307 – ALTERNATIVE PAYMENT MODEL INITIATIVE – STRATEGIES AND PERFORMANCE-BASED PAYMENTS INCENTIVE (CYE 20 THROUGH CYE 22)

EFFECTIVE DATES: 10/01/17, 10/01/18, 10/01/19, 10/01/20, 10/01/21, 09/30/22

APPROVAL DATES: 09/05/19, 03/19/20, 05/24/21, 10/15/21,10/06/22

I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DCS/Children's Health Plan (CHP), DES/DDD (DDD), and RBHA Contractors for dates of service from October 1, 2019, through September 30, 2022. This Policy establishes requirements for the Alternative Payment Model (APM) Initiative–Strategies and Performance Based Payments (PBP) Incentive. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM Strategies.

II. DEFINITIONS

For purposes of this Policy:

ENCOUNTER	A record of health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.

MEDICAID ACCOUNTABLE CARE ORGANIZATION (MEDICAID ACO)

An entity that enters into Value-Based Purchasing (VBP) arrangement with a Contractor which:

1. Improves the health care delivery system by increasing the quality of care while reducing costs.
2. Enters into VBP contracts with provider groups and/or networks of groups.
3. Coordinates provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM), combined with quality incentives (to ensure both quality outcomes and cost containment).
4. Supports providers participating in APMs by providing services such as, but not limited to: data analytics, technical assistance, provider education, and provider recruitment.
5. Operates as an intermediary between the Contractor and providers, is not a provider of direct services to members.
6. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS (Refer to ACOM Policy 438).

PERFORMANCE BASED PAYMENT (PBP)

A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the APM strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment shall typically occur after the completion of the Contract period but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement. Performance Based Payments shall not include Per Member Per Month (PMPM) payments or other amounts for provider care coordination, case management, care management, or other infrastructure costs.

PERFORMANCE BASED PAYMENT INCENTIVE (PBP INCENTIVE)

A payment from AHCCCS to the Contractors for the Performance Based Payments paid to providers during the Contract Year.

PREMIUM TAX

The tax imposed pursuant to A.R.S. §36-2905 and A.R.S. §36-2944.01 for all payments made to the Contractor for the Contract year.

TARGETED INVESTMENTS (TI) PROGRAM	For purposes of this Policy, the TI program requires activities designed to create a system of integrated care to incentivize providers to improve performance and increase physical and behavioral health care integration and coordination for individuals with behavioral health needs through incentive payments. Eligible providers must elect to participate in the TI program.
VALUE BASED PURCHASING (VBP)	A form of payment reform that seeks to reward providers for providing high-quality care to members through financial incentives. The financial incentives are tied to improving health outcomes while reducing the cost of care. VBP attempts to reduce inappropriate care and to identify and reward the best-performing providers.

LEARNING ACTION NETWORK ALTERNATIVE PAYMENT MODELS (LAN-APM)

ALTERNATIVE PAYMENT MODEL (APM) STRATEGIES (IN LAN-APM CATEGORY ORDER)

A model which aligns payments between payers and providers to incentivize quality, health outcomes, and value over volume to achieve the goals of better care, smarter spending, and healthier people.

The APM Strategies discussed in this initiative originate from the Alternate Payment Model Framework established by the Health Care Payment Learning & Action Network (LAN-APM) which include the following categories and strategies:

1. Fee-For-Service – No Link to Quality & Value
2. Fee-For-Service – Link to Quality & Value
   a. Foundational Payments for Infrastructure and Operations,
   b. Pay for Reporting, and
   c. Pay for Performance.
3. APMs Built on Fee-For-Service Architecture
   a. APMs with Shared Savings, and
   b. APMs with Shared Savings and Downside Risk.
4. Population Based Payment
   a. Condition-Specific Population-Based Payment,
   b. Comprehensive Population-Based Payment, and
   Integrated Finance & Delivery Systems

FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE (LAN-APM CATEGORY 1)	
BLOCK PURCHASE PAYMENT ARRANGEMENT METHODOLOGY	A payment methodology where the Contractor pays the provider for a contracted amount in 12 monthly installments and where payment has no relation to quality, outcomes, or efficiency. (LAN-APM Category 1)
FEE-FOR-SERVICE (NO LINK TO QUALITY AND VALUE)	A purchasing strategy in which the Contractor pays the provider a specific rate for every unit of service the provider delivers without regard to quality, outcomes, or efficiency. (LAN-APM Category 1)
FEE-FOR-SERVICE – LINK TO QUALITY & VALUE (LAN-APM CATEGORY 2)	
FOUNDATIONAL PAYMENTS FOR INFRASTRUCTURE & OPERATIONS	A purchasing strategy in which payments are made for infrastructure investments that shall improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. Examples include care coordination, case management, and care management fees and payments for health information technology investments. (LAN-APM Category 2A)
PAY FOR REPORTING	A purchasing strategy in which providers/physicians are rewarded with bonus payments for reporting quality data or penalties for not reporting quality data. (LAN-APM Category 2B)
PAY FOR PERFORMANCE	A purchasing strategy in which providers are paid for meeting performance targets on quality metrics. It may also include penalties for providers who do not perform well on quality metrics. In this strategy, payments are not subject to provider performance against aggregate cost targets but may account for performance on a more limited set of utilization measures. (LAN-APM Category 2C)
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE (LAN-APM CATEGORY 3)	
APMS WITH SHARED SAVINGS	A purchasing strategy where providers share in a portion of the savings the provider generates against a cost target or by meeting utilization targets if quality targets are met. However, Contractors do not recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. (LAN-APM Category 3A)

APMS WITH SHARED SAVINGS AND DOWNSIDE RISK	A purchasing strategy where providers share in a portion of the savings the provider generates against a cost target or by meeting utilization targets if quality targets are met. Contractors recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. This strategy includes episode-based payments for procedures and comprehensive payments with upside and downside risk. (LAN-APM Category 3B)
POPULATION BASED PAYMENT (LAN-APM CATEGORY 4)	
CONDITION-SPECIFIC POPULATION-BASED PAYMENT	A purchasing strategy of prospective, population-based payments, for all care delivered by particular types of clinicians structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice. This strategy includes Per Member Per Month (PMPM) payments, payments for specialty services, such as oncology or mental health, and bundled payments for the comprehensive treatment of specific conditions. (LAN-APM Category 4A)
COMPREHENSIVE POPULATION-BASED PAYMENT	A purchasing strategy of prospective, population-based payments, covering all an individual's health care needs, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a comprehensive collection of care. This strategy includes global budgets or full/percent of premium payments which encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct. (LAN-APM Category 4B)
INTEGRATED FINANCE & DELIVERY SYSTEMS	A purchasing strategy of prospective, population-based payments structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. This strategy includes global budgets or full/percent of premium payments in integrated systems. (LAN-APM Category 4C)

Additional definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

III. POLICY

A. GENERAL REQUIREMENTS

The APM - Strategies and PBP Incentive discusses the Contractor LAN-APM strategy VBP/APM contract requirements, as well as the PBP Incentive. The PBP Incentive is an arrangement under which the Contractor may receive additional funds over and above the capitation rates for providers successfully meeting targets established by the Contractor that are aimed at improving performance measures, access to care, and reducing cost of care.

The Contractor shall meet the APM Strategies qualifying criteria in the section of this Policy titled "Contractor Responsibilities" for the below, and certify as specified in "Contractor Responsibilities":

1. LAN-APM target requirements, and

2. LAN-APM sub-requirements for Categories 3 and 4.

Refer to Attachment A for the LAN-APM Strategies.

Failure to meet or certify to meeting the criteria in a particular contract year shall result in:

1. Disqualification of ACC and ALTCS E/PD Contractors from any Earned Withhold and/or Quality Measure Performance (QMP) Incentive payments discussed in ACOM Policy 306. AHCCCS reserves the right to include a new Contractor in the Earned Withhold and/or QMP Incentive payment specified in ACOM Policy 306 even if they did not meet or certify to meet the APM Strategies qualifying criteria.

2. Assessment of sanctions for RBHAs, CHP Subcontracted Health Plan, and DDD Subcontracted Health Plans up to a maximum of the amounts listed in the table below:

CONTRACTOR	MAXIMUM SANCTION AMOUNT
Maricopa County RBHA	$300,000
South RBHA	$200,000
North RBHA	$100,000
CHP Subcontracted Health Plan	$100,000
DDD Subcontracted Health Plans	$100,000

B. CONTRACTOR RESPONSIBILITIES

1. A minimum percentage of the Contractor's total Title XIX/XXI payments to providers (both APM and non-APM, contracted or non-contracted) excluding state directed payments paid outside of capitation (e.g., lump-sum directed payments), shall be governed by APM Strategies for the Contract Year Ending (CYE), according to the table below:

LAN-APM Target Requirements							
CYE	ACC [1]	ALTCS E/PD (E/PD MEDICARE ADVANTAGE-DUAL SPECIAL NEEDS PLAN (MA-DSNP[2])	CHP SUB-CONTRACTED HEALTH PLAN	RBHA		DDD	
				SERIOUSLY MENTALLY ILL (SMI)-INTEGRATED [1]	NON-INTEGRATED	SUB-CONTRACTED HEALTH PLANS [1]	LONG TERM SUPPORT SERVICES (LTSS)
CYE 20	60%	60%/60%	N/A	50%	25%	50%	20%
CYE 21	65%	65%/65%	N/A	55%	30%	55%	25%
CYE 22	65%	65%/65%	25%	55%	30%	55%	25%

[1] A minimum of 25 percent of the percentage requirement noted above shall be with an organization that includes Primary Care Providers (PCP)s.

