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I. Introduction and Purpose of the Brief

Medicaid programs have been increasingly contracting with managed care organizations (MCOs) to provide health coverage to their beneficiaries, and it is now the predominant method to do so.¹ At the same time, Medicaid programs are emphasizing a focus on value-based payment and are requiring their Medicaid MCOs to implement alternative payment models (APMs)² with MCO network providers. With these new requirements, it is important for states to develop ways to ensure that their MCOs are complying with the APM requirements within their contract, and monitoring the progress and challenges with the implementation of APM strategies with Medicaid providers.

States have adopted a variety of approaches to implementing APM strategies through their MCOs. While some states, like Minnesota and Tennessee, have required MCOs to implement specific APMs based on the state's defined parameters, many states provide their MCOs with a menu of potential APM strategies.

This brief focuses on different ways in which states may set standard APM definitions to a) track MCO progress toward meeting state APM goals, and b) support comparison of APM implementation within a state and nationally.

II. Defining and Tracking Alternative Payment Models

This section describes APM definitions developed by the Health Care Payment and Learning Action Network (HCP-LAN or LAN),³ Catalyst for Payment Reform (CPR)⁴ and two individual states (Massachusetts and Rhode Island), and describes how states have used these different frameworks for reporting purposes. Each approach was defined for a particular purpose, which impacts the APM definitions and categorizations. There is no one "right" approach to defining or implementing APMs, and there is no one "right" approach to reporting on them.

a. The Health Care Payment and Learning Action Network

The LAN is a public-private initiative to align APM strategies across the Medicare, Medicaid and commercial markets and advance the adoption of APMs. As part of its work, the LAN developed a national framework for defining and categorizing APMs as part of an effort to move 50 percent of all health care payments to be within contracts that include APM arrangements by 2018. The LAN APM Framework⁵ divides provider payment methodologies into four major categories:⁶ fee-for-service (Category 1), infrastructure support and pay for performance (Category 2), shared savings and/or risk based on a fee-for-service payment model (Category 3), and shared savings and/or risk, or even full risk, based on a prospective payment (Category 4). To be considered an APM, the payment model must be linked to quality.⁷ In addition, in 2017, the LAN APM Framework clarified that APMs in Category 3 or 4 must include measures of appropriate care to provide additional safeguards against provider incentives to limit necessary care.

The LAN Data Collection Tool was developed as a national tool to measure provider payments linked to APMs, within the LAN-defined categories.⁸ The voluntary tool has been used by health plans and organizations to report on the percentage of health care dollars within a payment year that are spent within the four LAN categories.⁹ Table 1 below shows the aggregated metrics included within the Medicaid tab of the LAN Data Reporting Tool.

Table 1. Excerpt for LAN Data Reporting Tool¹⁰

Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				
#	Numerator	Numerator Value	Denominator	Denominator Value
15	Total dollars paid to providers through legacy payments [(including fee-for-service (FFS)] without a quality component and Diagnosis Related Group (DRG) payments in coverage year (CY) 2016 or most recent 12 months.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2016 or most recent 12 months.	\$0.00
16	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2016 or most recent 12 months.	\$0.00
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2016 or most recent 12 months.	\$0.00

The LAN provides policymakers and stakeholders with a general idea of the amount of provider payment that has some link to APMs. However, it does not distinguish the level of payment that is linked to value (that is how much of an incentive or disincentive does a provider have based on the outcomes of the care provided). As shown in Appendix A, several states have included a link to the LAN APM Framework within their MCO procurements and require plans to increase APM adoption overall, and sometimes in particular LAN categories.

Some states have leveraged the LAN Data Collection Tool to create their own state-specific reporting tool. Appendix B provides a description of the reporting tools used in Michigan, Texas and Washington, all of which use the LAN APM Framework and Data Collection Tool as a base, but modify it to better fit the state’s needs.

b. The Catalyst for Payment Reform Scorecard

The Catalyst for Payment Reform (CPR) Scorecard was the first effort to develop a national report card for tracking and reporting on progress toward payment reform. CPR’s national Scorecard was developed for use in the Medicare, commercial and Medicaid markets.¹¹ The Scorecard looks at APMs, penetration rates by provider type, and a link to quality. The initial Medicaid Scorecard was developed for New York. Based on the national Scorecard, the New York Scorecard¹² utilized five reporting domains: public dollars paid, characteristics of payment reform environment (APMs), plan member reach (members reached by APM activities), provider participation, and a quality indicator (all-cause readmission measure). The CPR Scorecard APMs are similar to those included within the LAN APM Framework and the Scorecard includes a definition section that describes the different models. The CPR Medicaid Scorecard differs from the CPR Commercial Scorecard in that it does not include a domain for measuring the “building blocks for payment reform” which is focused on transparency tools. For more information on the approach utilized by New York, see Appendix C.

