolkit, we will refer to the following "LAN Categories" when describing the payment models.

LAN APM Framework Overview



Before You Choose Your VBP Model(s)

As you review this section of the toolkit related to different types of VBP models, consider:

- the populations, services, and providers which may present the greatest opportunity for your plan to achieve its defined value objectives;
- how each VBP model might work to improve care and costs of care for different Medicaid populations or subpopulations such as: traditional Temporary Assistance to Needy Families (TANF) populations, Aged, Blind and Disabled (ABD) populations, pregnant women, foster care children, Medicaid expansion adults, and persons dually eligible for Medicaid and Medicare, members with behavioral health needs;
- your data on provider entity structure, financial arrangements, and the distribution of your membership among providers, and
- providers that might be important to contract with under a value-based payment model based on your current financial arrangements with them, their VBP experience, capacity, and readiness as well as their current performance.

Plans operating in states with specific state-defined VBP thresholds should consider which type(s) of VBP model(s) would best enable the plan to meet state expectations and the plan's

value objectives – within budget constraints. Realize that it may make sense to implement a combination of VBP models over time, or one model with one group of providers or members (e.g. PCMH with PCPs) and a different VBP model with another group (e.g. maternity episode with OB-GYNs and hospitals). For information on Medicaid MCO VBP requirements in States with ACAP member plans, see **"Appendix A: Summary of Medicaid MCO VBP Requirements in ACAP-Member States."**

If your Medicaid agency has specific VBP thresholds for plans, pay close attention to how the thresholds are defined when considering your VBP model(s). Different types of threshold targets will drive you to certain VBP approaches in order to get sufficient volume of medical expenses, providers, or members as applicable to meet the targets.

If your contracted providers are required to participate in specific federal or state VBP programs, consider how your plan can best align with those models. Even if alignment is only along the quality performance metrics, rather than the payment metrics, leveraging broader VBP initiatives and simplifying administrative reporting issues for providers will help your VBP approach be more successful.

Now, let's go through details on the four types of VBP models. We urge you to keep an open mind. Consider the model definitions, pro and cons, why you might choose that type of model, and decisions to be made when designing each model. Finally, review the examples to learn more about how other plans have implemented similar VBP arrangements.

VBP Model 1: Supplemental Payment

Definition: This model involves additional per member per month (PMPM) payments to qualifying providers to support specified activities, including:

- non-reimbursed services (e.g., high-risk patient care management);
- infrastructure development (e.g., electronic medical record (EMR)), and
- operations (e.g., quality measurement and reporting).

LAN Category 2A:
Foundational Payments for Infrastructure & Operations

*Note: Supplemental Payment Models can be (and often are) combined with other payment models

The PMPM payments in these models are based on **attribution** to specific providers and sometimes vary based on patient characteristics reflecting risk. **Supplemental payment** models used by plans are common with, but not limited to, providers participating in Patient-Centered Medical Homes (PCMH).

VBP Model 1: Supplemental Payment

Pros	Cons
▪ Patient-centric ▪ Reduces impact of FFS-based incentives linked to volume for reimbursed services ▪ Provides practices with financial means to help maintain infrastructure and provide services for which there would otherwise be no funding. – Especially important for small, independent practices and less-resourced practices. – Can be focused on certain investments, such as: patient registry management, data analysis, practice coaching, and reporting on quality measures. – Can support traditionally non-reimbursable services, such as: care management, care coordination, e-visits, and can be targeted to supporting patients with complex care needs to improve care and lower overall costs of care.	▪ Typically modest PMPM sums, limiting impact on practice. ▪ Payment model does not *usually* promote accountability for quality or cost management. Often no accountability for funds, nor financial motivation to deliver better care unless linked with a complementary payment model.

Why Choose a Supplemental Payment Model?

A **supplemental payment** model is a good option for plans and contracted providers new to VBP. In addition to supporting care management and population health efforts, this model can help build capacity in your contracted network to successfully engage in more advanced VBP models in the future. Supplemental payments are also often used in conjunction with other VBP models as a complementary strategy, giving providers, for example, ACOs, the needed access to some prospectively paid funds to support the ongoing expenses of coordinated care.

What Decisions Need to be Made to Design a Supplemental Payment Model?

☐ **Step 1: Determine the Strategy for the Supplemental Payment.**

The first task to designing a **supplemental payment** is to determine what actions or activities is the health plan trying to promote with its providers. For example:

- support care management and other priority functions not typically reimbursed within FFS payment structures;
- promote the development of infrastructure and operations at the practice level, and
- provide practices with financial support to address costs incurred to transform clinical operations.

Identifying the specific action or activity will help you then determine how to value the supplemental payment.

☐ **Step 2: Determine Which Members Will Be Counted in the Supplemental Payments to Providers: All Members or a Subset of High-Risk Members?**

Depending on the strategic goal of the supplemental payment, you may count all or only a subset of members to be counted for the supplemental payment model.

- For example, if the plan is attempting to improve the care coordination of high-risk pregnant women, the supplemental payment may be directed only to providers who care for members who are pregnant.
- If your objectives include helping practices transition to PCMH certification or to function as a higher level PCMH, you might want to consider a broader program with supplemental payments applying to a larger number of members in a participating practice.

☐ **Step 3: Attribute the Targeted Patient Population to Providers.**

Whether the supplemental payment is for primary care or other services, it is necessary for patients to be attributed to providers for the purposes of distributing a supplemental payment. There are there are several ways in which patient **attribution** could be handled. For more information on patient attribution, see **"Identify an Attribution Methodology"** action item in "Section III: Implementing VBP with Providers."

☐ **Step 4: Determine 'Value' of the Supplemental Payment.**

When valuing a supplemental payment (meaning, determining whether it will be $1 or $100 PMPM) you could consider estimated costs practices incur for the target objective.

- If the plan is targeting high-risk pregnant women, it could consider the added costs of the services offered to those pregnant women (e.g., care management support, doula support, peer support, etc.).

A plan may also consider varying the supplemental payment by patient risk factor. For example, a tiered PMPM payment could vary based on a patient's Medicaid eligibility category (e.g., non-disabled adult, ABD, dual eligible). Payment could also vary by the number of chronic conditions a patient has, or social determinants of health (e.g., homelessness). This approach recognizes that it make take more or less effort for a primary care practice to adequately coordinate the care of certain populations of individuals, but requires data to accurately stratify payment based on the plan's objectives.

You might also consider existing "market rates" for PMPM payments in other programs, such as what other payers, or the state may already have established in multi-payer patient-centered medical home programs.

The value of a PMPM might also vary based on practice characteristics, which may not be mutually exclusive:

i. PCMH certification or recognition level;
ii. size of practice/attributed panel size;
iii. performance on quality measures, and
iv. patient populations.

According to prior research, **supplemental payments** in PCMH programs have ranged in value from: **$0.50 - $9.00 PMPM**.

☐ Step 5: Determine How the Supplemental Payment Model May Be Incorporated into Other Value-based Programs.

A supplemental payment alone is not considered to be a "value-based." The fundamental difference between a supplemental payment and a value-based payment is the incorporation of quality. Supplemental payments are sometimes part of a larger value-based payment model. There are several approaches a plan can take to convert a supplemental payment to a value-based payment.

- **Vary the supplemental payment by performance on quality indicators.** For example, ACAP member plan CareOregon varies its PMPM payment to patient-centered medical homes by their performance on a menu of quality measures, from which the providers can choose. **Click here for a fact sheet** with more specific information on the CareOregon primary care payment model.

- **Incorporate supplemental payments into a shared savings model.** ACAP-member plan CareSource participates in a multi-payer collaborative in Ohio in which primary care providers receive a supplemental payment for care management and share in savings with the plan based on **total cost of care**.

- **Put part of the supplemental payment at risk.** Under Medicare's **Comprehensive Primary Care Plus (CPC+)** demonstration, which launches January 2017 in 14 states[2], CMS and other payers will provide prospective monthly care management fees (CMFs) to practices based on beneficiary risk tiers. As highlighted in the table below, the Medicare CMFs will average $15 per-beneficiary per-month (PBPM) across 4 risk tiers in Track 1. In Track 2, the Medicare CMFs will average $28 PBPM across 5 risk tiers, which includes a $100 CMF to support care for patients with the most complex needs. Practices may use this enhanced, non-visit-based compensation to support augmented staffing and training needed to meet the CPC+ model requirements according to the needs of their Medicare attributed patient population. However, practices must repay a portion of the CMFs if they fail to meet predetermined performance targets.

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1st quartile HCC	$6	$9
Tier 2	2nd quartile HCC	$8	$11
Tier 3	3rd quartile HCC	$16	$19
Tier 4	4th quartile HCC for Track 1 75-89% HCC for Track 2	$30	$33
Complex (Track 2 only)	Top 10% HCC OR Dementia	N/A	$100
Average PBPM		**$15**	**$28**

VBP Model 2: Pay-for-Performance (P4P)

Definition: **Pay-for-performance** payment models offer providers a financial bonus for attaining pre-established targets of performance excellence or improvement on specific measures (e.g., access, quality, efficiency). In some cases, pay-for-performance programs include financial disincentives (e.g., eliminating payments for negative consequences of care or reducing payments for poor performance on specific measures).
Typically, **P4P** is layered on top of FFS payment arrangements.

LAN Category 2C:
Rewards for Performance

Or

LAN Category 2D:
Rewards and Penalties for Performance

[2] Arkansas, Colorado, Hawaii, Michigan, Montana, New Jersey, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Greater Kansas City Region, Northern Kentucky, and Greater Philadelphia.

In a P4P arrangement, the plan uses administrative or claims data to evaluate provider performance on different types of metrics such as:

- processes and activities to improve patient health outcomes;
- patient satisfaction about the quality and delivery of care;
- structural aspects of provider entities such as certain personnel, electronic medical records, or other equipment; and
- patient health outcomes.

VBP Model 2: Pay-for-Performance

Pros	Cons
▪ Counters the exclusive emphasis of FFS payment on volume to address performance. ▪ In addition to direct financial incentives, rewards can include increased patient volume, public recognition and exemption from administrative requirements.	▪ Rewards must be large to counter the FFS volume incentive. ▪ Often focus on quality with very little, if any, consideration of cost and efficiency. ▪ Hard to measure provider performance if patient counts are low – problem for plans with small market share and with specialists. ▪ Spotlight on one area can remove focus from other areas that might be just as important, but harder to measure. (*Note: This limitation applies to all VBP models with quality incentives.*)

Why Choose a Pay-for-Performance (P4P) Model?

P4P models help plans counter the powerful volume incentive created by FFS payment and recognize and reward providers based on performance. The purpose of P4P programs is to use financial incentives to "move the quality needle" in a deliberate and strategic manner. Simply requiring providers to meet standards does not achieve excellence. There are otherwise few external incentives for plans or providers to invest in quality improvement.

Plans and provider chose P4P models because they can be implemented on top of an existing FFS payment model and can be relatively simple to administer. They can also be implemented on top of a **capitation** model. Many plans have been measuring provider performance, particularly in areas where the plan itself faces performance incentives from the Medicaid agency. The P4P model gives plans a way to align provider performance incentives with plan incentives and to reward providers based on their performance to targeted areas.

You could consider a P4P bonus as a viable strategy in the following situations:

- As a transition step on the path to more meaningful payment reform for providers with no VBP experience, and
- For providers for whom other VBP models might not be viable options, such as practices serving smaller numbers of plan members, some physician specialties and other specialized services, and providers with relatively low capitalization.

What Decisions Need to be Made to Design a P4P Model?

☐ Step 1: Narrowing the Target for P4P Incentives.

The first step in developing a **P4P** program involves deciding where to focus your quality improvement efforts. With numerous opportunities for improvement in health care, the challenge for plans involves narrowing the target. You and your providers have limited time and resources to focus on quality performance initiatives. The **"Incorporate Quality into your VBP Model"** action item in "Section III: Implementing VBP with Providers" provides detail on six ways to identify appropriate quality measures that could be included in your P4P program.

