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VBP and Other Payment Reform Models and their Impact on the Delivery of Patient Care

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Alternative Payment Models (APMs)
Merit-Based Incentive Models (MIPs)
Value-Based Payment (VBP)

Track 2

Comprehensive ESRD Care Model

Comprehensive Primary Care Model

Upside Bonus

Total Care for General Population

Chronic Care Bundles

Upside and Downside Risk

Comprehensive Joint Replacement Payment Model

Capitation

Medicare Shared Savings (MSSP)

Pioneer ACO Model

Maternity Care Bundle

Integrated Primary Care (IPC)

Bundled Payments for Care Initiatives (BPCI)

Track 3

Bundled Payment Models

Care Coordination through Episode Payment Models

Next Generation ACO Model

Oncology Care Model

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Goal Is to Emphasize Value over Volume

- **Federal Goal for HHS:**
 - 50% of Medicare FFS payments shall be tied to an APM by 2018
 - 90% of Medicare FFS payments shall be tied to quality or value by 2018
- **NYS Goal for DOH:**
 - 80-90% of MCO payments to providers shall be through VBP by March 31, 2020 (Level 1 and higher)

The **Health Care Payment Learning and Action Network (LAN)** brings together private payers, providers, employers and other stakeholders to accelerate APMs in the commercial market

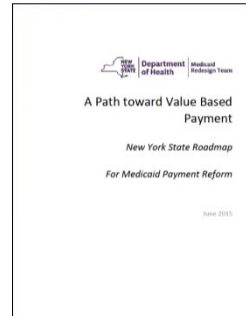
Federal APMs

- **In 2016, over 30% of Medicare payments were attributed to APMs**
- **Over the past 6 years, CMS has launched over 30 new payment models, including the following APMs:**
 - Medicare Shared Savings (MSSP)
 - Pioneer ACO Model
 - Next Generation ACO Model
 - Bundled Payments for Care Initiative (BPCI)
 - Comprehensive Primary Care Model
 - Oncology Care Model
 - Comprehensive ESRP Care Model
 - Comprehensive Joint Replacement Payment Model
- **Over 7.7 million attributed beneficiaries**

NYS Medicaid Payment Reform

- **The Path Toward Value Based Payment**

- The New York State Roadmap
- Annual update process



NYS VBP with MCOs Menu of Options

		Level 1	Level 2	Level 3
1.	Total Care for General Population (TCGP)	Upside Only	Upside and Downside Risk	Capitation
2.	Total Care for Special Need Populations (e.g., HIV, HARP, MLTC, I/DD)	Upside Only	Upside and Downside Risk	Capitation
3.	Episode Conditions (e.g., Maternity Care Bundle)	Upside Only	Upside and Downside Risk	Capitation
4.	Integrated Primary Care (IPC) (Chronic Care Bundles)	Upside Only	Upside and Downside Risk	Capitation
		FFS with Retrospective Reconciliation	—————>	Prospective Payments

Availability of Off-Menu Options

VBP Implementation Efforts

- **Stakeholder Engagement through Sub-Committees**
 - Program Integrity
 - Clinical Advisory Groups (CAGs)
 - Patient Confidentiality Issues and Considerations
 - Regulatory
- **VBP Pilot**
- **VBP Innovation**
- **Limited to Medicaid only but DOH is looking to integrate Medicare**

Performance Adjustment Incentives

- **VBP Incentives are built into MCO rates through plan-specific rate adjustments**
 - Efficiency
 - Quality
 - Stimulus
 - Penalty

2017 is a measurement year; performance adjustments will impact SFY 2019-2020 rates

Components of Retrospective VBP Contract

- 1) Measurement Period
- 2) Targeted Medical Budget
- 3) Services Included
- 4) Calculation Timing
- 5) Savings and Losses (10-90%)
- 6) Reporting
- 7) Financial Protections
- 8) Quality Measures

Components of Retrospective VBP Contract (cont.)

- **For all On-Menu VBP arrangements, DOH determines the risk adjustment methodology, services, and the quality outcomes and measures**
- **All VBP arrangements are conditioned upon meeting certain quality outcomes or targets per the CAGs:**

Outcome measures: (e.g., reducing medically unnecessary services – including, inpatient hospitalizations and readmissions)

Process Measures: (e.g., providing proper follow-up care and medication adherence)

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/clinical_advisory_group.htm

Negotiable Items

- Attribution
- Target Budget
- Amount of Shared Savings and Losses
- Reconciliation Time Periods
- Financial Protections
 - Letter of Credit
 - Reserve Fund
 - Stop Loss
 - Certified Financials

Legal / Compliance Issues

- **Federal Rules**
 - Physician Incentive Plans
 - The Anti-Kickback Statute and Civil Monetary Penalty Rule
 - New Safe Harbors:
 - Recent change to gainsharing rule
 - Remuneration between FQHCs and a Medicare Advantage Organization pursuant to a written contract
 - Antitrust
- **State Rules**
 - Regulation 164 and “business of insurance”
 - Department of Health Contract Guidelines
 - Financial Solvency Requirements

(Other Program Integrity Issues and Considerations)

Challenges with VBP and APM

- Sharing of confidential sensitive patient information and data
- Review of claims data to accurately and properly assess financial risk capabilities
- Providing accurate data for determining and meeting quality measures
- Accuracy of data for risk adjustment
- Downstream provider entities not withholding medically necessary services or restricting access to out-of-network providers

Resources

- https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm
- <https://hcp-lan.org/>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>
- [CMS / CMMI Report to Congress \(December 2016\), https://innovation.cms.gov/Files/reports/rtc-2016.pdf](https://innovation.cms.gov/Files/reports/rtc-2016.pdf)



A Path toward Value Based Payment: Annual Update

June 2016: Year 2

New York State Roadmap

for Medicaid Payment Reform

June 2016



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Introduction

CMS approved the New York State Roadmap for Medicaid Payment Reform in July of 2015. The Roadmap was conceptualized as a living document that would be updated annually to ensure that best practices and lessons learned throughout implementation would be leveraged and incorporated into the State's overall vision. This document represents the first annual update to the VBP Roadmap. The primary structure and content of the Roadmap remain consistent, however as work over the past year provided additional details needed for implementation, those updates have been made accordingly throughout the document.

Year 2: Annual Roadmap Update - June 2016

Upon CMS approval of the Roadmap in July 2015, the work of operationalizing the vision for payment reform commenced. New York State has committed to reaching 80% value based payments (VBP) by the end of the waiver period. To achieve success, all components of the New York State Medicaid program must understand the fundamental shift that DSRIP and VBP represent. Recognizing the far reaching impact of the State's ambitious goal, in Year 1 of DSRIP and the VBP Roadmap, the State developed and initiated what became one of the single largest stakeholder engagement processes ever undertaken by the State. With assistance and expertise from the VBP Workgroup, the formal stakeholder group, the State implemented a robust engagement process that resulted in over 500 stakeholders across the State participating in this critical work.

The State and the VBP Workgroup created subcommittees and advisory groups of stakeholders who were charged with moving the VBP Roadmap towards implementation. This work was carried out by VBP subcommittees, Clinical Advisory Groups, and ongoing policy work at the State level.