CPR is currently working to refine and expand its Scorecard, including for the Medicaid market, and is piloting the revised tool in Colorado, New Jersey and Virginia in 2018. The revised Scorecard will continue to focus on how much, what types and which combination of APMs have been implemented and will expand its focus on whether these APMs are having positive impact on quality, efficiency and cost of health care.¹³

c. Individual State Approaches

There are also examples of individual state approaches with state-developed definitions of APMs for contractual and regulatory purposes that expand beyond the Medicaid program. For example, the Massachusetts Center for Health Information and Analytics (CHIA) developed a standard reporting tool in order to measure use of APMs beginning in 2012.¹⁴ In addition, its Medicaid program, MassHealth, collects specific APM use information from its MCOs (see Appendix D). Similarly, the Rhode Island Office of the Health Insurance Commissioner (OHIC) developed its own APM definitions and reporting metrics in 2015. Medicaid MCOs are required to report on these metrics as well to the state Medicaid agency (see Appendix E).

Pennsylvania’s APM requirements are specific to Medicaid and require Medicaid plans to submit an annual report of its accomplishments and a list of APM arrangements that they utilize, including an explanation of each model and the payments for medical services during the past year in each model.

III. Considerations in Selecting an Approach

Which approach a state takes to defining and reporting on APMs will vary based on the state’s specific goals and needs. As in other MCO contractual and reporting requirements, states should consider the administrative burden on plans and the Medicaid agency, and how the data will be used when developing APM requirements.

a. Pros and Cons of Each Approach

Each approach has strengths and weakness that states should consider before adopting an approach.

Table 2. Strengths and Weaknesses of APM Frameworks

Model	Strengths	Weaknesses
LAN ¹⁵	<ul style="list-style-type: none"> National approach, being used by Medicare and leading commercial insurers Plans and payers may have familiarity with the approach Allows for comparison across states and marketplaces Provides detailed information on percentage of payment linked to value States can modify LAN reporting and still make some comparisons to national data 	<ul style="list-style-type: none"> Voluntary (unless a state makes it mandatory) Does not require reporting of how APM is linked to quality, only that it is Does not measure the portion of payment tied to an incentive (just that some amount is tied to it) Categorization does not recognize that many APMs are implemented simultaneously with a particular provider Does not assess the extent to which risk is shared
CPR ¹⁶	<ul style="list-style-type: none"> Developed by a leader in defining and monitoring APMs Includes opportunity to provide narrative to explain APMs Includes both impact in terms of percent of payment and percent of membership covered by models Includes quality measurement as part of reporting 	<ul style="list-style-type: none"> Proprietary tool Current quality measurement is limited to readmission Does not measure the portion of payment tied to an incentive (just that some amount is tied to it) Categorization does not recognize that many APMs are implemented simultaneously with a particular provider Does not assess the extent to which risk is shared
State-Based Approach	<ul style="list-style-type: none"> Opportunity to individualize to the state’s specific needs Use more refined APM definitions, allowing for more precise measurement of change in marketplace Can provide state with opportunity to create combination APM categories Depending on how it is structured, may have other strengths similar to LAN or CPR 	<ul style="list-style-type: none"> Harder to compare to other Medicaid programs If approach does not include other state payers, may not be able to compare in state Depending on how it is structured, may have other weaknesses similar to LAN or CPR

b. Operational Design Considerations

In deciding which approach to take, states should consider what their ultimate APM goals are and how the definition and reporting process can help the state to meet its goals. Goals will vary based on state size and geography, health outcomes, APM penetration in marketplaces and provider readiness for change. They will also vary depending on whether the state is focusing specifically on the Medicaid program, or more broadly on all state purchasers of health care. As a state develops its approach and reporting tool, it will be important to continue to come back to the state's defined goals. This focus will help the state to consider both how to define different models and options, what information is most important to monitor, and how to measure progress.