☐ Step 2: Determine the Type of Provider(s) on which to Focus.

A P4P program can target a number of different types of providers and provider organizations, including:

- Integrated delivery systems;
- Physician-hospital organizations;
- Hospitals;
- Medical groups, and/or
- Individual physicians (PCPs or specialists).

When determining which providers to include in a P4P model, consider:

1. Which types of providers drive quality in the targeted area(s)?
2. Do these providers work independently or in multi-disciplinary teams?
3. With which providers does the plan have sufficient membership volume to both measure performance and to have more meaningful P4P incentives?
4. Can the plan increase your P4P leverage by collaborating with other payers, including Medicare or your state Medicaid agency?

☐ Step 3: Determine How to Measure Provider Results.

Clearly define P4P measures and targets in advance of implementing any payment changes. Explicitly state how provider performance will be measured, the exact measurement period, and what sources of data will be used.

- For each P4P measure, set improvement targets that are a stretch, but still achievable. Consider whether to use provider-specific performance goals or uniform standards across all providers. This will depend, in part, on variation in the baseline performance of the providers, as well as the relative size and demographics of participating providers' patient panels.
- There are three ways to determine provider performance on quality and patient experience measures, which can be and often are used in combination with one another. For more information, see Step 3, "Determine Performance on Quality," under the **"Incorporate Quality in your VBP"** action item in "Section III: Implementing VBP with Providers."

☐ Step 4: Determine the P4P Incentive Payment Details.

To effectively motivate providers to improve, the number, range, and difficulty of targeted performance measures must be comparable to the power of the incentives being offered. Remember that financial incentives can include quality bonuses or penalties. Many health plans that start **P4P** programs phase it in by first reporting on performance at the provider level and/or paying providers for reporting, before actually paying for performance. You may wish to do the same thing if your providers are not used to reporting on quality measures. If they are, you can skip this step and move straight to paying for performance.

Determine the size of your P4P funding pool, consider the number of targeted improvement measures, the difficulty of the expected improvement, and the number of eligible providers. Decide on the P4P payment frequency (at least twice a year) and algorithm to be used to recognize provider improvement. Consider a P4P payment system that rewards providers who show significant improvement, providers who hit target benchmarks, and providers who maintain a level of performance excellence. Determine whether and when to link performance on some measure to financial disincentives, e.g., eliminating payments for negative consequences of care or reducing payments for poor performance on specific measures.

Note: Consider a range of complementary financial and non-financial incentives related to the targeted provider performance. Non-financial incentives (which may have indirect financial implications for providers and only administrative costs for plans) include:

- *Provider performance profiling,*
- *Publicizing and recognizing provider performance,*
- *Practice sanctions such as restricting a provider's panel size for low-performing providers,*
- *Practice rewards such as increasing default assignment for high-performing PCPs, and*
- *Technical assistance for quality improvement.*

☐ Step 5: Clearly Define the P4P Timeline.

When developing a P4P timeline, clearly establish baseline provider performance and the period of time during which provider performance will be measured. Consider major changes in your provider contracts and networks likely to affect performance or data over time. Minimize potential challenges by coordinating measurement periods with other key events such as Medicaid program changes.

Consult with providers to ensure the timeline is realistic and achievable in terms of both implementation and obtaining desired performance improvements. Talk to both the operational and clinical staff at provider organizations, since each group is likely to have different perspectives and competing priorities for their time.

*Note: Like other VBP programs, **P4P** models require a multi-year financial commitment from the plan, available staff expertise, data, and resources. Carefully consider what plan resources will be designated and what types of external assistance your providers might need. For more information on provider readiness, see the **"Assess Provider Readiness"** action item in "Section III: Implementing VBP with Providers."*

Examples: Since P4P examples differ depending on the types of providers being targeted, this toolkit provides one hospital P4P example (Medicare) and one primary care P4P (San Francisco Health Plan).

Hospital P4P Example: Medicare's Hospital Value-Based Purchasing Program. CMS has increasingly used P4P programs to reward or penalize acute care hospitals for quality of care to Medicare beneficiaries. The quality domains include measures related to clinical process of care, patient experience of care, efficiency, and outcome. Medicare withholds payments to participating hospitals by a specified percentage, and uses those funds for bonus payments based on how well a hospital performs on identified quality measures. A hospital's score is based on points for achievement of excellence and for improvement relative to other hospitals.

One of the challenges for Medicaid plans considering similar P4P arrangements is that many of the hospital performance measures are specific to care for Medicare beneficiaries and not applicable to the majority of Medicaid beneficiaries. **Click here for more information on Medicare's hospital VBP program**.

Primary Care P4P Example: ACAP member **San Francisco Health Plan** began a P4P program called the Practice Improvement Program (PIP) in 2011 to improve patient experience, improve population health, reduce per capita cost of health care, and improve staff satisfaction. Its guiding principles are:

(1) comprehensive measurement across multiple domains;
(2) collaborative measure and program development;
(3) standardized measurement across all provider groups;
(4) financial incentives to motivate improvement; and
(5) technical assistance that supports ongoing improvements.

The pay-for-performance program is funded through a withhold on capitated primary care payments, which are earned back based on performance on clinical quality, patient experience, systems improvement and data quality measures. If providers do not earn the full withhold back based on their performance, unearned funds roll over from one quarter to the next for the duration of the year. If at the end of the year there are still unearned funds, the plan can use those funds to train and provide additional technical assistance to improve performance on PIP-related measures. To be eligible for the program, providers must have at least 300 attributed members. For more information, see the **San Francisco Health Plan PIP Resource Webpage**.

VBP Model 3: Episode-Based Payment (Bundled Payment)

Definition: **Episode-based payment** is a fixed dollar budget target (or payment amount) that covers a set of services for a defined period of time. There are generally two types of episode-based payments:

- Acute care episodes or events, which include services related to a condition or procedure (e.g., joint replacement, URI, colonoscopy, pregnancy & delivery), and
- Chronic condition episodes, which include services for a fixed amount of time related to a chronic condition (e.g., one year's worth of care for a diabetic member).

LAN Category 3A or B:
APMs Built on Fee-For-Service Architecture

Or

LAN Category 4A or B:
Population-Based Payment

Payment is typically administered on a FFS basis with retrospective reconciliation to an episode budget. However, there are examples of prospective ("bundled") payment in use. Given the use of both FFS architecture and bundled payments, an episode-of-care model could be categorized as either 3 or 4 in the **LAN framework**.

At a minimum, providers participating in an episode-of-care model share in savings if the cost of services is below a risk-adjusted budget target. In some episode-based payment models providers may also share in a portion of the losses, if spending is above the budget target, this is also called "**shared risk.**" There is usually some financial protection offered to providers so that they are not financially responsible for high-cost outliers that may randomly occur within a population of patients.

The quality performance of a provider in an episode-of-care model might influence the gain/loss distribution for shared risk arrangements, and/or qualify a high performing provider entity for a separate bonus. Meaning, the amount of savings or loss a provider is accountable for would vary based on quality performance. A high-quality performer might be able to share in a greater proportion of savings it earns, or be responsible for a smaller percentage of losses that it may incur. In this way, quality performance plays a very important and centralized role within the payment model. Sometimes quality performance is used as a "**gate**" for a provider to obtain savings in an **episode-based payment**. A gate is a minimum performance benchmark(s) that a provider must meet or exceed for the provider to receive a specific incentive payment (e.g., **shared savings**), or in some cases, participate in the episode-based payment.

VBP Model 3: Episode-Based Payment

Pros	Cons
▪ Creates incentives for delivery of coordinated, evidence-based care and increases focus on high-quality outcomes. ▪ Rewards efficiency. Motivates providers to find efficiencies in care delivery, reduce cost variation and average unit cost. ▪ Motivates substantive change in health care delivery – the goal of payment reform. ▪ There is substantial variation in episode costs, in particular for Medicaid in pneumonia, asthma, hypertension, and diabetes. ▪ There is also substantial variation in complications tha ▪ t could have potentially been avoided if quality of care was improved, including for the pregnancy and delivery episode.	▪ A lot of work for a narrow set of conditions or procedures. ▪ Can be complex to implement. ▪ Increased price/utilization outside the bundle could limit overall savings. ▪ Many parameters of episode-based payments are up for negotiation and can erode the savings potential.

Why Choose an Episode-of-Care Model?

An episode-based approach addresses limitations of and concerns with existing delivery, payment and performance measurement systems which often focus on discrete services and separate providers. Typically, no single provider or set of providers claims responsibility for managing a patient's episode of care from start to finish. In an episode-of-care model, there are clearly identified accountable provider entities and quality measurement is focused on overall care delivered to manage a patient's condition over time. You can choose to design and implement episode-based approaches to strengthen financial incentives and accountability for greater coordination among providers involved in a patient's care.

What Decisions Need to be Made to Design an Episode-of-Care Model?

Your first step in developing an episode-based payment model should be the detailed instructions and information included in the **2015 ACAP Toolkit for Implementing an Episode-of-Care Program**.

The Episode-of-Care Toolkit will walk you through the following five steps to designing this type of VBP payment model:

Step 1: Choose and Define an Episode
Step 2: Calculate the Budget
Step 3: Determine the Risk Model
Step 4: Incorporate Quality
Step 5: Contract with Providers

Related resources for ACAP members include:

- A set of **recommendations** about which episodes to consider (including **pregnancy and delivery, asthma and diabetes),** based on a significant claims data analysis of nine plans that participated in ACAP's Bundled Payment Learning Collaborative during 2014,
- Webinars developed for Learning Collaborative member plans available through this **website**, and
- A **simple financial planning tool** that can help you determine the necessary investment in resources, estimated savings and return on investment that can be expected from implementing an episode-of-care payment program.

Example: ACAP-member plan Community Health Choice of Texas began piloting maternity bundled payment episodes in 2015 with two health systems. **Click here for more detailed information on the maternity and newborn care bundled payment pilot program**. The plan contracted with HCI3, one of a few vendors that assist plans with **episode-based payment** implementations. The episode is defined in the following way:

- For the mother, prenatal care (270 days prior to delivery), delivery, and post-natal care (60 days post-discharge) are all included in the episode.
- For the infant, the initial delivery stay and all services and costs up to 30 days post-discharge are included in the episode.

The plan established patient-specific budgets based on historical average costs. The historical average costs were calculated by blending C-Section and vaginal delivery rates to help mitigate the historical financial incentive to perform C-Sections, but to also recognize that C-Sections do occur. Then, the historical averages were adjusted based on plan-defined historic risk factors of the patient. Risk factors included:

- age;
- comorbidities, and
- clinical severity (gestational diabetes, multiple gestations, etc.).

The financial arrangements for the two health systems include:

- **shared savings** - 'upside-only' in year 1, with a provider quality scorecard, (the CHC example quality scorecard is embedded within the toolkit below);
- a projected move to **shared risk** in year 2;
- Year 2 quality threshold requirements for provider eligibility to receive **shared savings**, and
- Year 3 and beyond: a move to flat dollar or prospective payments.

Click here to see an example of a Quality Scorecard from ACAP-member plan Community Health Choice of Texas.

VBP Model 4: Population-based Payment (PBP)

Definition:

- **Population-based payment** involves defining **a budget / target on a *per-capita* basis** for a broad population of patients for whom the provider assumes clinical and financial responsibility.
- The PBP budget or **capitation** payment may be defined to include all covered services (**total cost of care (TCOC)**), or for the vast majority of services, or may be for a smaller set of services (e.g. primary care only).
- Populations can be defined based on PCP assignment and/or **attribution** (e.g., assigned to the provider based on visit history). Populations included in PBP arrangements can be broadly defined or reflect specific sub-populations.
- In PBPs, at a minimum, providers share in savings. PBPs may also be defined, however, such that providers may also share in risk, or assume full risk. Today there are more examples of retrospective payment for PBPs, but prospective (capitated) payment arrangements are also used.
- Quality is typically incorporated into the model as a "**gate**" to shared savings or as a "gate" to participating in capitation arrangements. Quality performance can also inform withhold return, **P4P** payment and trend adjustments to future budgets.

