Attachment R
Alternative Payment Methodologies
Value Based Payment Models that Qualify as APMs Overview

In addition to the already defined value-based payment (VBP) models that qualify as Alternative Payment Models (APMs) under California's PRIME program, below are additional types of arrangements that would qualify. These APMs will be used to calculate the program's stated goals of assigned managed care plan (MCP) enrollees in Designated Public Hospital Systems (DPHs) to receive care under an APM (50% beginning in January 2018, 55% beginning in January 2019, and 60% beginning in January 2020). The APMs used in the PRIME Framework align closely with the Health Care Payment Learning and Action Network (HCP LAN) Framework. Payments must also be tied to quality performance, using one of the methods defined below. While the state expects many DPHs will leverage their existing capitated arrangements to pursue Level 4 APMs, any method listed below will qualify as an APM.

Relationship between Payment and Quality

Payments for all APMs are affected wholly or in part 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

APM Descriptions

Introductory APMs (LAN Categories 2C and 2D)

Fee-for-service payments tied to quality performance: A purchasing strategy in which providers or provider organizations are financially rewarded or penalized for meeting certain pre-defined performance benchmarks for quality and/or cost.

This introductory level of APM will only be allowed for the first year of the APM requirement which is calendar year 2018.

APMs (LAN Category 3A)

Bundled payments with shared savings (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a pre-defined set of services. Under this strategy, providers continue to receive payments for the individual services included in the bundle based on the rates under the existing claims-based system. At the end of the predetermined time period, all of the paid claims for the set of services provided to an individual are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 20% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is not

at risk for that amount. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Episode-based payments with shared savings (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a clinically defined episode of care. Under this strategy, providers continue to receive payments for the individual services included in the episode, based on the rates under the existing claims-based system. At the conclusion of the episode, all of the paid claims for the episode are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 20% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is not at risk for that amount. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance. An example of an episode is the management of pregnancy, delivery, and post-partum care.

Shared savings tied to cost of care (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across a defined set of services delivered to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to a defined set of the services that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 20% of savings achieved. If actual spending exceeds the benchmark amount, participating providers will not be responsible for the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Total cost of care shared savings (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across all services provided to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to all of the services (total cost of care) that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 20% of savings achieved. If actual spending exceeds the benchmark amount, participating providers will not be responsible for the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

<u>Advanced APMs (LAN Category 3B)</u>

Bundled payments with shared savings/risk (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a pre-defined set of services. Under this strategy, providers continue to receive payments for the individual services included in the bundle, based on the

rates under the existing claims-based system. At the end of the predetermined time period, all of the paid claims for the defined bundle of services provided to an individual are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 30% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is financially responsible for up to 10% of the difference. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Episode-based payments with shared savings savings/risk (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a clinically defined episode of care. Under this strategy, providers continue to receive payments for the individual services included in the episode, based on the rates under the existing claims-based system. At the conclusion of the episode, all of the paid claims for the episode are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 30% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is not at risk for that amount. If actual spending exceeds the benchmark, the provider or provider organization is financially responsible for up to 10% of the difference. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance. An example of an episode is the management of pregnancy, delivery, and post-partum care.

Shared savings/risk tied to cost of care (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across a defined set of services delivered to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to a defined set of the services that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 30% of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to 10% of the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Total cost of care shared savings/risk (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across all services provided to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to all of the services (total cost of care) that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 30% of savings achieved. If actual spending exceeds the target amount, participating providers or

provider organizations will be responsible for up to 10% of the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Prospective payments (LAN Category 4A)

Bundled payments with full risk: A purchasing strategy in which providers or provider organizations receive an upfront payment designed to cover a bundle of services for each enrollee assigned to them, rather than payment for individual services actually provided. The payment is delivered upfront, or prospective to the delivery of services, once a pre-defined trigger event occurs (a specific service(s) is provided). The payment is inclusive of a pre-defined set of services and represents the full payment that will be provided by the payer to the provider or provider organization). If actual spending exceeds the payment, the provider or provider organization is fully financially responsible for any portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payment adjustments must be made based on measured quality performance.

Episode-based payments with full risk: A purchasing strategy in which providers or provider organizations receive an upfront payment designed to cover the expected costs of clinically defined episodes of care. The payment is delivered upfront, or prospective to the delivery of services, once a pre-defined trigger event occurs. Episodes may involve predefined range of provider types, different settings of care and is inclusive of predefined set of services and procedures over a defined time period. If actual spending exceeds the payment, the provider or provider organization is fully financially responsible for the portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payment adjustments must be made based on measured quality performance. An example is payment to obstetricians for ongoing management of pregnancy, delivery, and post-partum care.

Condition-specific capitated payments: A purchasing strategy in which providers or provider organizations receive an upfront payment designed to cover the expected costs for clinically defined health conditions. The payment is delivered upfront, or prospective to the delivery of services. Condition-specific capitated payments may involve predefined range of provider types, different settings of care and is inclusive of predefined set of services related to specified health conditions, over a defined time period. If actual spending exceeds the payment, the provider or provider organization is financially responsible for the portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payment adjustments must be made based on measured quality performance. An example is payment to pediatricians for delivering services related to the care of asthmatic children.

Table 1: Proposed Medi-Cal VBP Requirements

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
APMs LAN Category 3A				
Bundled payments with shared savings (upside only)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A
Episode-based payments with shared savings(upside only)	• Population(s) included • Clinical definitions of episodes of care • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Shared savings tied to cost of care (upside only)	• Population(s) included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A
Total cost of care shared savings (upside only)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A
APMs LAN Category 3B				
Bundled payments with shared savings (upside/downside)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Episode-based payments with shared savings (upside/downside)	• Population(s) included • Clinical definitions of episodes of care • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance
Shared savings tied to cost of care (upside/downside)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance
Total cost of care shared savings (upside only)	• Population(s) included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Prospective Payments (LAN Category 4)				
Bundled payments with full risk	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5%	100%	100%
Episode-based payments with full risk	• Population(s) included • Clinical definitions of episodes of care • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5%	100%	100%

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Condition-specific capitated payments	• Population(s) included • Clinical definitions of covered conditions • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5%	100%	100%

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.