[2] For a MA-DSNP contract for ALTCS E/PD Duals, if a Contractor's MA-DSNP contract serves AHCCCS populations other than ALTCS E/PD Dual members, the Contractor shall split out their MA-DSNP populations served to prove that they have met the minimum percentage requirements for the ALTCS E/PD MA-DSNP population. The Medicaid-funded VBP/APM amounts for the ALTCS E/PD MA-DSNP population shall be reported in the ALTCS-EPD tab of the APM Strategies Certification. The Medicare-funded VBP/APM arrangements with MA-DSNP providers for ALTCS-EPD members shall be reported in the MA-DSNP tab of the APM Strategies Certification. The Contractor may count both aligned and non-aligned members in their ALTCS E/PD MA-DSNP population.

2. AHCCCS intends to evaluate the minimum value thresholds annually using a data-driven approach. At this time, AHCCCS anticipates that the minimum value threshold may grow each year according to the schedule below:

LAN-APM TARGET REQUIREMENTS (ANTICIPATED)							
CYE	ACC	ALTCS E/PD (E/PD/ MA-DSNP)	CHP SUB CONTRACTED HEALTH PLAN	RBHA		DDD	
				SMI-INTEGRATED	NON-INTEGRATED	SUB-CONTRACTED HEALTH PLANS	LTSS
CYE 23	70%	70%/70%	35%	60%	35%	60%	30%
CYE 24	75%	75%/75%	40%	65%	40%	65%	35%

3. APM Strategies that qualify for this initiative shall not include:
   a. Block Purchase Payment Arrangement Methodology with no link to quality and value,
   b. Fee-For-Service Strategy with no link to quality and value (LAN-APM Category 1), or

c. Foundational Payments for Infrastructure & Operations strategy (LAN-Category 2A).

APM Strategies that incorporate the Pay for Reporting strategy (LAN-APM Category 2B) shall be considered by AHCCCS to meet the qualifying criteria on a case by case basis and prior approval is required. AHCCCS will only consider approval of LAN-APM Category 2B for expansion to services/service providers/provider types not traditionally utilized for APM arrangements. AHCCCS expects to consider approval only on a short-term basis.

Qualifying APM Strategies utilized shall meet the definitions provided under Section II "Learning Action Network Alternative Payment Models (LAN-APM)" of this Policy. APM Strategies shall be designed to achieve cost savings and quantifiable improved outcomes.

For ALTCS E/PD Contractors: Inclusion of payments for Room and Board for members residing in Nursing Facilities (which are included in per diem payments and not separately identifiable) is permissible when computing the percentage of total payments that are governed by APM Strategies.

The Contractor shall maintain a minimum percentage for usage of APM Strategies in LAN-APM Categories 3 and 4 listed in the table below of total Title XIX/XXI payments governed by all APM Strategies.

SUB-REQUIREMENT FOR LAN-APM CATEGORIES 3 AND 4							
CYE	ACC	ALTCS/ E/PD (E/PD/ MA-DSNP)	CHP SUBCONTRACTED HEALTH PLAN	RBHA		DDD	
				SMI-INTEGRATED	NON-INTEGRATED	SUB CONTRACTED HEALTH PLANS	LTSS
CYE 20	50%	35%/35%	N/A	20%	20%	50%	10%
CYE 21	55%	40%/40%	N/A	25%	25%	55%	15%
CYE 22	55%	40%/40%	20%	25%	25%	55%	15%

4. AHCCCS intends that the required percentage of APM Strategies in LAN-APM Category 3 and Category 4 of total Title XIX/XXI payments governed by all APM Strategies grow each year according to the schedule below:

SUB-REQUIREMENT FOR LAN-APM CATEGORIES 3 AND 4 (ANTICIPATED)							
CYE	ACC	ALTCS/ E/PD (E/PD/ MA-DSNP)	CHP SUB-CONTRACTED HEALTH PLAN	RBHA		DDD	
				SMI-INTEGRATED	NON-INTEGRATED	SUBCONTRACTED HEALTH PLANS	LTSS
CYE 23	60%	45%/45%	25%	30%	30%	60%	20%
CYE 24	65%	50%/50%	30%	35%	35%	65%	25%

Failure to attest to the sub-requirement for LAN-APM Categories 3 and 4 qualifying criteria, through the APM Strategies Certification as provided in Attachment B, in a particular Contract year, shall result in sanctions up to a maximum of $250,000.