Based on differing goals, states may want to monitor APMs at different levels of detail. For example, if states are focused on moving payments to providers to a risk-based model, the state may not be as interested in the delineation of payment models that are focused on infrastructure support [such as patient centered medical home (PCMH) models] or pay for reporting and/or performance models. On the flip side, if a state has less interest or ability to focus on risk-based models, its reporting design may focus more on these models, rather than models focused on total costs of care and shared savings or risk.

States may want to include within their reporting requirements the ability to monitor some specific design details that are not fully addressed in the LAN or CPR constructs, but which may be important for states to consider when evaluating the integrity of an MCO's APM strategy including, for example:

1. The extent of the financial consequences for quality performance;
2. What the quality performance link is, and whether the quality performance incentive requires excellence or improvement;
3. Whether providers are assuming meaningful downside risk; and
4. Whether APM-contracted providers have actually generated savings and/or quality performance financial rewards.

States will need to consider both what quality parameters MCOs must follow in implementing APM arrangements, and how to report on them. In terms of parameters, examples of possible approaches include:

- › Providers should not be allowed to share savings or earn incentive payments if a) quality is poor relative to state or peer averages or b) if quality significantly declined for one-third or more of the measures tied to payment, and
- › Plans should not tie financial performance to quality by setting quality targets that are at or below baseline provider performance, unless the provider's performance at baseline is at a "best practice" level.

Whether quality is part of the reporting process will depend on what other mechanisms that state Medicaid program has in place to measure quality performance. Most Medicaid programs have robust quality performance measurement and monitoring requirements built into their MCO contracts. For some states it may make more sense to make adjustments to the existing quality reporting strategy to include the impact of the APMs, rather than to also require quality reporting within the APM progress reports.

As state goals are solidified, a state can begin to think about whether it wants its Medicaid MCOs to report on use of APMs within other products (e.g., commercial or Medicare Advantage) as part of its reporting, and whether there are multiple Medicaid products to include (based on different MCO contracts for different Medicaid populations).

In addition, states will need to consider what services should be included and excluded from reporting, and the reporting period. In determining the reporting period, it will be important to be clear whether the reporting should include payments made during the reporting period or services rendered during that time. It is also important to specify

how the MCOs should include incentives based on underlying payments that occur during the reporting period (or services rendered during that time) that are made at a later date, typically following a reconciliation process or quality measurement.

The clearer the state can be with its MCOs about what to report and how to report it, then MCOs will have an easier time in collecting and reporting on the information correctly and accurately. Particularly when states begin the reporting process, it is important to build in sufficient time and support for MCOs to ensure that they understand the reporting approach and data needs. Another consideration is whether the state will validate the reporting provided by the MCOs through an independent entity, as occurs in both Washington and Iowa.

States should also consider what is required for initial reporting and what information is needed on an ongoing basis. Upfront, states may be interested in having their MCOs develop an APM strategic plan covering a specified time period that describes their approach to increasing the use of APMs and why they have selected particular strategies. The initial APM strategic plan could include current APM payment models and baseline reporting, and provide both estimated impact of the APMs and a narrative description of how the plan will achieve its goals. Following the initial APM strategic plan, the state may determine it is sufficient to receive a qualitative update on an annual basis. States that are initiating Medicaid MCO re-procurements could also utilize the procurement process to obtain the strategic plan and a committed approach to increasing APMs over time.

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ABOUT BAILIT HEALTH

This brief was prepared by Beth Waldman, Michael Bailit and Mary Beth Dyer. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

APPENDIX A

State Use of Learning and Action Network Categories within Managed Care Organization Contracts

A number of states have used the LAN APM Framework within their MCO contracts to require MCOs to focus APM implementation on particular models. Table 2 below highlights six of the states that have included the LAN categories within their MCO contracts to date, all are looking to move their providers to payment strategies that focus on shared savings and/or shared risk. Three of the six states will continue to count pay-for-performance programs throughout the contract period.