VBP Subcommittees

The VBP subcommittees were charged with developing detailed recommendations for the design and implementation of VBP based on outstanding questions and considerations outlined in the 2015 VBP Roadmap. The output of these subcommittees was a recommendations report, the contents of which are incorporated into this Year 2: Annual Roadmap Update. The recommendations come in the form of both statewide standards, which must be followed, and guidelines, which serve as an indication of the best practices and lessons learned. The State will continue to monitor the VBP environment and the impact of implementing these recommendations, with the understanding that the need for modification may arise. Five VBP subcommittees were created to focus on specific scope that was deferred from the 2015 Roadmap. Through a series of 4-6 meetings, these subcommittees developed recommendations to submit to the VBP Workgroup in January 2016 for approval.¹ The five subcommittees included the following:

- 1 Technical Design I: addressed remaining financial and methodological policy questions.
- 2 Technical Design II: addressed remaining quality, support and design policy questions.
- 3 Regulatory Impact: addressed remaining regulatory policy questions.
- 4 Social Determinants of Health & Community Based Organizations: formulated and provided specific recommendations that drive VBP by addressing social determinants of health, addressed the training needs for CBOs, and ensured all pertinent organizations were involved.

¹ For the full recommendations, please refer to the VBP Subcommittee Recommendation Report available online at https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf.



- 5 Advocacy and Engagement: assisted in the design of member incentives to promote lifestyle choices proven to improve health and reduce downstream costs, and discussed the members' right to know about the incentives that affect their care.

Clinical Advisory Groups

In addition to the subcommittees, Clinical Advisory Groups (CAGs) were created to review the care bundle design and subpopulation definitions most relevant to NYS Medicaid. The CAGs made recommendations to the State on quality measures, data and support required for providers to be successful, and addressed other implementation details related to specific VBP arrangements, including bundles and subpopulations. For CAG participation, VBP Workgroup members nominated individuals with specific skillsets including: clinical experience and knowledge focused on the care or condition being discussed; industry knowledge and experience; geographic diversity knowledge; and total care spectrum experience as it relates to the specific care or condition. The CAGs conducted in Year 1 include:

- Maternity
- Chronic Heart Conditions
- Diabetes
- Chronic Pulmonary Conditions
- Behavioral Health (ongoing)
- HIV/AIDS
- Managed Long-Term Care (MLTC) (ongoing)
- Health and Recovery Plans (HARP)

The aforementioned processes were orchestrated in order to drive payment reform in New York State towards a successful implementation. The output of this important work is included throughout this Roadmap, which will continue to serve as the guiding framework for VBP.² Additional work refining outstanding details and assessing the potential impact of VBP implementation will continue through the creation of several new workgroups and CAGs in Year 2, along with a focus on pilot initiatives to establish and encourage movement towards VBP. The State and its stakeholders continue to be fully committed to successful implementation of VBP, and present this updated Roadmap to highlight its advancement toward Medicaid payment reform and DSRIP goals.

² This update is intended to be readable as a 'stand alone' document. To facilitate readability, some sections of the original Roadmap have become integrated with newer parts.



Background

On April 14, 2014, the State of New York (the State or NYS) and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking waiver that allows the State to invest \$8 billion for comprehensive Medicaid delivery and payment reform primarily through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community-level collaboration and aims to reduce avoidable hospital use by 25 percent over five years, while financially stabilizing the State's safety net. A total of 25 Performing Provider Systems (PPSs) have been established statewide to implement innovative projects focused on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on achievement of performance goals and project milestones.

The State will continue working with CMS to optimally align NYS efforts with the goals of the U.S. Department of Health and Human Services on value based purchasing and alternative payment models.³ Over the next five years, many lessons will be learned from DSRIP and VBP implementation efforts in New York; nationally, CMS' priorities might evolve, and initiatives such as the Health Care Payment Learning and Action Network will yield new best practices. Therefore, this Roadmap was developed as and will remain a living document. It will be updated annually throughout the DSRIP period, so as to not lock in policies that may require adjustment in the future, and also to ensure that the New York DSRIP remains a national leader in committing towards the national goals of the U.S. Department of Health and Human Services (DHHS) on VBP and alternative payment models.

To ensure the long-term sustainability of the improvements made possible by the DSRIP investments in the waiver, the Terms and Conditions (T&Cs) (§ 39) require the State to submit a multiyear Roadmap for comprehensive Medicaid payment reform, including how the State will amend its contracts with Managed Care Organizations (MCOs). The T&Cs required the Roadmap address the following topics:

1. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its stated goal of 90% of managed care payments to providers using value based payment (VBP) methodologies.
2. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
3. How the State will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.
4. How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
5. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

³ Burwell, S. M. (2015). "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care." [N Engl J Med](#).



6. How the State will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
7. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how timely data will be incorporated into capitation rate development.
8. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the State will use benchmark measures (e.g. medical loss ratio (MLR)) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for State review and approval by January 31 of each calendar year.

The State Health Innovation Plan (SHIP) and Medicaid Payment Reform

DSRIP, Medicaid Payment Reform and SHIP form a coordinated whole. A core goal of SHIP, funded as part of the CMS’ State Innovation Models Initiative (SIM), is the strengthening of primary care in New York through the Advanced Primary Care model (see p. 9). The effort aligns fully with DSRIP and is the delivery platform for the Integrated Primary Care (IPC) VBP arrangement discussed below. To ensure consistent development, the Medicaid VBP team meets with the SHIP team and regularly participates in the Integrated Care Workgroup charged with developing the APC model.

In terms of payment reform, the State and stakeholders have determined that a gradual approach, starting with Medicaid, and subsequently ensuring that Medicare’s reform efforts maximally align with the Medicaid reforms, is the preferred way forward. A full description of the State’s work related to Medicare alignment is included on page 61. It is anticipated that payers and providers will learn from their Medicaid VBP experience and these learnings will influence their other contracting arrangements as they develop VBP strategies that best meet their private sector needs.



What New York State's Medicaid Value Based Payment Plan is Not

During the development of the Roadmap, stakeholders expressed concerns about the pace and scope of the changes that VBP represents. Throughout a series of detailed stakeholder discussions, it became clear that there were some misperceptions about the intent of the State's Roadmap. As such, to ensure all stakeholders understand the true direction the State is undertaking, the State has explicitly outlined what is not included in VBP.

What New York State's Medicaid VBP Plan is Not:

A new rate setting methodology: *The State will show benchmarks and give guidance, but it will not set rates or dictate detailed terms for value based payment arrangements.*

One size fits all: *There are a variety of options outlined in the Roadmap, and many details to negotiate between MCOs and providers. Also, MCOs and providers can jointly agree to pursue different or 'off-menu' VBP arrangements as long as those arrangements reflect the Medicaid VBP principles described herein. In addition, the State's VBP goals will be measured at the State's level, not at the individual PPS level, allowing for differences in adaptation between PPSs.*

The State backing away from adequate reimbursement for Federally Qualified Health Centers (FQHCs) and other community based providers: *Outlined in the figure on p.7, the State is committed to ensuring adequate reimbursement aligned with the value provided for the Medicaid population consistent with federal statute.*

An attempt to make providers do more for less: *In fact, the intent is the opposite. Under the State's VBP approach, reducing lower value care and increasing higher value care in equal proportions should lead to higher margins rather than lower margins.*

An attempt to make PPS leads responsible for all PPS providers' contracting: *The responsibilities providers delegate to their PPS is decided by themselves through the emerging PPS governance structure. Delegating contracting responsibility to the PPS is an option, which would, however, require the PPS to become a legal contracting entity in New York State.*