VBP Model 4: Population-based Payment

Pros	Cons
▪ Brings attention to management of patient populations, not just individual patients or episodes. ▪ Enhances the role of primary care. ▪ Can create a strong financial management incentive, particularly in PBPs with **shared risk** or capitation arrangements.	▪ Requires large patient populations and significant provider infrastructure. ▪ Many providers may not be ready to manage risk under such a payment system. ▪ Potentially financially threatening to hospitals and high-margin specialty care service providers.

Why Choose a Population-based Payment Model?

Compared to **supplemental payment** and P4P models, a PBP model provides stronger financial incentives for providers to improve performance and achieve excellence. Whether a PBP is retrospective or prospective, provider payment is more removed from the strictly volume incentives found in traditional FFS payment. PBP models explicitly link payment to providers based on both quality and efficiency targets and better align provider and plan incentives.

In contrast to **episode-based payment** care models, PBP models create incentives for providers to manage a broader set of services for a broader population and may be less technically complicated for plans to implement than an episode-based payment model.

What Decisions Need to be Made to Design a PBP Model?

☐ **Step 1: Identify the Targeted Patient Population.**

Potential target populations have different health needs and health risks. Consider PBP arrangements for different Medicaid populations or subpopulations: for example, pediatrics, adults, aged-blind and disabled population.

- Identify the costs and cost drivers of each of your populations to determine which patient populations should be included or excluded from the PBP.
- Consider what cost drivers the provider entities directly control and those drivers they will be able to influence.
-

☐ **Step 2: Determine Which Providers Will Participate in the PBP Arrangement.**

Identify those providers that might be amenable to contracting on a PBP basis, appear ready to accept risk, and have a high volume of plan members who are targeted for inclusion in the PBP arrangement. Oftentimes, primary care providers and integrated provider networks (e.g., IPAs or ACOs) are the focus of PBP because they have higher patient volume than other providers and more influence over referrals.

- Set a minimum threshold for provider size for participation in PBP models to ensure that savings and losses are not the result of random variation and to protect providers from assuming too much risk. For a relatively healthy population of children and moms, plans should consider setting minimum thresholds at 15,000-20,000 members to help protect from random variation. For higher-risk populations, the total size can be smaller.[3] CMS set a minimum population size of 5,000 for its Medicare Shared Savings Program (MSSP). Groups of smaller providers can be brought together, sometimes with plan facilitation, to pool patient populations. For more information on challenges with small populations, see **"Value-based Payment Models with Small Numbers of Attributed Lives"** in "Section IV: Overcoming Challenges."

- Consider conducting a provider readiness assessment that identifies the financial stability and functional abilities required to be successful under a PBP model for providers entering **shared risk** or full risk arrangements. For more information on Provider Readiness see the **"Assess Provider Readiness"** action item in "Section III: Implementing VBP with Providers."

[3] Weissman, J et al. "The Design and Application of Shared Savings Programs: Lessons From Early Adopters." *Health Affairs* September 2012.

☐ Step 3: Attribute the Targeted Patient Population to Eligible Providers.

You've got patients, and you've got providers – now you need to match the two up. For PBP programs involving Medicaid PCPs, **attribution** can be done several ways. For more information on patient attribution approaches, see **"Identify an Attribution Methodology"** action item in "Section III: Implementing VBP with Providers."

☐ Step 4: Determine What Services Will Be Included in the PBP Agreement.

Even contracts that are termed "**total cost of care (TCOC)**" contracts often exclude some covered services from the PBP arrangement. It is critical for a health plan to consider whether all covered services should be included in a PBP model, or whether some should be 'carved out' of the payment model. For example, certain high-cost services may be excluded (e.g., transplants) in order to protect against excessive and unmanageable provider risk. LTSS, non-medical transportation, and dental care are other examples of services excluded from the PBP arrangement to the extent these services are the responsibility of the health plan. Some services can be included in the PBP arrangement with special provider risk protection provisions. For example, prescription drugs can be included with an exclusion for certain drugs that have yet to come to the market, e.g. new pharmaceutical biologics.

Note: While most Medicaid VBP nationally has been focused on primary and acute care, mental health and long-term care are significant contributors to Medicaid budgets. From a VBP perspective, there are some important differences to consider with these services. The challenges are especially pronounced with LTSS where most providers are not well positioned to enter into many forms of value-based payment models.

i. *LTSS providers feel that lack of data analysis capability and value-based payment contracting expertise are barriers.*
ii. *Health plans point to provider lack of understanding of value-based contracting, lack of resources and small size as barriers to entering into agreements with LTSS providers.*
iii. *The heterogeneity of the population using LTSS makes measurement challenging, as does lack of standardized measures and benchmarks.*

☐ Step 5: Set the Budget for the PBP Arrangement.

Generally, there are three ways to create a PBP budget.

1. One common approach is to calculate historical averages and project forward. This approach can maintain and even exacerbate price variation in your network because the high-cost providers remain the high-cost providers. In addition, efficient providers are penalized because they have less waste to take out of their system and already start with a lower budget.

2. Alternatively, you can compare PBP costs to a control group – that is a group of similar providers who are not in the model or you could compare PBP costs to a regional or national average (depending on your size) that incorporates providers in and out of the payment models.

3. A third option is to set budgets based on historical costs, but to adjust the growth rate to account for a) baseline provider rates and b) baseline provider efficiency.

Once you have the budget target established, you need to:

a. Determine how to risk-adjust the budget. There are multiple risk-adjustment methodologies available as described later in the **"Value-based Payment Models with Small Numbers of Attributed Lives"** challenge in "Section IV: Overcoming Challenges." Consider using one that the state uses to help align programs, or an existing one to which the plan might already have access.

b. Determine whether and how to use stop-loss or other risk protections in your PBP arrangements, often in consultation with your participating providers. Limiting a provider's exposure to outliers can help protect providers from random variation. Stop-loss could be applied at the *individual level* by using a specific dollar amount on a per-member basis (e.g., $100,000). It could also be applied at the *aggregate level* by using a multiplier of the budget (e.g., costs above 10% of the budget). A plan might negotiate individual-level risk protection with providers for high cost outliers, and providers may seek to self-finance and/or purchase aggregate risk coverage from the plan or a third party.

c. Know when and how you'll determine financial performance against the budgets. Consider what your claims lag time might be for closing out a budget year, how the financial data will be analyzed, and whether the provider have an audit and/or appeal process on the budget calculation.

d. Decide how to distribute any savings or how to recoup any losses. Step 6 (below) addresses considerations for sharing savings based on quality. In the event of a loss, you could reduce the budget or FFS payment for the following year to spread the cost of the losses out over a year. This doesn't require the provider to actually pay the health plan dollars. Or, if the providers are large enough and have financial reserves, they could pay directly. Whatever approach to addressing losses you decide on could vary by provider size and financial stability and experience.

☐ Step 6: Determine How Quality Will Be Incorporated.

Identify opportunities for improvement on quality and outcomes that could be influenced by a PBP model. Since this is a concept that is important to all VBP models, determining how quality is incorporated is addressed in **"Incorporate Quality into your Value-based Payment Model"** action item in "Section III: Implementing VBP with Providers."

☐ Step 7: Determine How to Administer the Payment Model.

There are two approaches to administering a **population-based payment** model:

- On the FFS "chassis", using prospectively defined budgets and retrospective reconciliation, and
- Using prospectively paid budgets (i.e., **capitation**)

Note: There are a few things to consider, including:

- *Retrospectively-reconciled models do not give providers the upfront capital to invest in traditionally unreimbursed services and other resources, so providers will need to finance them in some other fashion.*
- *Prospectively-paid models require strong provider financial management, and in some cases administrative functionality to accept and distribute payments for a large panoply of services. Plans can provide this function or providers can arrange for it.*
- *Prospectively-paid models may also cause challenges with accurate data collection. For more information on this particular challenge see **"Moving Beyond Fee-for-Service Claims Payment"** challenge in "Section IV: Overcoming Challenges."*
- *Similar to the **episode-based payment** model, when implementing PBP models it is important to ensure the plan retains the insurance risk (i.e., the risk of whether patients have serious health problems) and that providers only accept performance risk (i.e., the risk of whether care for a particular health problem is delivered to attributed patients efficiently and effectively). This requires the use of a risk-adjuster. For a discussion and list of risk-adjusters, see **"Value-based Payment Models with Small Numbers of Attributed Lives"** in "Section IV: Overcoming Challenges."*

Shared Savings Examples:

1. In 2015, an ACAP-member plan, University of Arizona Health Plans, established a **P4P** and **shared savings** arrangement with select high-volume primary care providers and some smaller, rural, providers, based on PCMH recognition or transformation readiness. The participating primary care providers are eligible to receive a quarterly PMPM payment based on the number of quality measures they meet, and share in savings they earn based their ability to lower the **total cost of care** (which includes medical, pharmacy, dental and transportation expenses) from a historical benchmark.

The plan has two **gates** for sharing savings. First the plan varies the portion of shared savings a provider is eligible for based on its performance against medical loss (or expense) ratio (MLR) targets. MLR at the provider level is the proportion of the revenue the plan expects to receive for the patient population for a given provider (i.e., premium and reinsurance) compared to the expenses that provider incurs (e.g., paid claims). The MLR targets focus on efficiency of clinical resources and are set based on prior contract year MLR for the provider's attributed population. A provider is eligible to receive up to a maximum of 50 percent of the savings based on its MLR performance in the measurement period. If a provider does not meet its minimum MLR target, it is not eligible to share in savings. In this manner, the MLR performance acts as a **gate**.

The second **gate** relates to a provider meeting a certain number of established quality benchmarks. If the provider meets both the efficiency and quality gates, the **shared savings** distribution is contingent upon the provider's performance on quality measures and increases as the provider meets more measures. Quality measures that providers have to meet are outlined in the table below. These measures are based on state Medicaid requirements and can change over time.

Quality Measure
ED Utilization (visits/1000) (separate for pediatric/adult)
Readmissions within 30 Days of Discharge
Well Child Visits (15 Months)
Well Child Visits (3-6 Years)
Adolescent Well Child Visits (12-21 Years)
Children's Dental Visits (2-21 Years)
Follow-Up After Hospitalization Within 7 Days
E-Prescribing
Appointment Availability

2. Minnesota's Medicaid program developed the Integrated Health Partnership (IHP), which is a payment model in support of providers that voluntarily come together as ACOs to provide care that achieves the Triple Aim. There are two versions of the IHP model: (1) the "virtual IHP" supports primary care providers that are not supported by a hospital or integrated delivery system; and, (2) the "integrated IHP" is designed for integrated delivery systems that provide a broad spectrum of outpatient and inpatient care through a common financial and organizational entity. This example highlights the "virtual IHP" shared savings model. For a full discussion of the "integrated IHP" **shared risk** model, see **"Appendix C: Shared Risk on Total Cost of Care with ACOs."**

The "virtual IHP" model is one where primary care organizations not affiliated with a hospital or integrated system (or any small integrated system serving between 1,000-2,000 attributed members) can participate in a shared savings model. Minnesota's Medicaid program shares equally (50/50) any savings that a provider organization earns provided that the organization has earned greater than 2% savings on the **total cost of care (TCOC)**.

Quality is an important part of the "virtual IHP" model and the amount of **shared savings** the provider organization is awarded is contingent upon quality performance in the following manner:

Year 1: 25% of the portion of shared savings is based on reporting measures
Year 2: 25% of the portion of shared savings is based on performance
Year 3: 50% of the portion or shared savings is based on performance

Shared Risk in Medicaid

Nationally, payers and providers are rapidly engaging in risk-based payment models. Risk-based contracts are proliferating in the commercial insurance market, and Congress and CMS have created strong financial incentives and absolute requirements for Medicare providers to move to **shared risk** payment arrangements.