Table 3. State MCO Contract Language Requiring Use of Certain LAN APM Categories

State	LAN Language in MCO Contract
Arizona	2C or higher
California	2, 3 & 4 in 2018, 3 and 4A
New York ¹⁷	3A or higher
South Carolina	2C or higher
Virginia	“emphasis” on 3 and 4
Washington	2C or higher

In addition to using the LAN categories to define APM options some states, like Washington, have also utilized the categories to identify an overall benchmark for provider payments through APMs. Specifically, Washington’s Value-Based Payment Roadmap seeks to have 90 percent of its publicly funded health care payments to providers in LAN Categories 2C and higher by 2021.¹⁸ Similarly, Arizona seeks to have 40 percent of payments in Categories 3 and 4 by 2021.¹⁹

APPENDIX B

Examples of State Alternative Payment Model Reporting Requirements that Leverage the Learning and Action Network Data Collection Tool

Michigan

Under its MCO contracts, Michigan requires its MCOs to increase use of APMs and to report on an annual basis to the state. Michigan models its APM reporting from the LAN Data Collection Tool. The tool is consistent with the LAN in terms of the definitions used for APM categories and the methodology used for reporting provider payments (by date of payment rather than date of service).²⁰ Michigan has made some modifications and clarifications to the LAN data collection tool, including:

1. *Identifying the amount of a provider payment that is specifically linked to value.* Michigan has modified the LAN to require reporting of payments in two ways. First, the “Big Numerator” mirrors the LAN approach and measures the total payment with any link to value and quality. Second, the “Small Numerator” measures only that piece of the payment that specifically is due to value and quality (e.g., PCMH payments, quality bonus payments or shared savings payments). This allows the state to have a greater understanding of the percent of total payments that are actually based on value and quality. The grid for the Small Numerator is included below.
2. *Providing detailed direction to MCOs where payments cross LAN categories.* Michigan found that many of its MCOs had arrangements with providers that included a combination of APM strategies. The LAN directs MCOs to report the dominant APM, but Michigan placed additional emphasis on how to consider which APM is dominant to ensure MCOs reported appropriately. For example, a provider may have an agreement with an MCO where the provider participates in a PCMH model, is eligible to receive bonuses relative to quality measures through a pay-for-performance strategy and is also eligible to share in shavings based on a total cost of care. In these instances, Michigan wanted to ensure that, under the Big Numerator, MCOs did not receive “credit” more than once for provider payments and therefore directed its plans to include the full amount of the provider payments, inclusive of all APMs, within the most dominant LAN category—that is, the category under which the provider has the potential to earn the most additional dollars. Because Michigan uses the Small Numerator, MCOs still have the opportunity to report the actual value of the incentive payment itself.

Michigan first collected baseline data from its MCO in January 2017 and received supplemental data in July 2017. As required in contract, MCOs recently submitted APM strategic plans to delineate for the state how and by how much the MCO planned to increase APM adoption among its providers in the next three years. On an ongoing basis, MCOs will need to continue to report on APM progress and compare that progress to their strategic goals.

Table 4. Excerpt from Michigan's Data Collection Tool²¹

#	Numerator	Numerator Value	Denominator	Denominator Value
Alternative Payment Model Framework—Category 1-4 (Metrics below apply to total dollars paid to providers related to the MI Comprehensive Health Care Program Contract)				
	NA	NA	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified payment period. For January 2017 report, include payments made between 10/1/15 and 9/30/16. For July 2017 interim report, include payments made between 10/1/16 and 3/30/17. For January 2018 report, include payments made between 10/1/16 and 9/30/17.	\$0.00
Alternative Payment Model Framework—Category 2 (All methods below are linked to quality)				
2A	Total dollars paid to providers for foundational spending to improve care (Category 2A), e.g. care coordination payments, health information technology, during payment period.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
2B	Total dollars paid to providers in pay for reporting APMs (Category 2B) during payment period—just the reporting bonus, not the underlying FFS payments.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
2C	Total dollars paid to providers in pay for performance (P4P) APMs (Category 2C/D— bonus only) during payment period—just the amount of the P4P bonus paid, not the underlying FFS payments.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
2D	Total dollars collected from providers in P4P APMs (Category 2C/D - penalties only) during payment period. Include this as a positive number, just the amount of the P4P penalties, not the underlying FFS payments.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
2	Total dollars paid to and/or collected from providers in all Category 2 APMs.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
Alternative Payment Model Framework—Category 3 (All methods below are linked to quality)				
3	Total dollars paid to providers as part of APMs based on FFS architecture (Category 3) during payment period, include just amount related to shared savings/shared risk, etc., not underlying/base FFS payments related to provider contract.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
Alternative Payment Model Framework—Category 4 (All methods below are linked to quality)				
4	Total dollars paid in population-based APMs (Category 4) during payment period, include just amount of the population-based payment (condition-specific or capitation). Do not include payments outside of/in addition to the population-based payment.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00
Aggregated Metrics (APMs in Categories 2-4)				
	Total dollars paid to (and/or collected from) providers under Category 2-4 APMs during payment period.	\$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.	\$0.00