The Contractor shall be responsible for identifying which APM Strategy applies to each APM contract and whether each contract applies to a limited cost of care, where the provider may only impact direct and limited costs attributed to members, or the total cost of care attributed to members. For example, a contract with a transportation provider which rewards the provider for improvement in on-time pick-ups would count as a limited cost of care contract since the provider has no impact on the members' total medical costs and only directly affects transportation expense. Alternatively, a contract with a PCP which rewards the provider for reducing total medical expenses attributed to members, including those not directly provided by the PCP, would count as a total cost of care contract.

The same dollars shall not be counted under multiple contracts. Additionally, one contract shall not be counted under multiple APM strategies.

The Contractor may use performance measures for providers other than the measures identified in ACOM Policy 306 as part of the Contractor's APM strategies.

In order to count toward meeting the qualifying criteria, APM Strategies shall be evidenced by written contracts. For those contracts executed prior to April 1 of each Contract year, AHCCCS shall count the APM Strategies for the time period in the Contract year for which the Contract is in effect. For those contracts executed after April 1 of each Contract year, AHCCCS shall count the value of the APM Strategies for the time period from the execution date forward for which the Contract is in effect.

5. The Contractor shall certify and attest to AHCCCS that these requirements shall be met by submitting Attachment B as an executed Portable Document Format (PDF) copy, an electronic copy in an Excel format, and through the Structured Payment File specified in the section of this Policy titled "Structured Payment File and Post Adjudicated/Post Submitted File" and as follows:
   a. An initial APM Strategies Certification as provided in Attachment B by the due date specified in Contract,
   b. An interim APM Strategies Certification as provided in Attachment B by the due date specified in Contract, and
   c. A final APM Strategies Certification as provided in Attachment B by the due date specified in Contract.

   The Contractor shall report the PBP on an accrual basis. When reporting PBP on the APM Strategies Certification, the Contractor shall appropriately allocate PBP between the lines of business when these payments to providers impact multiple lines of business. The Contractor shall not report PBP amounts for unearned incentives. The provider must successfully meet its contracted goals and/or metrics to receive a PBP. If these goals and/or metrics are not met, this is considered an unearned PBP (e.g., a provider did not meet its contracted medical loss ratio target or a provider did not meet its contracted performance measure target) and shall not be reported on the APM Strategies Certification. Effective October 1, 2020, the Contractor shall report the percent of planned and actual PBP between Targeted Investment (TI) participants and non-TI participants. . The Contractor shall not include in the APM Strategies Certification PBP paid using MA-DSNP funding or for the MA-DSNP earned portion of the PBP. The Contractor shall include in the APM Strategies Certification the upside risk/shared savings amounts of PBP, as well as deductions and recoupments from providers for downside risk.

   For ALTCS E/PD and RBHA Contractors: Attachment B contains two tabs to be submitted as an executed PDF copy and an electronic Excel copy as listed below in accordance with the Section on Contractor Responsibilities for APM Strategies Certification.

CONTRACTOR	POPULATIONS	
ALTCS E/PD	E/PD	MA-DSNP
RBHA	SMI-Integrated	Non-Integrated

DDD shall include the APM requirements to DDD Subcontracted Health Plans and submit the APM Strategies Certifications on behalf of the DDD Subcontracted Health Plans. DDD Subcontracted Health Plans shall use the DDD Subcontractor tab on the APM Strategies Certification (Attachment B).

CHP shall include the APM requirements to the CHP Subcontracted Health Plan and submit the APM Strategies Certifications on behalf of the CHP Subcontracted Health Plan.

In the case of differences between the executed PDF copy and electronic Excel template submissions, the executed copies shall prevail.

Failure to certify and attest to the APM Strategies qualifying criteria in a particular Contract year shall result in disqualification from the provisions of ACOM Policy 306 or the application of sanctions as specified in this Policy.

AHCCCS reserves the right to request an audit of the Certifications included in Attachment B. The Contractor, upon the request of AHCCCS, shall provide documentation of APM contracts and payments to providers, including supporting calculations, for PBP.

6. The Contractor shall submit a Performance Measure and VBP Medical Loss Ratio (MLR) Report for the VBP Providers which includes performance measure outcomes (Attachment C) and VBP and non-VBP Providers MLR outcomes (Attachment D) by Tax Identification Number (TIN) and in total by Contractor to compare quality of care and cost of care measures by submitting Attachments C and D as executed PDF copies and electronic spreadsheet copies, as specified in Contract.