Shared risk in Medicaid is still new, but worth exploring in markets that have more experience with value-based payment. More information about shared risk programs is available in **"Appendix B: Shared Risk on Total Cost of Care with Primary Care Providers"** (shared risk with primary care providers) and **"Appendix C: Shared Risk on Total Cost of Care with ACOs"** (shared risk with ACOs).

Section III.

Implementing VBP with Providers

Implementing VBP with providers involves many different facets of plan operations. For example, it is important to ensure that you have a robust quality program associated with your payment model and that some of the technical details of administrating the payment model are addressed. In addition, part of implementing VBP with providers involves assessing their readiness, contracting with them, and then supporting providers to be successful under the new payment model.

Summary of Action Items in Section III

- ☐ **Incorporate Quality into your Value-based Payment Model**
- ☐ **Identify an Attribution Methodology (if necessary)**
- ☐ **Assess Provider Readiness**
- ☐ **Contract with Providers**
- ☐ **Promote Provider Clinical Transformation to Foster Success under VBP**

Action Item 1: Incorporate Quality into your Value-Based Payment Model

Incorporating quality measures into a value-based payment is an important way of ensuring that providers are focusing on the outcomes of the individual patient, not just on the cost of care.

☐ **Step 1: Choose How Quality Will Be Incorporated into the Payment Model.**

There are two ways in which quality is typically incorporated into a value-based payment model. Each is described below. These two general approaches, and the specific options that are categorized within them are **not mutually exclusive.** Both general approaches enable plans to budget available bonus dollars and give providers a sense of their reward for improved quality.

1. Integrate quality directly into the financial risk arrangement.
   Provider performance on quality measures can be incorporated directly in the financial risk arrangement by using that performance in the following ways:

- Withhold Arrangement
  - Determine whether or not to withhold a portion of provider payment that must be earned based on provider performance to identified quality targets on priority measures in a defined period. This might be in the range of 2-5%.

- "**Gate** and/or **Ladder**"
  - Determine whether a provider is eligible to share in savings by setting a particular quality threshold (or "gate") which a provider must meet. A gate is a performance benchmark(s) that a provider must meet or exceed for the provider to receive a specific incentive payment.
  - Determine what percentage of savings is to be distributed by tying varying levels of performance to savings percentages ("ladder"). A ladder is when provider incentives vary in a step-wise fashion (either up or down) based on performance against multiple levels of established performance benchmarks. For example, a provider that meets the highest level quality threshold could share in 50% of the earned savings and a provider that meets the lowest level of quality threshold might only be eligible to share in 25% of the earned savings.
  - Similarly, if using a **shared risk** model, performance on quality could be tied to varying levels of losses, thereby rewarding quality performance by reducing a specified percentage of incurred financial losses. For example, a provider that meets the highest level quality threshold might only need to pay 25% of its share of losses and a provider that meets the lowest level of quality threshold might have to bear the responsibility for 50% of its incurred losses.

- Future Payment Adjustment for Performance
  - Health plans can adjust base FFS or **capitation** payment rates from what it would have been for the next performance period if quality performance was below or above expectation during the prior performance period. For example, Medicare's Next Generation ACO model adjusts the ACO budget based on prior quality performance.

2. Reward quality performance independently of the financial model.
   Provider performance on quality measures does not have to be incorporated directly into the financial model. It can also be used in the following ways to enable plans to budget the available bonus dollars and gives providers a sense of the reward for improved quality.

- Plans can reward quality performance independently of the financial model by creating a separate bonus pool where:
    - The provider is eligible for a budgeted amount based on pre-determined quality performance, or
    - The plan sets aside a set amount of money that is guaranteed to be distributed to providers based on quality performance.
        - In this case, the entire pool is distributed to providers that achieve pre-established thresholds in actual performance or improvement and the percentage of the pool that each provider receives depends on the number of providers that achieved the pre-established threshold. In this option, providers "compete" with others for the same set of quality-bonus dollars.

Regardless of how you incorporate quality measures into your value-based payment program, you could consider weighting the measures differently to bring focus and attention to the measures and activities that are most important to the health plan. For example, if you incorporate quality into your financial model by requiring a certain threshold to be reached to receive a **shared savings** payment, you could require that a provider must meet one or two select measures thresholds, but require a statistically significant improvement in other measures. However you decide to design the quality program, it is important to balance the plan's desires for a certain level of performance with an easy-to-understand value-based payment methodology.

☐ Step 2: Identify Relevant Quality Measures.

Incorporating quality into a value-based payment program is only a successful strategy if the right measures are used to assess performance. There are six ways to identify which measures are the most meaningful to include in your program, none of which are mutually exclusive.

1. First, consider which value-based payment model you are using, and the chief goals of this model, to help determine which quality measures might be most relevant. For example:
    a. **Episode-based payment** programs should have quality measures that are most relevant to the episode at hand. (e.g., a maternity episode should include rate of C-sections).

b. **Population-based payment** programs will have broader quality measures, but they may vary depending on the contracted provider. For example, if a plan is implementing a capitated payment model with primary care providers for primary care services, quality measures might focus on clinical processes and outcomes that are influenced by primary care providers (e.g., blood pressure control, diabetes blood sugar control, etc.). If a plan is implementing a **population-based payment** model with an integrated health care system include measures that are influenced by hospitals and specialists (e.g., hospital patient safety measures, maternity measures).

2. Use data to which you already have access and which is relevant to the value-based payment model of interest to assess plan and provider performance relative to benchmarks and variation in provider performance. Consider including quality measures in your program where there is:
   a. Performance below benchmarks;
   b. Significant variation between the highest performing providers and the lowest performing providers, and/or
   c. Alignment with the state Medicaid program's plan performance measures.

Note: Health plans may find that they would like to measure an area for which they have no data. In that case, consider requiring providers to submit the applicable data in a "reporting only" mode for the first year or two while the plan gathers enough baseline data from which to measure future performance.

In addition to standard quality measures, plans may wish to place requirements on providers for accurate and timely submittal of data necessary for plans to operate a VBP model, or comply with its own state requirements, (e.g., HEDIS measures). These requirements can serve as a "**gate**" to any performance incentive.

3. Identify benchmarks to which a health plan will compare provider performance. Some example benchmark sources include:
   a. Medicaid-specific performance on HEDIS measures found in **NCQA's Quality Compass**;
   b. State-specific rates of health risks and behaviors found in the CDC's **Behavioral Risk Factor Surveillance System**;
   c. Benchmarks of FQHC performance recorded by **HRSA's National Program Grantee Data**, and
   d. Goals set by the CDC on a variety of health objectives in its **Healthy People 2020 goals**.

4. Engage providers in the process of choosing quality measures because they may have strong opinions about what measures to use, especially since the level of burden that collecting data and reporting that data may have on providers. In addition, they may react to their perception of the relevancy of the measure and their level of influence over the care process or outcome it assesses. A plan could consider using a tool, like Buying Value's **How to Build a Measure Set**, during a facilitated discussion with a committee of interested physicians.

5. Consider measures that are already collected, reported or publicly available. Providers are often subjected to many different quality measures as part of federal, state and payer requirements. Review those measures which are already being collected and reported upon in your state (whether or not they are publicly available) or by your plan and consider integrating those which are relevant into your value-based payment program.

6. Avoid modifying standard measures or creating "home grown" measures. There is a proliferation of measures that have not been tested, but tweaked or newly created by plans to fit programmatic needs. This should only be done when there is a strong rationale and there are no alternative measures.

There are many sources of evidence-based and tested quality performance measures, and examples of quality program methodology. The table below contains a few of the most popular examples, including the examples for several existing Medicaid value-based payment programs.

Source	Notes	Website or File
Centers for Medicare and Medicaid Services	The Affordable Care Act required the Secretary of HHS to identify and publish a core set of health care quality measures for adult Medicaid enrollees.	**https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html**
Agency for Healthcare Research and Quality	CHIPRA required the creation of a Pediatric Quality Measures Program to improve and strengthen a core set of children's health care quality measures.	**http://www.ahrq.gov/policymakers/chipra/pqmpback.html**

Source	Notes	Website or File
Core Quality Measure Collaborative	A collaborative between AHIP, CMS and NQF designed the following seven core measure sets for value-based payment: • ACO, PCMH, Primary Care • Cardiology • Gastroenterology • HIV and Hepatitis C • Medical Oncology • Obstetrics and Gynecology • Orthopedics	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html
National Quality Measures Clearinghouse	A public resource for evidence-based quality measures and measure sets.	http://www.qualitymeasures.ahrq.gov
National Quality Forum	An organization that endorses consensus standards for performance measurement.	http://www.qualityforum.org
HEDIS	A tool used by more than 90 percent of health plans to measure performance.	http://www.ncqa.org/HEDISQualityMeasurement.aspx
CMS Physician Quality Reporting System	A CMS incentive program for providers to report certain quality measures for their Medicare patients.	http://www.cms.gov/PQRS
Hospital Compare	A CMS program in which hospital quality of care data are reported publically.	http://www.medicare.gov/hospitalcompare/search.html
Buying Value	A suite of tools to assist in creating quality measure sets.	http://www.buyingvalue.org/resources/toolkit/
Health Care Payment and Learning Action Network	Performance measurement for **population-based payment** models	https://hcp-lan.org/groups/pbp/pm-final-whitepaper/
Medicaid Episode-of-Care Programs	Measures that Arkansas, Ohio and Tennessee have incorporated into their episode-of-care program.	AR: http://paymentinitiative.org/episodesofcare/pages/default.aspx OH: http://www.healthtransformation.ohio.gov/CurrentInitiatives/ImplementEpisodeBasedPayments.aspx TN: http://www.tn.gov/hcfa/strategic.shtml
Community Health Choice of Texas Maternity Episode Program	An example of Community Health Choice of Texas's quality measurement score card.	http://www.communityplans.net/portals/0/VBP/CHC%20TX_Quality%20Scorecard%20Example_2016.pdf
Minnesota's Integrated Health Partnership Model	The quality measurement methodology for Minnesota's **population-based** **shared risk** model.	http://www.communityplans.net/portals/0/VBP/MN%20IHP_Quality%20Measurement.pdf

☐ Step 3: Determine Performance on Quality.

There are three ways to determine provider performance on quality and patient experience measures, which can be and often are used in combination with one another.

1. Absolute performance.
   A health plan could choose to develop a threshold which must be achieved in order for a provider to receive a payment adjustment, or episode-of-care contract the following year. The threshold could be based on a benchmark or average.
   - The downside to this approach is that the providers may improve in a statistically significant way, yet not reach the established threshold, and therefore not be rewarded for their improvement.

2. Relative performance to other providers.
   A health plan could choose an approach where distribution of payment is determined relative to the performance of other providers.
   - The payer could budget the amount of dollars that will be allocated to providers in a performance pool. The pool could be funded with dollars that providers do not earn back in savings.
   - The downside to this approach is that the providers do not know for how much they are eligible, since their available funds total is informed by the performance of others.

3. Relative to past performance.
   A health plan could require providers to achieve a certain increase in performance over baseline, or the prior year, in order to receive an adjustment to payment or a value-based payment contract the following year.

Action Item 2: Identify an Attribution Methodology (If Necessary)

Patient **attribution** is a foundational component of value-based payment models as it identifies the patient-provider relationship and forms the basis for provider performance measurement, reporting and payment. Patient attribution methodologies are needed in **population-based payment** models where one provider or system of providers is responsible for the care for an entire population of individuals, and in some **supplemental payment models** where providers are paid a per-member per month payment for certain activities, like in many patient centered medical home programs. It also has salience for specialty payment models too, such as maternity episodes of care, or an oncology medical home.