Texas

Texas requires both its MCOs and its Dental Management Organizations (DMOs) to report on APM use on an annual basis. The state updated its reporting requirements, effective November 1, 2017. While Texas links to the LAN definitions for APM categories, it has developed its own unique reporting framework that includes the following information:

- › **Definitions:** This section provides definitions of APM types and providers, as well as incentives, disincentives and downside risk.
- › **Methodology:** This section describes the APM targets that MCOs and DMOs must meet. The state has developed two targets—one focused on overall APM adoption and the second focused solely on risk-based APM adoption, as shown below. Risk-based APMs are tied to LAN categories 3B, 4A, 4B, and 4C.

Table 5. Excerpt from Texas' Data Collection Tool²²

1	<p>Overall APM ratio: This is expressed as the TOTAL APM Dollars paid to providers by MCO divided by Total Medical and Pharmacy Claims Paid by the MCO. Data provided by MCO will be based on date of service.</p> <p>Numerator: TOTAL APM Dollars is the total amount paid to providers for the period for which some portion of the overall health care payment is based on quality-based performance (e.g., performance on a process of care measure, outcome measure, accessibility measure, efficiency measure, etc.). This includes base payments plus provider incentives or disincentives, across all service delivery areas served by the MCO and program.</p> <p>Denominator: Total Medical and Prescription Expenses as submitted by the MCO on Health and Human Services Commission (HHSC) financial statistical report for the APM reporting period for all service delivery areas served by the MCO program.</p>
2	<p>Risk Based APM ratio: This is expressed as the TOTAL RISK-BASED APM Dollars paid to providers by the MCO divided by Total Medical and Pharmacy Claims Paid by the MCO. Data provided by MCO will be based on date of service.</p> <p>Numerator: TOTAL Risk Based APM Dollars is the total amount paid to providers for the period of which some portion of the overall health care payment is based on quality-based performance (e.g., performance on a process of care measure, outcome measure, accessibility measure, efficiency measure, etc.) AND involves potential financial risk by the provider. To qualify as a Risk-Based APM the model should be categorized as 3B, 4A, 4B, or 4C model according to the Health Care Payment Learning & Action Network's APM Framework (released July 11, 2017). This includes base payments plus provider incentives or disincentives, across all service delivery areas served by the MCO and program.</p> <p>Denominator: Total Medical and Prescription Expenses as submitted by the MCO on the HHSC financial statistical report for the APM reporting period for all service delivery areas served by the MCO and program.</p>

- › **Existing APMs–Data Collection Tool:** MCOs and DMOs must provide information on APMs offered and level of financial risk across program types, service areas, providers and members. The information includes incentives and disincentives applied to participating providers during the reporting period as well as the total payments to the providers during that time period. MCOs and DMOs must also provide information on quality measures related to the APM.
- › **Existing APMs–Narrative:** MCOs and DMOs are required to provide a description of the APMs and the MCO's methodology for evaluating the APMs, including process and/or outcome measures, and actual or anticipated return on investment.
- › **Proposed or Planned APMs:** MCOs and DMOs have the opportunity to provide a confidential description of any planned APM.
- › **Assurances and Certifications:** MCOs and DMOs are required to certify that they use financial arrangement codes on encounters as appropriate and that they have requirements in place with their providers to ensure complete and accurate encountering.

Washington

In 2017, the Washington State Health Authority released a set of surveys²³ for MCOs and providers focused on assessing baseline MCO value-based purchasing implementation to assist the state in monitoring whether MCOs would be eligible to receive funds withheld pending documentation of plans meeting value-based purchasing requirements within the contracts. Specifically, the MCO survey aimed to collect baseline information on the amount of qualifying incentive payments and value-based purchasing arrangements.