An attempt to require MCOs to contract with PPSs for VBP Arrangements: *MCOs are free to continue to build upon their existing direct provider contracts or Independent Practice Association (IPA)/Accountable Care Organization (ACO) arrangements to achieve the VBP goals.*

A requirement that only PPSs can enter Medicaid VBP Arrangements: *All (groups of) providers that can deliver integrated care services, including, but not limited to, IPAs, ACOs and PPSs (if structured as a legal contracting entity), are intended to be able to enter into VBP arrangements.*

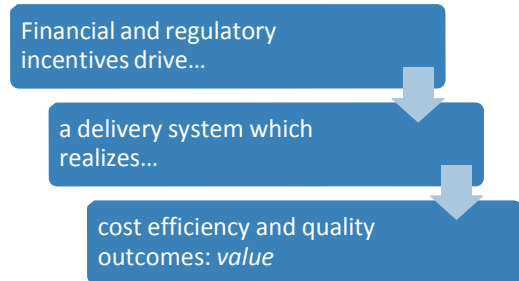
A Roadmap for all future payment reform: *This Roadmap pertains only to Medicaid payment reform and does not apply to payment reform in the commercial marketplace. A separate policy discussion will determine the future of payment reform concepts contemplated by the State Health Innovation Plan.*

1. Towards 80-90% of Value Based Payments to Providers⁴

Issue 1: What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its goal of 80-90% of managed care payments to providers using value based payment methodologies by end of demonstration year five (DY 5).

Sustainable Delivery Reform Requires Matching Payment Reform

DSRIP is a major collective effort to transform the State’s Medicaid health care delivery system from a fragmented, inpatient care focused system, to an integrated and community based system focused on providing care in or close to the home. Where the delivery system is currently predominantly reactive and (acute) provider-focused, DSRIP aims to create a more proactive and member-focused system, with a vibrant workforce throughout the continuum of care, emphasizing population health and closely involving social services.



These objectives have broad stakeholder support and are made measurable by a set of DSRIP metrics on potentially avoidable (re)admissions, emergency department (ED) visits and other potentially avoidable complications, as well as patient experience. Underlying these overall outcomes is a broader range of project-specific process and quality measures.

Reducing avoidable (re)admissions, ED visits and other potentially avoidable complications through more effective clinical and service models that partner primary, acute, home and community based care will improve health, while further stabilizing overall Medicaid expenditures. This will further allow the State to remain under the Global Cap without curtailing eligibility, strengthen the financial viability of the safety net, support continued investment in innovation, and improve outcomes.

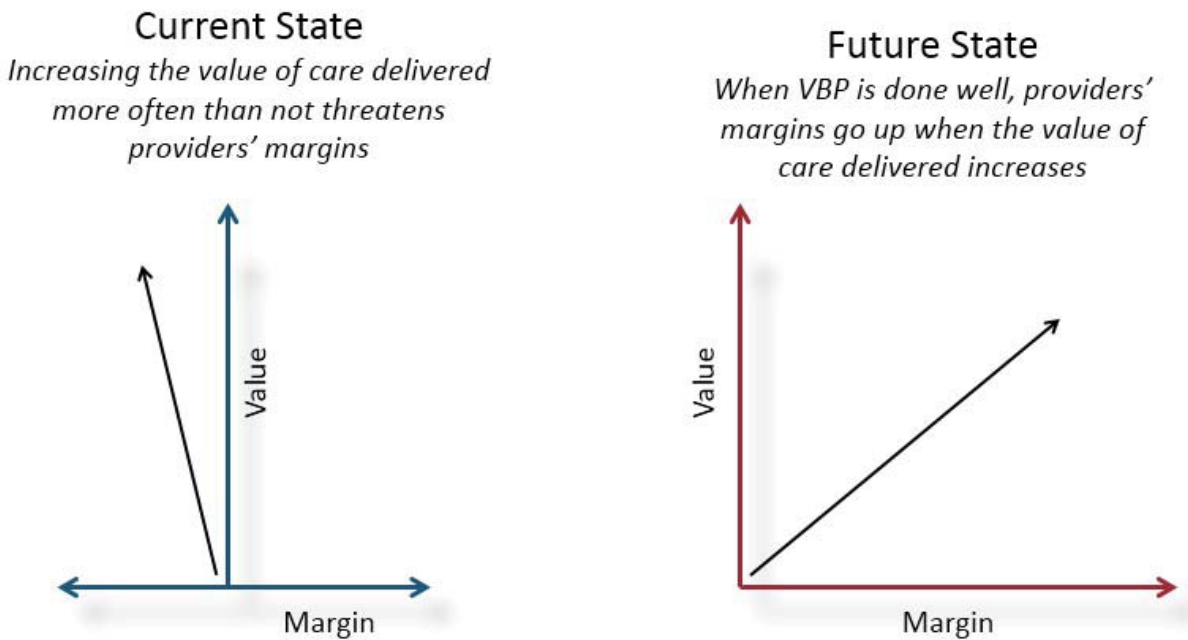
Such a thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well. Many of the Medicaid delivery system’s problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how providers are reimbursed. In most cases, siloed providers are still being paid fee-for-service (FFS) by their MCOs, incentivizing volume over value, and creating a focus on inputs rather than realizing adequate outcomes. To this day, an avoidable readmission is often rewarded more than a successful transition to integrated home care or a nursing home; likewise, prevention, coordination or integration activities are rarely reimbursed adequately, if at all.

In addition, the current FFS system and the diversity of contracting regimes between individual providers, individual MCOs, and other non-Medicaid payers, creates an administrative burden on providers that would be unfathomable in any other health care sector in the world – or in any other US industry. Often, payment

⁴ As expressed in the Terms and Conditions (T&Cs) (§ 39), the State’s ultimate goal is 90%. Because NYS’ definition of VBP has become more ambitious than originally contemplated, the State has agreed with stakeholders to lower the official target for the Roadmap to 80-90%.

reform initiatives initially seem to increase the administrative burden; they necessarily constitute a change from the way current administrative processes and systems operate. They may require upfront investment for redesign and may require providers to temporarily straddle different payment systems simultaneously. Yet well-executed payment reform can significantly offset this complexity by reducing the need for micro-accountability (such as the need for utilization review throughout the care process), by not only standardizing rules and incentives across providers, but also by increasing transparency.⁵

In essence, the State’s Medicaid payment reform goals attempt to move away from a situation where increasing the value of the care delivered (preventing avoidable admissions, reducing administrative waste) has a *negative* impact on the financial sustainability of providers, towards a situation where the delivery of high value care can result in *higher* margins (see figure below).



Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period, so that member engagement and care coordination activities, including peer-based activities, can be reimbursed, value-destroying care patterns (avoidable (re)admissions, ED visits) do not simply return when the DSRIP dollars stop flowing, a stable and well-trained primary and community based workforce is maintained, and dollars currently lost in non-value-added administrative processes become available for member care. Importantly, payment reform is equally essential *to ensure that the savings realized by DSRIP can be reinvested in the Medicaid delivery system*. Without payment reform, savings would accrue to MCOs, whose yearly rates would, in the current payment system, subsequently be revised downwards. In fact, many PPSs are already actively discussing the importance of payment reform as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits, etc.).