To get started with patient attribution, the health plan must develop a standard methodology based on best available data. There are often multistep models. There are three options for

patient attribution that a health plan can consider when attribution is linked to a primary care provider, as is the case with PCMH and ACO-based VBP arrangements:

1. Based on the patient's chosen (or self-reported) primary care provider.
   Patients can be attributed to providers based on which provider they have chosen or were assigned during enrollment. Because one major downfall to this approach is that a patient-chosen or assigned PCP may not be always the one who cares the most for the patient, it is often used in tandem with a retrospective approach. Payers using this approach alone may find that they are making a financial commitment to providers for patients who never seek their services.

2. Based on historical claims data.
   Patients can be attributed to providers based on claims history, both prospectively and retrospectively. For example, patients could be attributed to a provider or ACO for whom the patient has the plurality of E&M services delivered by a primary care provider or by which the patient has been prescribed majority of their prescription drugs.

   - Prospective assignment: Patients can be paired with a provider at the start of the performance year allowing the providers to know which panel of patients they will be responsible for in a value-based payment model, and further allowing them to actively reach out to patients for engagement and care coordination. This approach works best when plans can access historical data on patient patterns of primary care provider visits, when the patient designates the primary care provider or the health plan designates the primary care provider. There are a few downfalls this to approach:
     i. One plan might not have enough claims history to determine accurate patterns of primary care provider visits.
     ii. There could be a mismatch between the plan recorded primary care provider and the one the patient utilizes on a regular basis.

     To guard against these downfalls, it's important for health plans to have a mechanism based on data to double check initial patient **attribution** assumptions.

   - Retrospective assignment: Patients can be paired with providers at the end of a performance year based on claims data. The major advantage of this model is that the health plan will be paying (through the value-based payment model) only for its members who obtained care from the provider during the identified period. It also gives providers "credit" for new health plan members it sees, especially those who might be newly eligible for Medicaid during the

performance year. One study has shown that this method may more fully and accurately reflect an ACO's patient population.[4] However, there are a few downfalls to this approach as well,

i. It does not give providers the opportunity to know which patients will be assigned to them in advance.
ii. Because of claims lag, retrospective assignment will be delayed, and therefore quality performance and cost measurement will be as well.

3. A hybrid approach:
   A plan could adopt a hybrid approach, the most common approach used, where the first step in attributing patients to providers is through prospective assignment based on PCP chosen or assigned during enrollment, or through a historical look at claims. The plan could update the provider on a quarterly basis with the list of patients for whom the provider should assume accountability. At the conclusion of the performance period, the plan could reconcile the prospective assignment based on a retrospective review of claims and pay the provider based on the reconciled results.

*Note: It is important for plans to understand what PCP is on record with the state Medicaid program, but it is not essential for the VBP model and the state's record to match. To mitigate any challenges that may arise with inconsistencies between the two, plans could consider giving providers the opportunity to dispute the results of the patient **attribution** at the end of the year based on provider data that a) showed a member patient received a significant amount of care from the provider or b) showed that an attributed member did not receive care from the provider.*

There are several example methodologies a health plan can draw from when creating its own patient attribution methodology and are available in the table below.

Source	Notes	Website
Health Care Payment and Learning Action Network	Patient attribution guidelines for **population-based payment** models.	**https://hcp-lan.org/groups/pbp/pa-final-whitepaper/**
Vermont's Blueprint for Health	Vermont's attribution algorithm for its patient centered medical home program.	**http://www.communityplans.net/portals/0/VBP/VT%20Blueprint_Attribution%20Algorithm.pdf**
Health Partners in Minnesota	A technical brief that examines various patient attribution methodologies.	**http://www.communityplans.net/portals/0/VBP/MN_HealthPartners%20Attribution%20Technical%20Brief.pdf**

[4] Lewis, V et al. "Attributing Patients To Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests." *Health Affairs* 32, no. 3 (2013): 587-595.

Source	Notes	Website
New York State's DSRIP Program	Options and considerations with pros and cons to attribution methodologies.	**http://www.communityplans.net/portals/0/VBP/NY_VBP%20Patient%20Attribution.pdf**
NASHP Briefing	NASHP conducted a review of patient attribution methodologies in four multi-payer patient centered medical home programs. While the briefing goes beyond the immediate interests of a Medicaid MCO, it provides a good analysis of different methodologies.	**www.nashp.org/sites/default/files/PCMH_Attribution_and_Enrollment.pdf**
Ontario Patient Rostering	An approach used in Ontario, Canada that involves a dual commitment between patients and providers.	**http://www.communityplans.net/portals/0/VBP/Ontario_Patient%20Rostering%20PowerPoint.pdf**

Action Item 3: Assess Provider Readiness

When engaging providers in value-based payment, it is important to ensure they are financially and operationally prepared to be successful specifically for the model that a health plan is implementing. By conducting a provider-readiness assessment, health plans can gauge whether the providers are ready to take on value-based payment, and what opportunities a health plan may have to support provider readiness.

☐ Step 1: Choose or Create a Provider Readiness Assessment.

- A plan may choose to utilize an existing provider readiness assessment like those produced by the **Rural Health Value** team at the University of Iowa College of Public Health, or adapt a provider-oriented value-based care toolkit like this one published by the **American Medical Association**.

- Alternatively, a health plan can create their own provider readiness assessment tool based on the identification of qualities a health plan expects its value-based contracted providers to possess. **Click here to see an example of the University of Arizona Health Plans' self-created readiness assessment tool**.

At a minimum, a plan-created readiness assessment tool should address the following core competencies:

- Operational capabilities required to be successful in VBP.
  A health plan needs to assess whether the contracted provider is able to operationally transform its clinical care practices to be successful under a value-based payment. Certain operational capabilities may be required, a small sample of those capabilities include, that practices:
  - have open access, allowing for same-day scheduling of patients;
  - can accommodate patient appointments or phone calls after-hours and on weekends;
  - meet patient response or scheduling time standards;
  - meet health plan accessibility requirements; and/or
  - have processes for obtaining release of medical histories to and from behavioral health providers

- Staff needed to be successful with VBP.
  A health plan needs to assess what staff are most critical for providers to employ, or contract with, to be successful under their value-based payment model of choice. Here are some examples:
  - If the health plan is paying a supplemental PMPM payment for care management support, then a health plan may want to articulate certain qualifications of the care manager (e.g., care managers must be RNs or LICSWs, or that care managers must have specific training in areas like identifying highest risk patients, supporting planned care visits, etc.). In addition, the health plan may want to institute a caseload requirement that defines the minimum and maximum panel size of a care manager.
  - In some cases, health plans are providing care management support directly to practices through the use of embedded care managers. For an example of ACAP member plan UPMC Health Plan using this model, see Step 3, "Best Practice Sharing and Collaborative Opportunities," under the **"Promote Provider Clinical Transformation to Foster Success under VBP"** action item in "Section III: Implementing VBP with Providers."
  - If a health plan is engaging a primary care provider in a value-based payment model that supports behavioral health integration then a health plan may want to ensure that the practice has adequate behavioral health support (e.g., through contracted mental health and substance use services, or qualified behavioral health care managers).

Behavioral Health Integration

Integrating behavioral health with primary care is an important delivery system transformation that is occurring in many primary care practices across the country. A health plan can support behavioral health integration by:

1. helping primary care practices understand the **best practice models for behavioral health integration**;
2. articulating what services, and staff are required to operate an integrated practice, much like **MassHealth did in its VBP model**;
3. supporting practices with **toolkits and resources for integration**.

- Data capabilities needed to be successful in VBP.

  Being able to access and analyze administrative and clinical data is important for providers participating in value-based payments. While a health plan can support providers by giving them data (as discussed in the **"Promote Provider Clinical Transformation to Foster Success under VBP"** action item of this section, "Implementing VBP with Providers") it is important for plans to assess the existence of basic capabilities for a provider to make use of the data once provided. Here are some examples of the capabilities that providers should have when taking on **episode**, **shared savings**, **shared risk**, or **capitation** value-based payments arrangements:

  - A formal data and health informatics plan that includes a strategy for collecting and analyzing data;
  - The ability to access key data elements of clinical information from EHRs, including patient problems, medications, tests, demographics, vital signs and care plans to facilitate care management and other clinically related activity, and
  - The appropriate software needed to receive and analyze both administrative and clinical data.

- Adequate financial resources to be successful in VBP.

  Health plans that are engaging providers in financial risk arrangements (through **episodes**, **shared risk** or **capitation**, for example), should ensure that the provider has the resources to cover any potential losses that may be incurred. A recent National Association of ACOs survey of 35 ACOs found that on average ACOs need $2 million of start-up capital during the first 12 months of operation and in total will need $4 million of capital until there is a chance for recoupment from savings. Questions that health plans should ask providers include:

- Has the provider conducted a financial analysis to ensure that it understands the resources required to change clinical care operations, managed with data, and to accept financial risk?
- Does the provider have a means – perhaps facilitated by the plan – to continuously monitor the costs to deliver services compared to revenue?
- Does the plan hold reserves or have other financial means that are adequate to cover any potential contractual financial losses?

- Additional requirements that may be specific to the payment model, or to the health plan. These may include:
  - Minimum attributed patient count
  - Participation in existing quality improvement programs offered by the plan
  - Expectations for quality data collection and measurement
  - organizational leadership, and
  - External certification or some other form of recognition of preparedness and competency.

☐ Step 2: Implement the Provider Readiness Assessment Tool.

1. Once a health plan has chosen or created a readiness assessment tool, it should implement it before contracting with providers. Readiness assessment can be performed in several ways, including:
   - Make the provider readiness assessment tool a self-assessment that providers conduct on their own and report back to the plan.
   - Interview the provider's leadership team (e.g., CEO, CFO, COO), responsible managers and clinical leaders to ensure that they are able to engage in a value-based payment. Such interview could be conducted by provider relations staff in coordination with contracting staff, medical staff or senior leaders within the health plan and could involve review of evidence of operational readiness such as documentation of staffing, examples of reports, etc.
   - Make the provider readiness assessment tool a set of criteria that is included in a contract with providers. This option is better for plans that have a good relationship with providers and already have a sense of their capabilities to enter into value-based payment arrangements.

☐ Step 3: Follow-Up with Provider-Specific Action Plans.

1. After conducting a readiness assessment, plans can create provider-specific action plans that target the areas most important to individual providers as they continue preparations for value-based payment.
    - By creating provider specific action plans, health plans can assess across all providers it is engaging in value-based payment what plan-resources or tools might be most valuable to providers.

For more information on how plans can support providers to transform their clinical practice to be successful under value-based payment, see the **"Promote Provider Clinical Transformation to Foster Success under VBP"** action item in this section, "Implementing VBP with Providers."

Action Item 4: Contract with Providers

It is important for health plans to strategically consider their provider partners when first engaging in a value-based payment model. There are three steps to take when contracting with providers.

☐ Step 1: Selecting Providers.

1. Identify providers that might be amenable to contracting with a value-based payment model. There are several factors that make providers good contracting partners, none of which are mutually exclusive. Consider approaching providers with:
    - A high volume of plan membership;
    - A high volume of plan expenses;
    - Whom you have a good working relationship;
    - High (or low) quality scores in areas related to the payment model of interest;
    - Success at engaging patients;
    - Strong internal management systems and effective leadership well-poised to make any necessary changes to clinical operations;
    - Wide variation in costs, or variation from health plan best practice benchmarks, and/or
    - Current or prior engagement in another value-based payment program that might be similar to the one considered by the plan (e.g., Medicare's MSSP or Next Gen ACO models, or Medicare's Bundled Payment for Care Improvement).

Note: Certain states require a percentage of plan membership or plan expenses to be included in a value-based payment. Plans operating in those states should take the time to calculate the number of providers with whom contracts must be developed to meet state expectations.

2. Share data with providers for the purposes of engagement. Before contracting with providers, plans should engage interested providers by sharing data on costs and quality of clinical area that is being targeted under the value-based payment model. This should also include sharing with providers any modeling done by the plan to help providers understand why a value-based payment is potentially advantageous to the provider. A plan could also share data specific to interested providers contrasted with blinded data from other similar providers or plan-wide information.