The survey utilized LAN categories and requires MCOs to provide information for their commercial and Medicare products as well as Medicaid. The MCOs are required to report both on the total qualifying value-based payments by LAN category, as well as the incentive payments by LAN category. MCOs report total annual payments made through each APM arrangement by region (linked to the state's Accountable Community of Health program). This is distinct from the LAN approach, and the state provides additional guidance on how to report where providers are split across regions:

$$\text{\$ for APM Subcategory} \times \frac{\text{number of billing providers (i.e., clinicians) in region}}{\text{number of total providers}} = \text{amount}$$

Washington also requires MCOs to report on covered lives within APM arrangements by region.

MCOs have six months to report the qualifying payments and eight months to report the incentive payments. The Health Care Authority contracts with an independent vendor to validate the payments made by LAN category.

In addition to the MCO survey, the Health Care Authority also released a voluntary survey to providers in 2017 to understand participation in value-based payment arrangements from the perspective of the providers. As with the MCO survey, the provider survey leverages the LAN categorization of APMs and requests information on provider participation in APMs by line of business (Medicaid, Medicare, other government, commercial, and self-pay coverage). The survey also requests information on what has enabled participation in APMs, what the barriers have been, and what the realistic increase or decrease in APM participation will be over time.

APPENDIX C

New York's Approach to Defining and Measuring Alternative Payment Model Usage Through Managed Care Organizations

New York bases its APM categories on the LAN APM Framework, but has labeled them differently, as shown below.

Table 6. APM Categorization Differences between LAN and New York

LAN Category	NY Category
1 (FFS with no link to quality)	NA
2 (FFS with infrastructure or pay for performance)	Level 0
3a (Shared savings on FFS framework)	Level 1
3b (Shared risk on FFS framework)	Level 2
4 (Global payment with shared savings and/or risk)	Level 3

In 2015, CPR helped New York gather APM adoption information using the CPR Scorecard. CPR developed Scorecards across the commercial and Medicaid markets using data it collected through the National Business Coalition on Health's eValue8 health plan survey platform. The CPR Scorecard developed for New York included six domains:

1. *Public Dollars Paid*: Total dollars paid to providers (provides the denominator for Domain 2).
2. *Characteristics of the Payment Reform Environment*: Measure traditional forms of payment, including FFS and other payment methods that do not include quality, as well as payment reform methods, such as shared savings, shared risk, capitation, bundled payment, etc., that include quality.
3. *Plan Member Reach*: Volume of patients treated by providers with payment reform contracts.
4. *Provider Participation*: Proportion of payments made to hospitals and physicians in the outpatient setting that is value-oriented.
5. *Building Blocks of Payment Reform*: Metric on whether transparency tools are available to consumers (*note: this domain did not apply to Medicaid*).
6. *Quality Indicator*: All-cause readmissions (measures both quality and efficiency).

In the CPR Scorecard, the data on APMs includes the total dollars paid through payment reform programs. It does not measure the incentive portion of the payment. The CPR Scorecard directs states to categorize the dominant APM based on the primary method of payment, similar to the LAN definition.

As noted above, CPR is in the process of piloting a Scorecard 2.0 in Colorado, New Jersey and Virginia in 2018. This process will likely result in modifications to the content employed in the 2015 New York Scorecard.

APPENDIX D

Other State Approaches: Massachusetts

The Center for Health Information and Analytics (CHIA) has developed a reporting template to collect APM information across markets in Massachusetts. CHIA collects this information from the 10 largest commercial health plans in the state, Medicare Advantage plans, ConnectorCare (the Massachusetts Exchange), Medicaid MCOs and the MassHealth Primary Care Clinician Plan. CHIA has developed a detailed data specification manual and reporting template which:

- › Requires both provider level and ZIP code level reporting
- › Includes flow charts that help payers to determine where particular APMs may fall based on the payment method allocation logic and global payment method allocation logic

CHIA uses a narrow definition of APMs as “non-FFS based payments between payers and providers in which some of the financial risk associated with both the occurrence of medical conditions as well as the management of those conditions is shifted from payers to providers to incentivize cost containment and quality care delivery. Types of APMs include global payments, limited budgets, and bundled payments. The primary metric used to measure APM adoption is the proportion of members whose care is paid for under non-FFS based payment methods.”²⁴ This is in contrast to both the LAN and CPR which have both included a shared savings model in their APM definitions. In addition, the CHIA definition does not specifically require a link to quality. Payers are required to submit two APM files to CHIA annually—one for the previous calendar year and one for the calendar year ending 16 months prior.