7. AHCCCS shall review the LAN-APM target requirements and sub-requirements for LAN-APM Categories 3 and 4 on an annual basis and may adjust percentages or change the LAN-APM strategies requirements listed in the section of this policy on Contractor Responsibilities, in subsequent years, as is in the best interest of the AHCCCS Program and/or the State. AHCCCS intends to notify the Contractor of the changes no less than two months prior to October 1 or the effective date.

C. AHCCCS RESPONSIBILITIES

1. The Contractor shall be reimbursed for PBP made by the Contractor to providers through a lump sum payment. AHCCCS will only reimburse for PBP where providers successfully met their contracted targets. No PBP incentive payments shall be made by AHCCCS for PBP made by DDD and CHP Subcontracted Health Plans or PBP made by any Contractor with E/PD/MA-DSNP funding Upon receipt and review of the final APM Strategies Certification, AHCCCS will perform testing of the PBP amounts reported by the Contractor prior to payment of the PBP incentive, including review of the Contractor‘s documentation of APM contracting, the Contractor‘s payments to providers for PBP, and the Contractor’s PBP calculations and allocations by line of business. The PBP incentive will be adjusted for premium tax.

   AHCCCS reserves the right to perform a look-back and adjustment of the previous year’s PBP accrual in a subsequent year’s payment.

2. For any APM contract that is effective for a period other than the measurement year, AHCCCS will allow PBP to be included in the year to which the lump sum PBP Incentive is attributable. For example, a contract effective from July1, 202X to June 30, 202Y will have six months (July 1, 202X – December 31, 202X) in the 202X lump sum

payment and six months (January 1, 202X – June 30, 202Y) in the 202Y lump sum payment.

The Contractor is not required to meet the APM Strategies qualifying criteria for LAN-APM target requirements and sub-requirements for LAN-APM Categories 3 and 4 in order for the PBP Incentive to be paid to the Contractor.

AHCCCS will limit the PBP Incentive to the Contractor beginning October 1, 2019, to 0.75% of medical payments (APM and non-APM contracted and non-contracted), excluding state directed payments paid outside of capitation (e.g., lump-sum directed payments). AHCCCS will exempt Contractors from the 0.75% reimbursement limit if the Contractor is a state agency and the Contractor provides the state share of funding for their PBP Incentive.

AHCCCS will test the total amount of the PBP Incentive due to the Contractor to ensure that the Federal limit of 5% of the approved capitation payments attributable to the members or services covered by the incentive arrangements is met. Any amount in excess of the limit shall be reduced to bring the final due payment within the Federal requirement. Federal regulation requires that all incentive payments made under this policy as well as any other incentive arrangements made under the Contract or another policy combined shall not exceed this 5% limit, thus the test of the 5% limit will include both the PBP Incentive included in this Policy, and the QMP Incentive payments specified in ACOM Policy 306.

AHCCCS reserves the right to periodically request ad hoc data for data-informed decision making, as specified in Contract.

D. STRUCTURED PAYMENT FILE AND POST ADJUDICATED/POST SUBMITTED FILE

1. AHCCCS has developed a Structured Payment File to automate the APM Strategies Certification Excel file. The Contractor shall submit the Structured Payment File annually. (Refer to the section of this policy on Contractor Responsibilities for APM Strategies Certification.) For details on the file layout and File Transfer Protocol (FTP) submission process, refer to the AHCCCS Structured Payment Transmission User Manual:
   https://azahcccs.gov/Resources/Downloads/OperationsReporting/StructuredPaymentTransmissionCompanionGuide.pdf.

2. In order to link encounters to the Structured Payment File, the Contractor shall add an APM Indicator to encounters paid under an APM contract. Refer to the AHCCCS Technical Interface Guidelines (TIG) - Post Adjudicated Structured Payment File for information on the APM Indicator:
   https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PostAdjudicatedStructuredPaymentFileLayout.pdf.

If the Contractor knows at the time of submitting the encounter that the payment is tied to a provider under APM contract, it is recommended that the Contractor include the APM Indicator in the original encounter submission.

If the Contractor does not know at the time of submitting the encounter that the payment is tied to a provider under APM contract, the Contractor shall add the APM Indicator to the adjudicated encounter via the Post Adjudicated/Post Submitted File. The Contractor may choose to only use the post adjudication adjustment process to add the APM Indicator to adjudicated encounters, if desired.

All applicable encounters shall have the APM Indicator included within nine months following the Contract year end.