Payment reform must also maintain or improve funding and incentives for essential and mandatory costs

⁵ Cutler, D., E. Wikler and P. Basch (2012). "Reducing administrative costs and improving the health care system." *N Engl J Med* 367(20): 1875-1878.



within the system that includes provider/system for public goods, critical infrastructure support, and fulfillment of state/federal public health and compliance requirements. These components include such input costs as: hospital/clinic/home care, indigent care, graduate medical education, federal conditions of participation, health information technology (HIT) capacity and interoperability, health care worker training and certification, quality assurance, emergency preparedness, community public health (e.g., immunization, disease response), and other vital needs.

Payment Reform Guiding Principles

This Roadmap is built upon the foundation already put in place by the State’s Medicaid Redesign Team (MRT) Payment Reform & Quality Measurement Work Group. In 2012, that Workgroup concluded that innovative payment reform and quality initiatives should:

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting, and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning, and preserve an efficient and essential community provider network.
3. Allow for a flexible multi-year phase in to recognize administrative complexities including system requirements (i.e. Information Technology).
4. Align payment policy with quality goals.
5. Reward improved performance as well as continued high performance.
6. Incorporate a strong evaluation component and technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market.
8. Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health.

Starting Point: How Should an Integrated Delivery System Function from the Consumer/Member’s Perspective?

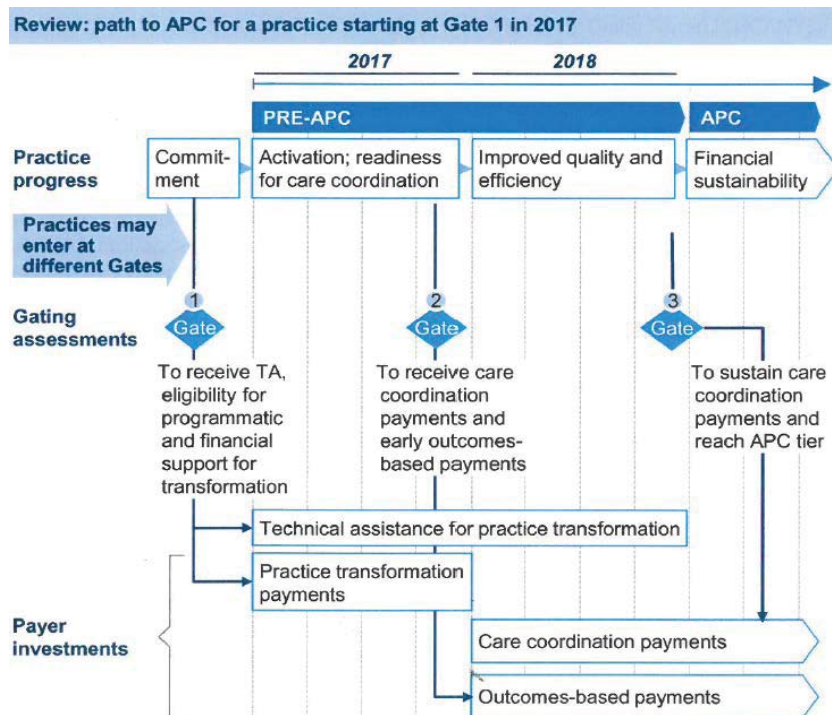
The fundamental vision of NYS DSRIP is the creation of integrated delivery systems capable of meeting the diverse needs of Medicaid members. Different types of members require different types of care. As foreseen in DSRIP, a high performing care delivery system encompasses three types of integrated care services, with optimal coordination between them:

1. **Integrated Primary Care (IPC)** including behavioral health, primary care, effective management of chronic disease, medication management, community based prevention activities, and clear alignment with community based, home, and social services agencies (Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) models). This type of care is continuous in nature, strongly population-focused, based in the community, culturally sensitive, oriented towards primary and secondary prevention, and aims to

act as the primary source of care for the majority of everyday care needs.

New York State’s Vision on Advanced Primary Care

Advanced Primary Care (APC) plays a core role in the State’s Health Innovation Plan (SHIP) and within DSRIP. The figure below briefly explains how NYS sees the progression from ‘Pre-APC’ status towards ‘Premium APC’ status, which fully aligns with DSRIP’s end goals for Integrated Primary Care (see the SHIP plan for more details).



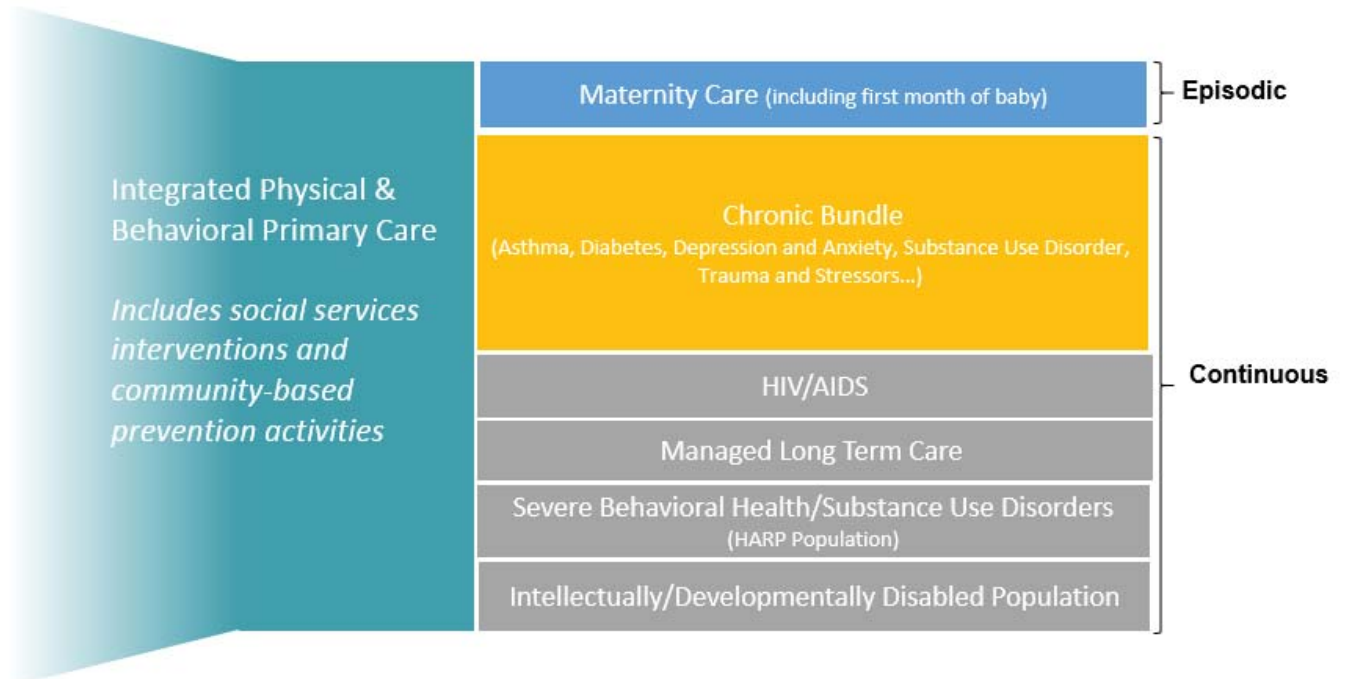
The State has had extensive experience with what will later be described as Level 0 Value Based Payments, FFS with quality bonus payments, during the early and ongoing support of the PCMH model, and involvement in medical home demonstrations in a variety of settings across the State. As these initiatives have progressed, it has become clear that transformation of primary care practices to an APC model will include three (3) broad phases during which the practices require different types of financial support:

1. Initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff (or re-training existing staff).
2. Interim support for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support shared savings payment. In the early years of the APC’s operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not (yet) generating cost savings.
3. Ongoing support once the APC model has begun to have a measurable impact on total cost of care and to generate measurable savings. The practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

From the perspective of Medicaid, phase 1 and 2 will be funded through DSRIP; phase 3 is the transition toward Level 1 (and higher) VBP for IPC, as discussed in the Roadmap.