Separately, the Executive Office of Health and Human Services monitors the implementation of APMs by Medicaid MCOs. As required by contract, the MCOs are required to provide at a minimum 1) a list of APM contracts and associated network providers, ACOs or other entities included in an arrangement, and 2) the total amount paid under APMs both in absolute dollars and as a percent of medical premium.²⁵

APPENDIX E

Other State Approaches: Rhode Island

As the only state in the nation with a department focused solely on health insurance, Rhode Island pays particular attention to the role of health insurers (both commercial and Medicaid) in improving the quality of health care and reducing the costs paid by Rhode Islanders for care. The Office of the Health Insurance Commissioner (OHIC) is required by regulation to define APMs and reduce use of FFS payments. OHIC has set APM targets for PCMH penetration, population-based contracts, and level of risk within population-based contracts.

For 2016 to 2017, approved APMs included: total cost of care budget models, limited scope of service budget models, episode-based (bundled) payments, infrastructure payments and pay for performance, and other non-FFS payments approved by OHIC.²⁶ Plans must meet associated targets set by OHIC, including:

- › *“Alternative Payment Methodology Target”*: aggregate use of APMs as a percentage of an insurer’s annual commercial insured medical spend.
- › *“Non-Fee-for-Service Target”*: use of strictly non-FFS alternative payment methodology payments as a percentage of an insurer’s annual commercial insured medical spend.
- › *“Risk-Based Contract Target”*: the percentage of commercial insured covered lives attributed to a population-based contract that holds the provider financially responsible for a negotiated portion of costs that (i) exceed a predetermined population-based budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget, and (ii) incorporates incentives and/or penalties for performance relative to quality targets.

While there is no specific link to quality within the APM definition, there is an underlying regulation that requires incorporation of incentives and/or penalties for performance relative to quality targets. OHIC has also focused on the development of a core set of quality measures for use by all private and public payers in Rhode Island.

Medicaid MCOs are required to report on these metrics annually to OHIC as well as to specifically report to the state Medicaid agency. Rhode Island’s Executive Office of Health and Human Services (EOHHS) certified accountable entities (AEs) and requires its MCOs to contract with them as at least one part of their overall APM approach. The MCO contract includes specific language regarding the level of APM implementation that MCOs must reach by certain dates. To measure MCO progress, EOHHS has developed a reporting template that includes information on:

- › Total attributed lives and member months within an APM
- › Total projected annual payments in an APM arrangement
- › Percentage of medical portion of capitation arrangement in an APM arrangement
- › Percentage of medical portion of capitation arrangement with a certified AE
- › Percentage of primary care practices recognized as a PCMH by OHIC

Information is reported by Medicaid plan type and population and in the aggregate. In addition to reporting specifically on the AE model, the template also requires MCOs to complete quantitative and descriptive information on the following potential APM strategies which may be in use by an MCO:

- › Other population based total cost of care models
- › Integrated health home contracts
- › Other specialized population total cost of care contract models
- › Episode based bundled payment contracts
- › PCMH (including listing of PCMH practices)

