CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Waiver APM Requirements

Overview:

PRIME seeks to support sustainable delivery system reform through a requirement that Designated Public Hospitals use Alternative Payment Models (APMs) in which the system assumes some risk for the cost and quality of services provided to assigned Medi-Cal members.

There are two requirements in the waiver Special Terms and Conditions for Designated Public Hospitals to move toward APMs, some of which may require changes to managed care contracts by January 1, 2018.

a. Aggregate requirement: 50 percent of all Medi-Cal managed care beneficiaries assigned to Designated Public Hospitals by their managed care plan (MCP) will receive all or a portion of their care under a contracted APM by January 2018 (DY 13); 55 percent by January 2019 (DY 14); and 60 percent by the end of the waiver renewal period in 2020 (DY 16). Failure to meet these requirements will result in a reduction in Designated Public Hospitals PRIME funds.

b. Individual requirement (for each system): Designated Public Hospitals will be required to contract with at least one Medi-Cal MCP in the service area that they operate in using an APM **by January 1, 2018**. If a Designated Public Hospital is unable to meet this requirement and can demonstrate that it has made a good faith effort to contract with an MCP in the service area that it operates in and a gap in contract period occurs, DHCS has discretion to waive this requirement.

An APM should include the following features:

- A defined patient population the Designated Public Hospital is accountable for, defined through assignment either by DHCS or by a managed care plan.
- A set of quality accountability metrics that are aligned with the contracted MCPs quality accountability and clinical outcome metrics.
- Some contractual level of risk for cost of care. This accountability does not need to be full risk capitation, but must include a form of risk sharing, incentives or shared savings for reduced cost.
- Models that lack one or more of these three features will not qualify as an APM.

Accepted Forms of APM:

- **Capitation**
  - Partial (primary care only)

  - Partial-plus (primary care and some specialty care)
  - Global (primary, specialty, ancillary and/or hospital care)

- **Additional models yet to be approved by the State and CMS.** Details NOT finalized, but we expect outstanding Attachment R to include:
  - Bundled payments with shared savings and potential downside risk as well phased in over time
  - Episode-based payments with shared savings and potential downside risk as well phased in over time
  - Shared savings tied to total cost of care with potential downside risk as well phased in over time
  - Bundled payments with full risk for the bundled service
  - Episode-based payments with full risk

APM Link to Quality

The following is additional language proposed in Attachment R; it is not yet approved.

Payments for all APMs are affected by quality performance against a benchmark (e.g. vs. prior performance, vs. peers, vs. national/regional/state standard). Quality performance impact could be in the form of:

- Bonus payments for meeting or exceeding quality benchmarks
- Withholds or clawbacks of FFS or capitated rates for failing to meet quality benchmarks
- A lower/higher percentage of shared savings/losses being paid for meeting/exceeding/failing to meet quality benchmarks
- No shared savings being paid for failing to meet quality benchmarks
- Quality pool payments for highest performing practices funded by a quality withhold