- 2. **Episodic care services** are utilized for circumscribed periods of time when people require more specialized services for a specific health problem or condition. Within the Medicaid population and DSRIP, maternity care may be the best example; for elderly members, hip and knee replacement episodes are the most prevalent examples. These services, which may involve a single service or combination of services across the continuum of care, should be tightly integrated with multidisciplinary teams working with evidence-based care pathways, organized around these members’ specific needs, resources (including community resources), and cultural sensitivities.
- 3. **Specialized continuous care services** are required for those individuals who require ongoing, dedicated, and specialized interdisciplinary services for their health problem(s) or condition(s). This type of care can involve both evidence-based specialty care for individual conditions (e.g. diabetes, Chronic Obstructive Pulmonary Disease (COPD) , Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD)), as well as care for severely co-morbid and/or special needs populations (e.g. the Health and Recovery Plan (HARP) and Managed Long-Term Care (MLTC)/Fully Integrated Duals Advantage (FIDA) populations, members with significant developmental disabilities and members with HIV/AIDS). For the latter groups of members, personalized goal setting and intensive care coordination become more dominant than disease management. In both examples of care, a focus on maximizing a member’s capability for self-management and personal autonomy in the most integrated settings (e.g. home and community) appropriate to a person’s needs, is central.





Facilitating the Development of an Optimally Functioning Delivery System through Value Based Payments: A Variety of Options

Following the spirit of the DSRIP program, the State does not foresee a single path towards payment reform. Rather, the State aims to give PPSs, providers, and MCOs a comprehensive range of VBP options to consider. This allows providers and MCOs to select those types of value based payment arrangements that fit their strategy, local context, and ability to manage innovative payment models, which has been proven to be a critical success factor in successfully realizing payment reform.⁶

When entering into such arrangements, organizations become 'VBP contractors'; a VBP contractor is defined as an entity that contracts VBP arrangements with an MCO, and can be an Accountable Care Organization (ACO), an Independent Practice Association (IPA), or an individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers). Multiple providers can contract a VBP Level 1 arrangement by cooperating clinically and operationally, and making individual shared savings agreements with the MCO. Jointly, VBP contractors and MCOs can create VBP arrangements around:

- Total Care for General Population (TCGP); and/or
- Integrated Primary Care, including the Chronic Bundle (IPC); and/or
- the Maternity Bundle; and/or
- Total Care for Special Needs Subpopulations.

The *population based* arrangements include the total care and costs of that care for the included members, irrespective of where, how, or for what reason, the care was delivered. VBP contractors assume responsibility for the outcomes and costs across all conditions and types of care for these members. Based on the existing categories in New York State Medicaid, the prioritized special needs subpopulations are HIV/AIDS, members included in a Health and Recovery Plan (HARP), Managed Long-Term Care (MLTC) members and members with significant developmental disabilities.

A *bundle or episode*, on the other hand, is a VBP arrangement in which costs of a patient's office visits, tests, treatments and hospitalizations associated with a patient's illness, medical event, or condition are grouped together. A VBP contractor assumes responsibility for both the outcomes and the costs of the care across the continuum of the patient's trajectory for that condition.⁷ There are different categories of episodes: acute episodes that focus on the integrated care around an acute stroke, for example, or trauma; procedural episodes that focus on the care around gall bladder surgery, for example, or hip- and joint replacement; and chronic episodes that focus on the care for chronic conditions such as diabetes or bipolar disorder. The former categories have a clear start and end date, starting, for example, at the time of admission and ending 3 months after surgery; the latter are continuous. Based on prevalence in Medicaid, total costs of care, observed variability in costs and outcomes and prioritization in DSRIP, NYS has prioritized the Maternity Bundle (spanning the pregnancy, delivery and first month of the baby's care) and the Chronic Bundle (including the chronic conditions with the highest prevalence in NYS). The State will follow the internationally emerging best practices to treat chronic conditions as full-year-of-care bundles, emphasizing the continuous nature of this care,

⁶ Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." *Health Aff (Millwood)* 32(5): 929-934; Miller, H. D. (2009). "From volume to value: better ways to pay for health care." *Health Aff (Millwood)* 28(5): 1418-1428.

⁷ NYS uses the HCI3 Evidence-informed Case Rate (ECR) grouper (also known as 'Prometheus'). Playbooks will be made available with details on definitions and indicators per bundle. See also <http://www.hci3.org/programs-efforts/prometheus-payment>.



including all condition-related care costs.⁸

In searching for the right balance between flexibility and standardization, consistency in VBP arrangement definitions has been identified as a key success factor in VBP implementation both national and globally. This includes:

- Services to be included and excluded from each VBP model;
- Members eligible for attribution to each model;
- Selection and specifications of quality and outcome measures for each model; and
- Methods to calculate the risk-adjusted cost of care in each model and in benchmarks used by the State to reflect changes in the clinical and demographic mix of attributed members.

Such consistency enables transparency in performance between MCOs and VBP contractors, adequate monitoring of the quality and expenditures of the overall Medicaid system, and significantly reduces the administrative burden for both MCOs and providers.⁹ Especially for smaller providers, varying definitions of a VBP arrangement between MCOs and/or differences in reporting requirements could cripple their ability to fulfil their role. The statewide definitions and quality measures have been set based on national standards and the recommendations from the Clinical Advisory Groups and the Technical Design Subcommittees.¹⁰ VBP contractors must report on these measures to their MCOs, and MCOs have to report these measures to the State on a VBP contractor specific basis.¹¹

Providers and MCOs are, however, free to jointly agree to other types, or 'off menu' versions of VBP arrangements, including currently existing arrangements, as long as those arrangements reflect the underlying goals of payment reform as outlined above, and sustain the transparency of costs versus outcomes as detailed in Appendix II. Such arrangements will not require separate approval from the Department of Health (DOH) beyond the contract risk review process, but will require attestation from the parties, and be subject to periodic audits. NYS will report annually to CMS and other stakeholders on the progress and content of these 'off menu' VBP arrangements.

Most other components of the VBP contracting process, such as how to attribute members, setting and adjusting target budgets, rewarding performance, sharing savings and/or losses and so forth are left to the MCOs and providers to design and negotiate. The *guidelines* that have been developed to facilitate this will be discussed below.

Total Care for the General Population (TCGP)¹²

In this model, the VBP contractor assumes responsibility for the total care for its total attributed population. This excludes members who fall into a 'subpopulation' category described below, although VBP contractors

⁸ de Bakker, D. H., J. N. Struijs, C. B. Baan, J. Raams, J. E. de Wildt, H. J. Vrijhoef and F. T. Schut (2012). "Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination." *Health Aff (Millwood)* 31(2): 426-433; De Brantes, F., A. Rastogi and M. Painter (2010). "Reducing potentially avoidable complications in patients with chronic diseases: the Prometheus Payment approach." *Health Serv Res* 45(6 Pt 2): 1854-1871.

⁹ This standardization is also required to allow realizing the statewide information support strategy for providers and payers to facilitate VBP contracting as well as statewide transparency and cost- and outcomes-reporting.