☐ Step 2: Determining the Contracting Entity.

The payment model that requires the most strategic thought regarding contracting entities is the episode-of-care payment model. For more discussion on contracting entities related to episode-of-care models, please see Step 5.2 of the **Episode-of-Care Toolkit published by ACAP in January 2013**.

Note: When contracting on a value-based payment model with providers that are employed by an integrated network, a plan might want to advocate that the integrated network align its physician compensation model with its value-based payment models to help increase the likelihood of success under the value-based payment model.

☐ Step 3: Developing the Contractual Details.

The last step in contracting with providers is to develop contract language, ensuring that all of the important components of the plan's value-based payment program are included and well-articulated in the contract.

1. Clear description of the payment methodology. When creating a value-based payment contract, the plan needs to clearly define what the payment methodology is and how the payment will be calculated. This includes any calculation of **supplemental payments**, **P4P** bonuses or penalties, **shared savings** payments and **shared risk** calculations. It is helpful to include examples since often the methodology will have written mathematical equations. For example, in the Massachusetts's Primary Care Payment Reform Program, the contract provided an example of savings and risk sharing calculations, as displayed below.

Target Spend	Actual Spend	Savings variance $$	Variance as % of Target Spend	Provider Risk Share	MassHealth Risk Share
100.00	115.00	(15.00)	15%	(6.00)	(9.00)
100.00	110.00	(10.00)	10%	(6.00)	(4.00)
100.00	105.00	(5.00)	5%	(3.00)	(2.00)
100.00	101.00	(1.00)	1%	0	(1.00)
100.00	99.00	1.00	-1%	0	1.00
100.00	95.00	5.00	-5%	3.00	2.00
100.00	90.00	10.00	-10%	6.00	4.00
100.00	85.00	15.00	-15%	6.00	9.00

The contractual language should also specify the financial implications of quality performance with sufficient specificity to avoid future discord during performance calculations.

2. How the payment model might change over time. Many plans implement 3-5 year long contracts for value-based payment models that by design change over the course of those years. Plans must articulate whether and how the payment model will change over time. For example, if shared savings is the model for the first two years, and shared risk is the model for the third year, both models will need to be adequately detailed.

3. Terms of payment. The contract should lay out timelines for any prospective payments (e.g., supplemental PMPM payments, episodes, **capitation**). It should do the same for calculations required for retrospectively assessing financial and/or quality performance, citing data sources, plan and provider roles, and processes and timing for performance payments between the parties.

4. Appeals process. Include whether and how a provider can appeal calculations related to the value-based payment model. For example, in an **episode-based payment** model can the provider appeal the inclusion or exclusion of entire episodes, or claims within an episode, or can a provider appeal the application of the patient **attribution** methodology?

5. Provider responsibility. Be sure to include details on when and how to submit claims, data required for quality measurement and, if required, notification of the plan at the start of an eligible episode.

6. Payer responsibility. Plans should articulate within the contract what reports will be provided and the timing of those reports. Having access to plan data is critical for providers to be successful under value-based payment models.

7. Clear description of the risk adjuster. While proprietary risk-adjusters sometimes don't provide the specific calculations of their model, a health plan should include in its contract with providers what risk adjuster it is using (if it's a licensed product), and a clear explanation of how the methodology works.

The table below offers some model contracts as examples.

Source	Notes	Website or File
State of Minnesota	Model contract for Integrated Health Partnership (the state's **shared risk** value-based payment model for pregnant women, children and non-disabled adults). For a written description of the methodology of this program, see **"Appendix C: Shared Risk on Total Cost of Care with ACOs."**	**http://www.communityplans.net/portals/0/VBP/MN%20IHP_Model%20Contract_2016.pdf**
State of Massachusetts	Model contract for the MassHealth Primary Care Payment Reform Initiative (the state's shared risk value-based payment model that promoted behavioral health integration). For a written description of the methodology of this program, see **"Appendix B: Shared Risk on Total Cost of Care with Primary Care Providers."**	**http://www.communityplans.net/portals/0/VBP/MassHealth_PCPRI%20Contract%20Addendum.pdf**
Pacific Business Group on Health and Catalyst for Payment Reform	Model contract language for arrangements between ACOs and health plans.	**http://www.communityplans.net/portals/0/VBP/PBGH%20CPR_Model%20ACO%20Contract%20Language.pdf**

Action Item 5. Promote Provider Clinical Transformation to Foster Success under VBP

Health plans can be valued partners of providers when it comes to transforming clinical care to respond to value-based payment and population health strategies. There are three actions that health plans can take to promote success among its providers under VBP.

☐ Step 1: Provide Consultative Support.

Many providers will benefit from consultative support from plans early on to learn how to operate under a VBP contract. In particular, providers may need support on how to review and interpret reports in a VBP context, as well as prioritizing and tracking progress on their opportunities for performance improvement. A plan could offer consultation in the form of hands-on support delivered through dedicated teams with individual provider organizations and/or in a group setting with regular meetings to discuss trends and suggest potential action steps. Here are three examples of other plans are providing consultative support to their providers:

- CareOregon has established a Technical Assistance team that consists of staff skilled in EHR usage, nurse care managers, and other support staff that can assist practices in everything from coaching nurse care managers on caseload volume, to assisting providers in outreach telephone calls to patients. **Click here to see a job description of CareOregon's Primary Care Innovations Specialist** for an example of a Technical Assistance team member and his or her primary responsibilities in supporting providers.
- Other health plans regularly holds meetings between health plan staff (i.e., medical director, pharmacist, social worker and/or nurse) with providers to focus on concrete action steps to improve quality and cost performance.
- Another ACAP-member plan has small teams that meet regularly with providers—especially safety net providers—to share and discuss data, and help them translate the data into action. They also offer providers tools to help them query the plan's database.

☐ Step 2: Provider Training Programs.

Some plans may wish to offer training programs for all in-network providers that inform them on skills they might need to polish to be successful in value-based payment. Training programs can range from care management to leadership development. Below are some examples from other health plans:

- **San Francisco Health Plan (SFHP)**, an ACAP-member plan, offers a practice coaching program to safety-net clinics in its network to guide them through primary care transformation. SFHP also offers numerous other training programs, including around improving patient-provider communication, customer experience and staff experience. For more information on SFHP training and technical assistance courses, click **here**.
- One health plan has developed training programs for its providers that have included leadership programs on topics like developing internal capacity for organizational learning and development and behavior change. These training sessions take place one day per month over eight months, and also include a 2.5-

day specialist leadership training focusing on negotiation skills and practice variation analysis.

☐ Step 3: Best Practice Sharing and Collaborative Opportunities.

It is important for plans to disseminate best and evidence-based practices among its providers to reduce unnecessary variation in care delivery models employed by network providers. Some plans do this by disseminating guidelines, while others give providers a forum for collaboratively discussing ideas with others. For example:

- Beacon Health Options issued a white paper on an evidence-based approach to integrating behavioral health physical health care that gives all providers (not just their network providers) a roadmap for implementing the Collaborative Care Model. For more information click **here**.
- Beacon Health Options also convenes a provider forum three times a year to discuss topics of interest to its network providers.

☐ Step 4: Provide Direct Staffing Support.

Some health plans are providing direct staffing support to practices in the form of embedded care managers. Embedding a care manager, employed by the health plan, can help providers that have high volumes of plan membership achieve more effective care coordination. Embedded care managers, whether full-time or part-time, become part of the primary care practice's team. ACAP member UPMC Health Plan embeds care managers in some of its contracted provider's practices participating in its **shared savings** program, which includes some providers not employed directly by the UPMC Health System. Because the care manager supports the practice in meeting its quality and cost targets, UPMC is considering modifying its shared savings model such that the practice would cover the costs of the embedded care manager through its earned shared savings. **Click here for to see a job description of UPMC's embedded care manager for more information**.

Section IV.

Overcoming Challenges

Value-based payment models are still new and experimentation is happening across the country, and within different segments of the market. There are still a number of challenges that exist with value-based payment models, and this toolkit offers some tips on how to manage some of the most common challenges.

Summary of Challenges in Section IV

Challenge 1: Value-based Payment Models with Small Numbers of Attributed Lives.[5]

Generally there are three problems that could occur when value-based payment models do not have enough attributed lives, either due to small providers, or small volume of plan members at any given provider.

1. The plan could erroneously reward providers when no savings actually occurred or penalize them when savings did occur (false positive).
2. The plan could not reward (or penalize) providers when true savings (or losses) did occur (false negative).
3. The structure of the payment arrangement could make provider achievement of awards nearly impossible.

This is because there are natural fluctuations in service use and associated expenditures in any given population that occur randomly. Statistically significant performance improvement on a small data set sometimes requires implausibly large provider achievements.

[5] Source for this challenge and tips derived from: McCall, N. and Peikes, D. "Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance." *Robert Wood Johnson Foundation* April 2016.

Tips to manage this small numbers challenge:

- **Tip 1: Set a Minimum Savings/Loss Percentage.**

  Small gains and losses are most subject to random variation. Setting a minimum savings/loss percentage is the approach CMS has taken with the MSSP. For example, CMS established a Minimum Savings Level (MSL) of 2 percent before any savings are shared with the accountable provider. However, implementing a MSL has also contributed to provider criticism that the bar for obtaining any **shared savings** is set too high in MSSP.

- **Tip 2: Discount Small Gains or Losses.**

  Discounting small gains or losses, and not enabling (or requiring) that an accountable provider share in those savings (or losses) to the full extent, helps mitigate the risk of false positives and false negatives. For example, in the Minnesota IHP model (detailed in **"Appendix C: Shared Risk on Total Cost of Care with ACOs"** and in the fourth VBP model, **"Population-based Payment (PBP),"** in "Section II: Choose Your VBP Model(s)" the state requires that the providers achieve a 2 percent minimum savings threshold before any additional savings will be shared. Research indicates that payers using this approach discount savings between 2-5 percent.[6]

- **Tip 3: Model Potential Value-based Payment Scenarios across Different Populations and Providers.**

  It is important to test the value-based payment model the plan is going to use to determine how the model will work and whether or not the model experiences any of the challenges associated with small numbers.

  a. Specifically, the plan should model the variation in expenditures during a prior time period (ideally two years) and establish confidence intervals around for each provider's mean expenditures.
  b. The plan should also test the model to determine what the minimum detectable savings rate will be and whether a provider could plausibly achieve it.

- **Tip 4: Reduce Variation in Data by:**

  1. Truncating extreme or outlier values by setting a maximum annual aggregate claim level (e.g., $100,000) and exclude every claim above that level. This could also be done by truncating claims at a percentile (e.g., 99th) of all population expenditures as done in Medicare's NextGen ACO model.
  2. Excluding all dollars associated with predefined exceptional circumstances (e.g., transplant or cancer patients).

[6] Weissman, J et al. "The Design and Application of Shared Savings Programs: Lessons from Early Adopters." *Health Affairs*. September 2012 vol. 31, no. 9 1959-1968.

☐ Tip 5: Restrict Performance Measurement or Risk-Bearing to the Highest Risk-Patients.

Higher-risk patients tend to have more homogeneity in their expenditures than do lower-risk patients and therefore the payment model could be limited to just the highest-risk patients to reduce random variation that might result in erroneous savings or penalties.

☐ Tip 6: Use a Risk Adjuster.

Risk-adjustment software can modify expected spending levels to reflect the patient population served by a provider and reduce the risk of financially penalizing providers for serving patients with a higher than average burden of illness or reward providers for serving a healthier than average patient population. The most common risk adjusters are summarized in the table below.