Endnotes

1. Gifford K, Ellis E, Coulter Edwards B, et al. (2017, October). *Medicaid moving ahead in uncertain times: Results from a 50-state medicaid budget survey for state fiscal years 2017 and 2018*. Kaiser Family Foundation. www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2017-and-2018/. Accessed January 17, 2018.
2. While this brief mainly uses the term “alternative payment model” to be consistent with the LAN APM Framework, states and others often use the term interchangeably with “value-based payment.”
3. <https://hcp-lan.org/>
4. <https://www.catalyze.org/>
5. The LAN APM Framework was refreshed in 2017 as described in this fact sheet: <http://hcp-lan.org/workproducts/apm-factsheet.pdf>. The LAN national data collection efforts in 2016 and 2017 used the original LAN APM Framework: <https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf>. Accessed January 17, 2018.
6. For more details on APMs and how they fit within the LAN APM Framework see http://shvs.org/wp-content/uploads/2018/02/SHVS_APM-Categorization_Brief-Final.pdf.
7. The LAN defines an APM linked to quality as “payments that are set or adjusted based on evidence that providers meet a quality standard or improve care or clinical services, including for providers who report quality data, or providers who meet threshold on cost and quality metrics.” See the definitions on page 15 of the Health Care Payment and Learning Action Network’s 2017 “APM Measurement, Progress of Alternative Payment Models, Methodology Report.” http://hcp-lan.org/workproducts/apm_measurement_report_2017.pdf. Accessed January 17, 2018.
8. For more detail on how the LAN instructed plans to report using the national data collection tool, see their training video: www.youtube.com/watch?v=DaRZhsxKyGk. Accessed January 17, 2018.
9. Health Care Payment and Learning Action Network. (2017). *APM measurement, progress of alternative payment models, methodology report*. http://hcp-lan.org/workproducts/apm_measurement_report_2017.pdf; Table 1 (pp. 5-8). While voluntary, the data included combined data from Medicare FFS, the Blue Cross Blue Shield Association and the America’s Health Insurance Plans and represented 84% of covered lives in the United States. Health plans and associations could elect to submit information by line of business (e.g., Medicare, Medicaid, commercial) or combined. Similarly, organizations submitting APM data to the LAN were allowed, but not required to, report payments at the subcategory level.
10. <https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf>
11. www.catalyze.org/product-category/scorecards-report-cards/scorecards-on-payment-reform; CPR later worked with the LAN to develop the LAN data reporting tool.
12. www.catalyze.org/product/2015-new-york-medicare-scorecard/
13. www.catalyze.org/product/scorecard-2-0/
14. www.chiamass.gov/assets/Uploads/standard-statistics/APM-Standard-Statistic.pdf
15. The strengths and weaknesses of the LAN noted here are based on the LAN definitions and data reporting tool, and not any changes made by specific states.
16. The strengths and weakness of the CPR scorecards are based on Scorecard 1.0; the CPR scorecards are in the process of being updated and may address some or all of the weaknesses included here.
17. While New York bases its categories off of the LAN APM Framework, the state has labeled them differently (e.g., Level 0 aligns with LAN Category 2, Level 1 aligns with LAN Category 3A, Level 2 aligns with LAN Category 3B, and Level 3 aligns with LAN Category 4). New York State Department of Health, Medicaid Redesign Team. (2016, March). *A path toward value-based payment: Annual update*. www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/1st_annual_update_nystate_roadmap.pdf. Accessed January 17, 2018.
18. Washington State Health Care Authority. (2016). *HCA value-based road map 2017-2021*. www.hca.wa.gov/assets/program/vbp_roadmap.pdf. Accessed January 17, 2018.
19. Arizona Health Care Cost Containment System. (2017, January). *AHCCCS value-based purchasing (VBP) activities*. p. 5. www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/ValueBasedPaymentPublicCommentProposal_011317.pdf. Accessed January 17, 2018.
20. For more information on LAN data collection reporting, see the training video at www.youtube.com/watch?v=DaRZhsxKyGk. Accessed January 17, 2018.
21. The APM report is included at the end of the following contract: *State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services*. State of Michigan. https://www.michigan.gov/documents/contract_7696_7.pdf. Accessed January 17, 2018.
22. For a copy of the MCO Value-Based Contracting Data Collection Tool see: Texas Health and Human Services (2018). *Uniform managed care manual*. Chapter 8.10.
23. The survey instruments are included as part of the *HCA Value-Based Roadmap, Apple Health Appendix*. Health Care Authority website. https://www.hca.wa.gov/assets/program/vbp_roadmapw-ah.pdf. Accessed January 17, 2018.
24. Massachusetts Center for Health Information and Analysis. (2015, August). *Methodology paper, alternative payment methodologies*.
25. Massachusetts MCO contract, Section 2.2.
26. Office of Health Insurance Commissioner. (2017). *Rhode Island alternative payment methodology plan, adopted by Health Insurance Commissioner Kathleen C. Hittner*.