¹⁰ Playbooks detailing these definitions and outcome measures per VBP arrangement will be made available.

¹¹ Claims based measures will be calculated by the State.



and MCOs are of course free to add one or more subpopulations to their contract. All services covered by mainstream managed care are included (for exclusions see p. 30), and all attributed members are included (see p. 23). The default method for attribution is the MCO-assigned PCP. Investing in population health, care coordination, referral patterns and discharge management are some of the DSRIP-enabled capabilities that will make VBP contractors successful.¹³

Integrated Primary Care with the Chronic Bundle (IPC)

In this model, the MCO contracts Patient Centered Medical Homes (PCMH) or other primary care providers for preventive care, routine sick care and the care and coordination for patients with chronic conditions. Preventive care includes care activities such as wellness visits, check-ups, immunizations, screening and routine tests; routine sick care includes care for symptoms such as headache or abdominal pain as well as minor acute conditions such as flu, rhinitis and so forth.¹⁴ The Chronic Bundle consist of 14 chronic conditions that have been prioritized on the basis of prevalence and total costs (see textbox, and p.33 for more details on the selection process). Given the prevalence of chronic co-morbidity, VBP contractors by default contract the Chronic Bundle as a whole rather than selecting one or more of the individual chronic conditions.

The default method for attribution for this VBP arrangement is the MCO-assigned PCP (see p. 23). All services covered by mainstream managed care that are part of routine primary care are included¹⁵, as well as those services included in the Chronic Bundle definitions. Members eligible for one of the subpopulations (p. 14) are excluded. As is the case today, IPC contracts can include additional payments for practice transformation, care management, and can tie additional rewards to progression towards APC status, for example.

The IPC arrangement emphasizes population health, the integration of physical and behavioral health, care coordination, adequate referral management (including actively working with hospitals on discharge management), amongst others.

Savings in an IPC contract are primarily based on reductions of so-called ‘downstream’ costs: expenditures for routine sick care and chronic care that would be reduced when integrated primary care is functioning optimally. Avoidable ED visits and hospital admissions due to a lack of care coordination or ease of primary care access are good examples, as are exacerbations of chronic conditions or the occurrence of complications due to poor secondary prevention. Cancer care costs and significant trauma care, on the other hand, are not included when calculating potential downstream savings.

Such savings can substantially increase funding to primary care practices because the potential downstream savings are much larger than the practices’ total current revenues. To maximize shared savings in this model, professional-led practices are encouraged to collaborate with hospitals and other providers on activities such as outreach, care management, and post-discharge care. Because shared savings will derive in large part from avoided hospital use, earned savings should be shared evenly between professional-led practices and associated hospitals, provided that the hospitals work cooperatively with the practices to better manage their

¹³ Professional-led TCGP VBP contractors are expected to cooperate with downstream providers. See the section on ‘Integrated Primary Care’ and Appendix III.

¹⁴ Because IPC includes only the care activities associated with preventive and routine sick care, it is technically a bundle rather than a population-based VBP arrangement. Because IPC includes all members assigned to a PCP, however, and a population-based focus is essential, the distinction between ‘bundle’ vs ‘population’ can be confusing in this context. For this reason, the Roadmap does not explicitly describe IPC as a ‘bundle’.

¹⁵ See textbox on p. 37 for additional details.



patient populations (see Appendix III for more detailed criteria).¹⁶

Similarly, compared to TCGP arrangements, moving to risk-based contracts in an IPC VBP arrangement is much more feasible for primary care professionals and organizations. Although the total costs included in an IPC arrangement are significant (about 40% of the total costs of care for the general population), the risk is limited to those costs that most primary care providers consider to be within their control: preventive care, and costs associated with routine sick care and chronic care.

Maternity Bundle

In this model, the MCO contracts with a VBP contractor (usually a hospital and/or professionals involved in maternity care, who may also work with community based organizations) for care from onset of the pregnancy, delivery, post-delivery and the first month of the newborn's care.¹⁷ All maternity services covered by mainstream managed care are included. Members eligible for one of the subpopulations are excluded. Bundles with a total cost above a certain threshold (so called 'stop-loss') are excluded to protect the VBP contractor from the insurance risk of high-cost NICU admissions. The member is attributed to the core pregnancy care provider. VBP contractors who focus on health education, increased uptake of prenatal care, pre- and interconception counseling, adequate c-section rates and resource utilization, screening for post-partum depression, evidence-informed maternal/infant home visiting and so forth have the opportunity to further improve maternity care outcomes while realizing shared savings.

Total Care for Special Needs Subpopulations

For some specific subpopulations, severe co-morbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care delivery and costs are determined by the specific characteristics of these members. For these subpopulations, including the total care (and thus total costs) for these often vulnerable members is best suited. As part of the movement towards managed care, the State has already identified several special needs subpopulations that have their own dedicated managed care arrangements:

- HIV/AIDS
- Health and Recovery Plan (HARP)
- Managed Long-Term Care (MLTC)
- Intellectual and/or Developmental Disabilities (I/DD)

The transition of the last subpopulation, those with intellectual and/or developmental disabilities, to managed care and VBP will be included in the next update of the VBP Roadmap.

For these special needs subpopulations, VBP contractors can contract Total Care for the Total Subpopulation. All services covered by the associated managed care plans are included, and all members fulfilling the criteria for eligibility to such plans are included. HIV/AIDS members are by default attributed to the MCO assigned PCP; HARP members are by default assigned to the MCO assigned Health Home (see p. 23). Members cannot be assigned to multiple subpopulations. When members are eligible for more than one subpopulation (e.g. HARP and HIV/AIDS), the MCO/SNP decides with the VBP contractor(s) which VBP subpopulation prevails. As

¹⁶ These criteria also apply to the Total Care for General Population VBP arrangement if it is contracted by professional-led VBP contractors.

¹⁷ Post-delivery care is included to 60 days after discharge of the mother; the care for the newborn is included to 30 days after discharge of the newborn. Pregnancies that do not result in a vaginal delivery or c-section are excluded. (See the Maternity Care Playbook for more details.)



mentioned above, VBP contractors and MCOs are free to combine e.g. the HIV/AIDS and/or HARP subpopulation with a TCGP arrangement.

Possible Contracting Combinations

There are various VBP arrangement options for MCOs to choose when contracting with a VBP contractor. As noted previously, a VBP contractor is defined as an entity that contracts VBP arrangements with an MCO, and can be an Accountable Care Organization (ACO), an Independent Practice Association (IPA), or an individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers). When contracting at the PPS level, it is important to note that a PPS in its current structure is not a legal entity, and thus cannot enter into VBP contracts. The PPS would have to evolve to one of the first two options above, in order to contract on behalf of the entire PPS.

Within mainstream managed care, MCOs and VBP contractors may opt to contract Total Care for the General Population with or without other Subpopulations (ACO models), or they can, for example, combine a risk-based IPC arrangement with a savings-only TCGP arrangement. The latter not only increases the chances of increased savings; it also helps providers, MCOs and the State achieve the percentage of value based payments required by the waiver. Some MCOs and VBP contractors may prefer to contract for IPC separately to optimize the chances of successful primary care reinforcement; other VBP contractors may want to contract Total Care for the General Population and ‘carve out’ a Maternity Bundle to create a dedicated drive to improve outcomes for maternity care.