	Grouper	Developer
1.	**Adjusted Clinical Groups (ACGs)** - Categorical system - Commercial and Medicaid models	Johns Hopkins University
2.	**Clinical Risk Groups (CRGs)** - Categorical system	Yale University, refined by 3M
3.	**Chronic Illness and Disability Payment System (CDPS)** - Hierarchical system - Medicaid-focused (SSI) - Free of charge	University of California, San Diego
4.	**Diagnostic Care Groups (DCGs)** - Hierarchical system with cumulative effects - Commercial and Medicaid models	Verisk Health
5.	**Hierarchical Condition Categories (HCCs)** - Hierarchical system - Medicare Advantage and Exchange models	Research Triangle Institute (for CMS)
6.	**Symmetry Episode Risk Groups (ERGs)** - Hierarchical system	Ingenix (purchased by Optum)

When choosing a risk-adjuster, consider the cost to license the product, the ease of use and access to ongoing support, the features of the product that matter to the plan; and whether or not it is used by other payers or programs in plan's marketplace.

☐ **Tip 7: Require a Minimum Numbers of Lives to Participate in Shared Risk and Full Risk Models.**

Depending on the plan's modeling, it may be able to set a required minimum number of attributed lives for providers that wish to join a risk-bearing contract. The level might be lower for providers wishing to join a **shared savings** contract. If the plan is concerned about incorrectly rewarding the provider for savings as a result of random variation, the plan could identify a different payment model.

Challenge 2: Safety-Net Provider Limited Capitalization.

For safety-net providers, participating in certain value-based payment models can be costly, both in terms of their operational expenses, but also in terms of their reimbursement. However, for many providers, the gains from participating have the potential of being worth the investment. A chief challenge for some safety-net providers serving the Medicaid population is the affordability of the upfront investment needed by providers to be successful. Health plans can play a critical role in supporting these structures, and many safety-net plans are already doing so.

Tips to manage this challenge:

☐ **Tip 1: Consider One Time Investments in Safety-Net Providers.**

As part of an overall plan strategy, the plan may consider providing "seed funding" or one time investments to safety-net providers to close the gap in operational and clinical capacities. For example, one Oregon CCO provided one-time grants to primary care clinics for infrastructure building that was designed to support practice's ability to achieve optimal health care outcomes, improve experience of care and better managed costs.

☐ **Tip 2: Consider Payment Models that Support Safety-Net Providers.**

Value-based payment models can support less resourced providers when upfront investment payments are made. This can range from prospectively paid **population-based payment** models, to supplemental per member per month payments that support key activities (e.g., care management). A plan could attach certain accountability or quality metrics to investment payments, or require that investment payments be netted out of any shared savings that might be earned. Similarly, a plan could provide staff support, like an embedded care manager, and have the costs of the care manager netted out of any shared savings. For more information on an embedded care manager, see the example of UPMC Health Plan discussed in see Step 4, "Providing Direct Staffing Support," under the **"Promote Provider Clinical Transformation to Foster Success under VBP"** action item in "Section III: Implementing VBP with Providers."

Support safety-net providers in nonfinancial ways. As noted in "Section III: Implementing VBP with Providers," there is a wide variation in provider readiness to accept value-based payments. A plan can support safety-net providers in their transition to value-based payments by offering training and technical assistance opportunities targeted to their special needs and considerations. For example, as noted in "Section III: Implementing VBP with Providers," San Francisco Health Plan (SFHP) offers a practice coaching program to safety-net clinics in its network to guide them through primary care transformation.

Challenge 3: Moving Beyond Fee-For-Service Claims Payments

Most value-based payments are built upon the fee-for-service architecture where payers continue to pay claims as they always have and reconcile claims payments to budgets for **episode-based** or **population-based** payment models at the conclusion of a performance period. This can be challenging for providers because in some value-based payment models, they don't have access to up-front dollars to pay for traditionally unreimbursed care. And, if a plan reconciles the claims payment to the value-based payment too long after the conclusion of a performance period, it dilutes the motivational impact of the incentive.

However, moving beyond a fee-for-service architecture and paying prospective budgets, or capitated payments, can be challenging, too. When a health plan pays fee-for-service claims, the health plan is able to receive valuable data on every service that was performed. When a health plan moves to a prospective budget, or capitated payment, the incentive for a provider to submit accurate "encounter data" wanes. Without the encounter data, plans are limited in their ability to have the accurate data needed for risk-adjustment and performance measurement.

In addition, paying providers prospectively or on a capitated basis requires providers to accept a lot of financial risk. In addition, providers would need to pay claims to its network of providers, which requires the financial and technical capability.

Tips to manage this challenge:

- **Tip 1: Hold Providers Financially Accountable for Submitting Encounter Data.** Many states hold Medicaid managed care plans accountable for submitting accurate encounter data, and plans should do the same of providers. Not only does accurate data affect a health plan's premium payments from the state, it also trickles down to provider's risk-adjustment and performance measurement. In California, some plans offer financial bonuses, have corrective action plan requirements, or withhold funds from the prospective payment that can be earned back on data quality performance.[7]

[7] Hardesty, A and Yegian, J. "Encounter Data: Issues and Implications for California's Capitated, Delegated Market." Issue Brief Integrated Healthcare Association. September, 2015.

- **Tip 2: Perform Audits to Identify Gaps in Data Quality, and Provide Direct Feedback and Support to Providers.**
  Plans in California have reported analyzing gaps in data and providing technical assistance to providers through webinars to educate data submitters on best practices.[8]

- **Tip 3: Go Slow and Ensure Providers are Ready.**
  If your plan does not have experience in paying a prospective or capitated payment, pilot such payment with a small number of trusted, collaborative providers and use feedback loops to identify any challenges the provider may have and any data quality concerns the plan has and adjust the process as needed. In addition, it is critical to ensure providers have the financial acumen and ability to accept and manage a prospectively paid budget, or **capitation** – and can pay claims to its network of providers.

[8] Ibid.

Appendix A: Summary of Medicaid MCO VBP Requirements in ACAP-Member States (as of September 2016)

State	No VBP Requirements for MCOs	State Requires MCOs to Report on VBP	State Requires MCOs to Implement VBP at a Certain Threshold	State Requires MCOs to Implement State-defined VBP	Notes
Arizona			X		AZ requires MCOs to have 20% of their medical spend in value-based arrangements. Of that, a minimum of 25% must be with an organization that includes PCPs. If a plan meets the VBP requirements it is eligible to earn from a bonus pool (1% of withheld capitation) based on performance on six measures. For the contract period starting 10/16, the VBP percentage requirement will be 35%, increasing to 50% on 10/17.
California	X				No specific payment reform requirements in Medi-Cal MCO contracts. However, most MCOs in CA already utilize APMs.
Colorado		X			CO has limited MCO contracts. Its main contracting vehicle is through Regional Collaborative Care Organizations (RCCOs). However, where CO has MCOs, the state requires the MCOs to report on VBP.
Connecticut	X				CT does not currently contract with MCOs, but has administrative service contracts with ASOs. CT is developing and implementing different payment reforms for 2017 including a shared savings initiative with FQHCs and "advanced networks" based on the Medicare Shared Savings ACO model, common performance metrics, and health neighborhoods.

State	No VBP Requirements for MCOs	State Requires MCOs to Report on VBP	State Requires MCOs to Implement VBP at a Certain Threshold	State Requires MCOs to Implement State-defined VBP	Notes
Florida				**X**	VBP requirement for MCOs to adopt Medicaid's physician incentive program which applies to PCPs and Obstetricians or request approval for an alternate physician incentive model meeting minimum state requirements. Designated providers qualify for enhanced payments from MCOs at the Medicare fee schedule by meeting quality and access standards.
Hawaii		**X**	**X**		HI will require MCOs to increase their proportion of value-based payments from 50% to 80% over a three-year period.
Illinois	**X**				IL does not contractually obligate MCOs to implement APMs.
Indiana	**X**				IN does not contractually obligate MCOs to implement APMs.
Kentucky	**X**				KY does not contractually obligate MCOs to implement APMs.
Maryland	**X**				MD encourages and surveys MCOs on VBP activity.
Massachusetts	**X**			**X** (see note)	MA encourages MCOs to implement APMs, but does not contractually obligate plans to do so. MA will be implementing a state-defined VBP requiring MCOs to contract with ACOs. A Medicaid MCO procurement is expected in late 2016.

State	No VBP Requirements for MCOs	State Requires MCOs to Report on VBP	State Requires MCOs to Implement VBP at a Certain Threshold	State Requires MCOs to Implement State-defined VBP	Notes
Minnesota				X	MN MCOs must implement a state-defined ACO model, called the Integrated Health Partnerships (IHPs), with a shared savings/risk payment methodology. MN has also implemented Integrated Care System Partnerships (ICSPs) for dual-eligible beneficiaries which requires partnerships across MCOs, primary, acute, long-term care, and mental health providers. Medicaid MCOs must submit ICSP proposals, including specified quality measures, to the state for approval.
New Hampshire	X				NH does not contractually obligated MCOs to participate in VBP arrangements. As part of its 1115 Waiver, however, NH has committed to increasing APMs in Medicaid, including through MCOs.
New Jersey	X				NJ does not contractually obligate MCOs to implement APMs.

State	No VBP Requirements for MCOs	State Requires MCOs to Report on VBP	State Requires MCOs to Implement VBP at a Certain Threshold	State Requires MCOs to Implement State-defined VBP	Notes
New York		**X**	**X** (see note)	**X** (see note)	NY strongly encourages Medicaid MCOs to implement state-defined VBP models through a rate enhancement incentive. NY set a goal of having 80-90% of all managed care payments to providers using VBP methodologies by end of 2020 and a goal of 35% in risk-based arrangements by 2020. As part of its DSRIP program, NY developed 4 APMs, including episode-based payment models, and population-based payment models focused on total and high-risk populations. NY is developing an analytics platform to give providers and plans access to data to help them manage under APMs. The state is not discouraging MCOs from entering into MCO-defined APMs (i.e., "off-menu"), but these approaches need to be approved by the state.
Ohio			**X**	**X**	OH requires MCOs to implement its PCMH and episode-of-care models. Plans were required to develop a strategy that makes 20% of all aggregate net payments to providers value oriented by 2020. Plans must also develop a strategy to report comparative performance of providers using nationally recognized measures of hospital and physician performance.
Oregon				**X** (see note)	OR CCOs are required to implement a schedule of alternative payments that meet state requirements. CCOs must assign a high priority to implementing APMs and incentives for primary care medical homes. OR does not specifically indicate the payment model that plans must implement.

State	No VBP Requirements for MCOs	State Requires MCOs to Report on VBP	State Requires MCOs to Implement VBP at a Certain Threshold	State Requires MCOs to Implement State-defined VBP	Notes
Pennsylvania			X		PA will require MCOs to make a specific percentage of provider payments through VBP arrangements meeting state criteria. PA intends to impose a 2% withhold on MCOs that do not have 7.5% of the medical portion of capitation and maternity revenue expended via VBP in 2017. The minimum VBP proportion for plans is expected to shift to 15% in 2018 and 30% in 2019.
Rhode Island			X	X	RI requires its MCOs to contract with at least two state-certified Accountable Entities (AEs/ACOs) and requires a specified percentage of payments be made through AEs, and more comprehensively that 30% of provider payments be made through APMs by 6/2017; 60% by 6/2018, and 80% by 6/2020.
Texas		X			TX requires MCOs to annually report on value-based contracting.
Virginia		X	X		RFP for LTSS MCOs indicates that VA will require APM reporting and establish future VBP targets. The RFP indicates that MCOs should expect VBP targets to be at least 5% above baseline.
Washington		X	X		Washington has a goal of having 80% of state-financed health care and 50% of commercial market in value-based payments by 2019.
Wisconsin	X				WI does not contractually obligate MCOs to implement APMs.

Appendix B: Shared Risk on Total Cost of Care with Primary Care Providers

In 2014, Massachusetts's Medicaid (MassHealth) program instituted a new payment model, the Primary Care Payment Reform Initiative (PCPR). PCPR is a three-year payment model pilot, ending December 2016, designed to support primary care practices that operate under the principles of a Patient-Centered Medical Home and, optionally, are able to deliver integrated behavioral health services. It currently has 62 primary care practices and approximately a quarter of non-managed care enrollees (~90,000). Full cost and quality results will not be available until the conclusion of the program.