Because of the comprehensive care needs on which the Total Care for Total Subpopulation VBP arrangements focus, IPC or other bundle arrangements within these subpopulation arrangements cannot be separately contracted.¹⁸

Both providers and health plans have suggested that although joint contracting at the higher level (e.g. PPS as a VBP contractor) for the most vulnerable, multi-morbid subpopulations could be highly beneficial, joint contracting at such a level for more circumscribed and prevalent types of care – such as maternity care – would stifle competition. Some PPSs (in the form of an ACO or IPA) might consist of 2-3 hubs that would prefer contracting for Total Care for the General Population separately rather than as a single PPS. While in some cases, contracting at the PPS or hub level for Integrated Primary Care may be the best path to rapidly develop region-wide APC model capabilities, in other cases it may disrupt locally grown collaboration patterns that require differential treatment to truly blossom.¹⁹

The State does not limit providers and MCOs from introducing additional arrangements ‘below’ a recognized VBP arrangement, such as existing Pay for Performance contracts with hospitals or primary care providers. In fact, such contracts can be used synergistically to achieve the overall goals of the VBP arrangement: rewarding PCPs to prevent avoidable ER visits, for example, can help a health system achieve its TCGP targets.

It is important to note that because PPSs/hubs do not legally participate as contracting entities in VBP arrangements without becoming an IPA or ACO, there are concerns about maintaining the population health-focused infrastructure, patient-centered integration and associated overall workforce strategy that DSRIP sets out to build. To address this concern, the PPS or its hubs will have to submit a plan outlining how this

¹⁸ For HARP and HIV/AIDS, when a specific subpopulation in a MCO or provider’s service area is not contracted (because of low numbers of eligible members for example), MCOs and providers are free to make the additional arrangements they deem necessary to adequately cover the needs of these members.

¹⁹ What care the PPS can actively contract for on behalf of the providers in the PPS is decided through the governance structure the PPS has put in place.



infrastructure will be sustained. In addition, impacts on patient-centeredness, population health, social determinants of health and workforce infrastructure, will be measured at the overall delivery system level (PPS, hub or otherwise). These measures will remain in place after DSRIP funding stops, and will be considered a component of the overall outcomes of care contracted within the different VBP arrangements.



From Shared Savings towards Assuming Risk

In addition to choosing the integrated services on which to focus, the MCOs and VBP contractors can select different levels of VBP arrangements. While assuming risk is a fundamental part of VBP, contractors should focus first on building out their DSRIP projects, maturing their capabilities, and creating strong networks, before focusing on potential downside risk-sharing arrangements. Combining the different types of VBP arrangements with different levels of VBP creates the following options:

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature VBP contractor)
Total Care for General Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)
Integrated Primary Care with Chronic Bundle	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM add-on) with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS (plus PMPM add-on) with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	PMPM capitated payment for primary care and Chronic Bundle services (with quality-based component)
Maternity Bundle	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Prospective bundled payment (with quality-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)



Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of this Roadmap (with the exception of select preventive services, see p.31, and Managed Long-Term Care, see textbox).

Level 1 consists of ‘upside only’ shared savings arrangements.²⁰ Here, the capitation and bundled payments exist only virtually. When the accrued fee-for-service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the parties in the contract (‘retrospective reconciliation’).²¹ Potential provider losses are not shared; contractors are not ‘at risk’ in Level 1. For example, if a provider or a combination of providers meets most of its contracted quality outcomes, MCOs can return more of the savings; when fewer goals are met, the shared savings percentage is reduced (see table on page 19). When outcomes worsen, no savings are shared.²²

Level 2 consists of ‘upside and downside’ risk-sharing arrangements. Again, the capitation and bundled payments exist only virtually, and the percentage of contracted quality outcomes affects the amount of savings and losses shared.²³ In Level 2, because the contractors share in the risk, if a contractor meets most of its contracted quality outcomes, the MCOs can return most or all of the savings. Conversely, if a contractor exceeds the virtual PMPM capitation or bundle budget, and a smaller percentage of outcome goals are met, then these providers may be held responsible for the majority of this difference (see table below).²⁴

To reduce unwarranted insurance risk for providers, the State suggests using stop loss, risk corridors and/or

Managed Long-Term Care (MLTC), Dual Eligibles and Shared Savings

The dual eligible population may seem relatively small (some 15% of Medicaid members are also eligible for Medicare), but these 700,000 individuals comprise 27% of total Medicaid spending. Many of these individuals use long term care services (LTCS) as well as hospital and other services; the former costs are covered by Medicaid (often through a MLTC plan), the latter are generally covered by Medicare. Preventing avoidable hospital use in this population is part of DSRIP’s goals, and should be equally incentivized through payment reform. Improving palliative care, for example, can greatly enhance the quality of care and quality of life for some patients. If the Medicare dollars cannot be (virtually) pooled with the State’s Medicaid dollars, and savings in Medicare cannot be shared with Medicaid providers (or vice versa), the impact of payment reform for this population threatens to be limited, and long term care providers will have difficulty achieving scale in VBP transformation.

To remedy this, the State is working with CMS to create aligned shared savings possibilities within Medicaid and Medicare (see p. 61). In anticipation, the State aims to treat potentially avoidable hospital use as ‘quality outcomes’ for this subpopulation, improving the quality of life for these members, and rewarding MLTC providers when certain levels of reduced avoidable hospital use are reached. Such arrangements could be treated as Level 1 VBP arrangements, and would be eligible for financial incentives. Even if the savings would primarily accrue to Medicare, the State will not pass on the opportunity to make significant strides in meeting the needs of this part of the dual eligible population. Improved quality and reduced overall costs can also be realized by delaying or avoiding nursing home admissions through targeted interventions amongst the MLTC population residing at home.

The MLTC CAG which is exploring these options is underway.

²⁰ A minimum amount of savings should be shared for an arrangement to be counted as a Level 1 VBP arrangement. See Appendix X.

²¹ Alternatively, shared savings can be distributed through inter-organizational arrangements within or by the VBP contractor. In practice, however, Level 1 and 2 arrangements usually leave the distribution of savings/losses to the payer (based on pre-agreed upon sharing formulas).

²² Savings should be allocated appropriately among providers; behavioral health, long term care, and other community based providers should in particular not be disadvantaged.

²³ A minimum amount of risk is required to be able to be labeled a ‘Level 2’ VBP arrangement (see Appendix X).

²⁴ The State suggests not imposing a minimum savings/losses threshold before savings/risk sharing begins.



other risk-mitigation strategies. The following table reflects the shared savings percentages that the State and the Technical Design Subcommittee established as a guideline to support providers and plans in their VBP contracting negotiations. Plans and providers may, however, decide on other percentages in their VBP agreements.

Quality Targets % Met	Level 1 VBP Upside only	Level 2 VBP Up- and downside	Level 2 VBP Up- and downside
		when actual costs < budgeted costs	when actual costs > budgeted costs ²⁵
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% of losses
<50 % of Quality Targets Met	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
Quality Worsens	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

The following general guiding principles for the distribution of shared savings amongst providers by the VBP contractor have been established:

- i. Funds are to be distributed according to provider effort, provider performance and utilization patterns in realizing the overall efficiencies, outcomes, and savings.
- ii. Required investments and losses of the involved providers can be taken into consideration in calculating and distributing available savings.
- iii. The relative budgets of the providers involved should not be the default mechanism for making the distribution of savings/losses (i.e. distributing the savings among providers by the relative size of each provider’s budget).
- iv. The distribution of shared savings should follow the same principles as the distribution of shared losses.