Primary care practices that voluntarily contracted with MassHealth receive a risk-adjusted, capitated payment for primary care services for an attributed population. Providers also share in any savings or losses on spending on all non-primary care services, referred to as "**total cost of care" (TCOC)**. In this manner, primary care providers are freed from the strictures of fee-for-service payment through an enhanced **capitation** rate (and are nominally at financial risk for the primary care services they provide), and are also at risk for the TCOC.

The model breaks down to the following three components:

1. **Comprehensive Primary Care Payment (CPCP)[9]:**
    a. The CPCP is the capitated payment that each primary care provider receives for primary care services. The base rate of the CPCP consists of the average PMPM billing of primary care services plus funding for non-billable transformation costs ("Medical Home load").
        i. At the option of the contracting entity, behavioral health services can be included in the base rate. Primary care providers have the option of choosing three payment levels to support the practices' level of behavioral health integration.
            - Tier 1: no separately billable behavioral health services are included in the CPCP
            - Tier 2: family consultation, case consultation, diagnostic evaluation, couples/family treatment, individual and group treatment, inpatient-outpatient bridge visits are included in the CPCP
            - Tier 3: all services in Tier 2, plus medication visits, medication administration, and psychological testing are included in the CPCP
    b. The base CPCP is then risk-adjusted to reflect the health status of the members attributed to each primary care provider.[10]

[9] Sources: Executive Office of Health and Human Services, Commonwealth of Massachusetts. Request for Applications for the Primary Care Payment Reform Initiative. March 7, 2013. Primary Care Payment Reform: Applicant Meeting. Presentation delivered by MassHealth, November 2013.
[10] The PCPR program utilizes a customized version of Verisk Health's primary-care specific grouper, PCAL, to risk-adjust the capitated primary care payment.

c. Finally, the base CPCP is adjusted once more to account for attributed members' expected service utilization outside of the contracted-entity. This allows the payer to pay the contracted primary care provider only for the primary care services it is likely (based on historical data) to provide to the member, and mitigate the possibility of overpaying primary care providers on the capitated payment amount.

2. **Quality Incentive Payment:**
   a. There is an annual incentive payment given to the primary care providers based on their performance on primary care metrics. In the first year of the program, incentives were awarded for reporting quality metrics only. In subsequent years, primary care providers have been eligible to receive incentives for both reporting and performance.
   b. Quality metrics are focused on primary care activities, including, for example, adult prevention and screening, depression screening, ADHD medication management for children, access, care coordination, and certain measures focused on chronic illness care.

3. **Shared Risk on Total Cost of Care (TCOC):**
   a. For the first year of the program, all participants were in a **shared savings** arrangement based on their TCOC for non-primary care, including specialist and hospital care. TCOC includes long-term supports and services, at the option of the provider.
   b. In the second two years of the program, all participants have had to move to one of two different downside risk tracks, unless they were able to provide good cause for staying in the upside-only track.[11] The two risk tracks vary the risk from 0-6% and vary the savings up to 6%.

      The downside risk tracks are structured as follows:
      i. Risk Track 1 (**Shared Risk**): Providers that choose this risk track receive or owe 60% of the difference between the actual spend and the budget unless:
         1. the difference between the actual spend and budget is less than **1**% of the budget, in which case no savings are accrued and no losses are incurred, or
         2. the difference between the actual spend and the budget is more than **10**% of the budget, in which case savings and losses are capped at six percent of the actual spend.

[11] In Massachusetts any provider taking on nominal risk must obtain a certificate from the Department of Insurance to be a "risk-bearing provider organization."

Table 1. Level of Savings under Risk Track 1[12]

Target Spend	*Actual Spend*	*Savings variance $$*	*Variance as % of Target Spend*	*Provider Risk Share*	*MassHealth Risk Share*
100.00	*115.00*	*(15.00)*	*15%*	*(6.00)*	*(9.00)*
100.00	*110.00*	*(10.00)*	*10%*	*(6.00)*	*(4.00)*
100.00	*105.00*	*(5.00)*	*5%*	*(3.00)*	*(2.00)*
100.00	*101.00*	*(1.00)*	*1%*	*0*	*(1.00)*
100.00	*99.00*	*1.00*	*-1%*	*0*	*1.00*
100.00	*95.00*	*5.00*	*-5%*	*3.00*	*2.00*
100.00	*90.00*	*10.00*	*-10%*	*6.00*	*4.00*
100.00	*85.00*	*15.00*	*-15%*	*6.00*	*9.00*

ii. Risk Track 2 (Transition to **Shared Risk**): Providers that choose this risk track receive or owe 60% of the difference between the actual spend and the budget unless:
   1. the difference between the actual spend and budget is less than **2**% of the budget, in which case no savings are accrued and no losses are incurred, or
   2. the actual spend exceeds the budget by more than **5**% of the budget, in which case the provider's losses are capped at **3**% of the budget, or
   3. the actual spend is lower than the budget by more than **10**% of the budget, in which case the savings are capped at **6**% of the budget.

4. Behavioral Health Integration

a. A key focus of the MassHealth PCPRI model is behavioral health integration. The clinical delivery model requires the primary care practices participating in this payment model to develop the capacity to provide the core components of a patient centered medical home, and to integrate behavioral health services into the primary care setting. The PCPRI contract specifically requires practices to:

i. Employ or provide through a contractual arrangement, a clinical care manager to coordinate and provide care management services to the highest risk panel enrollees, including managing the development, implementation and monitoring of the integrated care plans.

ii. Conduct behavioral health screenings using standardized tools and track the results.

[12] Executive Office of Health and Human Services, Commonwealth of Massachusetts. Request for Applications for the Primary Care Payment Reform Initiative. March 7, 2013.

iii. Have written agreements with behavioral health providers, including expectations for accessing services, protocols for joint problem solving, information sharing, care coordination and provider-to-provider consultations.
iv. Use electronic medical records to monitor and manage chronic diseases, and behavioral health conditions.
v. Provide patients with timely access to behavioral health providers 24/7.

Appendix C: Shared Risk on Total Cost of Care with ACOs

Shared Risk on Total Cost of Care with ACOs[13]

Minnesota's Medicaid program developed the Integrated Health Partnership (IHP), which is a payment model in support of providers that voluntarily come together as ACOs to provide care that achieves the Triple Aim. There are two versions of the IHP model: (1) the "virtual IHP" supports primary care providers that are not supported by a hospital or integrated delivery system; and, (2) the "integrated IHP" is designed for integrated delivery systems that provide a broad spectrum of outpatient and inpatient care through a common financial and organizational entity. This appendix focuses only on the "integrated IHP" model.

Integrated IHPs are paid for services on a fee-for-service basis, unlike primary care practices in the Massachusetts example described in **"Appendix B: Shared Risk on Total Cost of Care with Primary Care Providers."** IHPs are then held accountable for their performance against a risk-adjusted **TCOC** target for an attributed population.

1. **Total Cost of Care Target**:
   The Target TCOC is expressed as a per-member-per-month target based on historical claims trended forward. The TCOC is calculated as follows:

   a. **Included Services**: The Target TCOC consists of approximately 35-45% of all claims incurred in the population.[14] Specifically, it includes: a broad range of primary care, hospital inpatient and outpatient care, chemical dependency services, mental health services, hospice, home health, pharmacy, vision, rehabilitation services, laboratory and radiology. Excluded from the Target TCOC are long-term care services and supports, dental care, DME, transportation, child welfare case management, and intensive and residential mental health and chemical dependency services. Notably, ACOs contracting with the state under this model may propose additional Medicaid covered services for inclusion in the TCOC target.

   b. **Base TCOC**: The Base TCOC is initially established on claims incurred during a recent time period, called the "base year." The Base TCOC is then adjusted by excluding cases that fall outside of pre-determined thresholds to remove "catastrophic" cases from the calculation of the PMPM TCOC value.[15] The Base TCOC is then risk-adjusted using the Johns Hopkins ACG risk adjustment tool.

[13] Sources: Memo from FORMA Actuarial Consulting Services, LLC to Minnesota's State Medicaid Director. January 17, 2013. Minnesota Department of Human Services Health Care Administration. Request for Proposal for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnership (IHP) Demonstration. April 25, 2016.
[14] Memo from FORMA Actuarial Consulting Services, LLC to Minnesota's State Medicaid Director. January 17, 2013.
[15] The predetermined thresholds vary by size of the population. For populations of 1,000-1,999 attributed patients, the maximum annual claims per patient (claims cap) is $50,000. For populations of 2,000-4,999, the claims cap is $100,000; and for populations greater than 5,000 the claims cap is $200,000.

c. **Expected Trend**: Once the Base TCOC is calculated, a "trend factor" is applied to it to account for the expected increases in spending across the attributed population during the performance period.

d. **Adjusted Target TCOC**: The Adjusted Target TCOC is the final PMPM to which a provider's performance will be compared. The Adjusted Target TCOC consists of the Base TCOC, the Expected Trend and then one final adjustment to remove any "catastrophic cases" and for any change in the relative risk of the attributed population between the base year and the performance period.

2. **Risk Sharing:**
Integrated IHPs are in a **shared savings**-only model in the first year of the contract, and must move to downside risk in the second and third years of the contract. The components of the risk sharing model are as follows:

a. **Minimum Performance Thresholds:** IHPs must meet a minimum performance threshold of 2% before they are eligible to share in any savings or be at risk for any losses. Meaning, the Performance TCOC must be at or above 102% of the Adjusted Target TCOC in order to be at risk for losses and at or below 98% of the Adjusted Target TCOC in order to receive any savings distributions.

b. **Proportion of Savings or Losses:** For the first two years of the program, the IHPs share equally in savings or losses with the state / MCO. In the third year of the program, different distributions of earned savings or experienced losses can be proposed by the IHP. Savings and losses are calculated back to the first dollar, after meeting the minimum performance threshold, meaning if a provider's performance is 97% of the adjusted TCOC, it is eligible to keep the negotiated share of the 3% saved.

c. **Shared Savings and Shared Risk Caps:** IHPs are given the opportunity to propose their preferred risk sharing cap, with some parameters set by the state. The parameters are as follows:
   i. **Year 1:** The provider can choose its savings cap, up to the maximum cap set by the state, which is 85% of the Adjusted Target TCOC. The maximum threshold must be the same in Year 1 and Year 3. This is important because in Year 3, the risk must be symmetrical and therefore, if a provider chooses 85% as its savings cap, it will also be at risk for a negotiated portion of all losses up to 115% of the adjusted TCOC.
   ii. **Year 2:** Asymmetrical risk capping is accepted in Year 2, so long as the ratio of the shared savings cap is 2:1 to the downside risk cap. In other words, if the provider chooses to cap risk its risk at 106% above the adjusted TCOC, its savings cap would be set at 88% of the adjusted TCOC (which is 3 percentage points below the state cap).
   iii. **Year 3:** Symmetrical risk capping is required in Year 3 and as mentioned above, IHPs are able to propose different distributions of earned savings or experienced losses.

3. **Performance on Quality:**
   Performance on quality measures affects the portion of shared savings for which a provider is eligible. In the first two years, performance will affect 25% of the shared savings a provider is eligible for (i.e., 12.5% of total savings) first based on reporting, and then based on performance. In the third year, 50% of the provider's portion of shared savings (i.e., 25% of total savings) is based on quality performance. The state determines the minimum and maximum level of quality performance and which measures will be included in the payment program.

The MN IHP program has 19 ACOs, nearly 350,000 beneficiaries and close to 9,000 providers participating in the program. Providers saved $14.8 million compared to trended targets in 2013, and estimated $61.5 million in 2014. Quality targets have been met by all providers in 2013.