²⁵ The percentages for the Level 2 arrangements will depend on, amongst other factors, the risk-mitigation strategies chosen. In many cases, especially when more ‘focused’ VBP arrangements are contracted (e.g. a bundle vs a TCGP contract), actuarial analysis shows that the percentages of savings returned to providers can be higher than the percentages of losses shared with providers.



- v. For shared losses, smaller providers, financially vulnerable providers, or providers with a regulatory limitation on accepting certain losses may be treated differently by the VBP contractor to protect these individual providers from financial harm. It is legitimate that this ‘special treatment’ would weigh in as an additional factor in determining the amount of shared savings that these providers would receive.²⁶

In Level 3, the underlying FFS payment system is replaced by prospective PMPM and/or prospective bundled payments. No retrospective reconciliation is necessary. As in Level 2, stop loss arrangements may remain to prevent providers from inadvertently taking on insurance risk.

There is a possibility that situations may arise where a MCO and a VBP contractor enter into a value based payment arrangement, but the parties fail to agree upon the terms of a contract. The State, MCOs and providers will collectively monitor whether action or additional guidelines may become necessary in the future.

Further, the State will plan an assessment of progress toward the end of DSRIP Year 3 of participation in VBP contracting, as well as of the market dynamics, which will better equip plans, providers/contractors and the State to address challenges that arise as VBP accelerates. The State will work with the VBP Workgroup to define the details of the assessment in calendar year 2016. This time frame will allow for the finalization of the amendments to the Medicaid Managed Care Model Contract (Model Contract) and the Provider Contract Guidelines.

Pharmaceutical Costs and the Role of the Pharmacist

Costs for drugs and the dispensing of drugs (including adequate pharmaco-therapeutic management) are included in the value based payment arrangements described. Pharmacists can add great value in managing polypharmacy, for example, or in enhancing proper medication usage and compliance. As adverse reactions to medication is a key driver of avoidable hospital use, state of the art Medication Therapy Management (MTM) can improve outcomes and reduce overall costs. Many innovative contracting models are available for MCOs as well as PPSs and (groups of) providers to incorporate the benefits that MTM can bring into the value based arrangements discussed here. The Regulatory Subcommittee reviewed the current state of comprehensive medication management in the State and recommended amending the Public Health Law to create a voluntary program for collaboration between qualified pharmacists and physicians ruled by a written protocol that would enable physicians to refer certain patients with chronic conditions who (1) have not met the goals of therapy, (2) are at risk for hospitalization or (3) otherwise considered to be in need of CMM services, to qualified pharmacists.

²⁶ Shared savings and losses calculations will not be included in the VBP dynamic analytics platform that the State will make available for the providers and the MCOs.



Contract Risk Review Process

Overview

In order to ensure that appropriate safeguards are in place for providers entering into VBP contracts (with a focus on protecting providers from taking on more risk than is financially sustainable), the State will implement a new contract review process. To the extent possible, the updated contract review process will coordinate and standardize the review of the Department of Health and the Department of Financial Services (DFS).

Three review Tiers have been created to reflect the new VBP Levels as per the Roadmap (see Appendix VI, Figure A for definitions of the Levels). These Tiers will be used to determine the type of review required for all provider contracts.²⁷ DOH will collapse the existing five contract review levels per the existing Provider Contract Guidelines into three Tiers.

The third Tier will be comprised solely of prepaid capitation arrangements that are currently subject to DFS's Regulation 164, and will continue to be reviewed and approved by DFS in accordance with the terms of Regulation 164²⁸, which provides guidance concerning Financial Risk Transfer arrangements and outlines the requirements for providers to enter into such arrangements. Prepaid capitation will include all prepayments made to one or more health care providers, in any form and for any arrangement, in exchange for one or more covered health care services to be rendered referred or otherwise arranged by such providers and by its participating providers. DOH will continue to conduct a programmatic review of the contracts in this third Tier.

The application of the three Tiers will apply uniformly to all types of VBP contractors and will apply to all types of provider contracts.

Summary of the Three Tiered Approach

Multi-Agency Review Tier (Tier 3)

The Multi-Agency Review Tier (Tier 3) includes all contractual arrangements where at least one of the following is true:

- i. the contract implicates Regulation 164; or
- ii. the provider's Prepaid Capitation payments are more than \$250,000; or
- iii. at the request of DOH.

DFS shall conduct a financial review for all contracts in this Tier. In accordance with current policy, DOH may conduct its own financial review in its sole discretion, but may also defer to the DFS financial review. DOH will conduct a programmatic review for all contracting arrangements within this Tier whether or not DOH also performs a financial review.

DOH Review Tier (Tier 2)

The DOH Review Tier (Tier 2) includes VBP Level 2, VBP Level 3, and all other contractual arrangements (whether fee-for-service, value based, or otherwise) where the provider's annual prepaid capitation payments from the health services plan do not trigger DFS Regulation 164, but represent more than \$1,000,000 of the

²⁷ Regardless of which Tier a particular agreement falls, the financial and/or programmatic reviews referenced here only apply from the State's perspective to assess financial risk and programmatic risks to the Medicaid program. The State is not providing legal advice to either plans or providers, nor is the State determining whether the contractual arrangement is a fair business deal between the parties.

²⁸ 11 NYCRR Part 101.



provider's annual at risk payments (of any type), and at least one of the following is true²⁹:

- i. more than twenty-five percent (25%) of the annual Medicaid Managed Care or Medicaid Managed Long Term Care payments are at risk; or
- ii. the payments consist of more than fifteen percent (15%) of the provider's overall Medicaid revenue; or
- iii. the contract contains a value based payment arrangement that is off-menu (see Appendix II) and not previously approved by DOH.

DOH shall conduct both a financial and programmatic review for contracting arrangements which fall within this DOH Review Tier. DFS will not conduct a financial review for contracts falling within this Tier unless DOH requests an additional review from DFS.

For contracts that fall into this DOH Review Tier, DOH will continue to develop a framework for determining which type(s), if any, of financial viability will be required. Once developed, this framework will be publicly available. While the framework will be used for guidance and predictability for contracting plans and providers, DOH will review each contract on a case-by-case basis with discretion to require more or less demonstration of financial viability depending on the specific facts and circumstances of the contract.

File and Use Tier (Tier 1)

The File and Use Tier (Tier 1) includes all VBP Level 1 arrangements (upside only arrangements) and all other arrangements that do not meet the minimum review thresholds for a Multi-Agency Review (Tier 3) or DOH Review (Tier 2).

DOH will conduct a programmatic review only for contracts that fall within this File and Use Tier. This programmatic review will be an abbreviated review as compared to the DOH Review Tier, but will ensure that certain requirements are met including, but not limited to, ensuring the mandatory provisions are present and the financial attestations are complete. Generally, neither DOH nor DFS will conduct a financial review for contracts falling within this Tier.

²⁹ See Appendix VI, Figure B for a detailed description of the formulas and calculations.



Attribution and Target Budget Setting Guidelines

To ensure a consistent approach in implementing VBP, the Technical Design Subcommittees have recommended several guidelines to assist MCOs and VBP contractors in negotiating VBP arrangements. Essential components of any VBP arrangement are attribution and the setting of the target budget for the VBP contractor.

The paragraphs below outline the methodologies that the State recommends VBP contractors and MCOs use for attribution and target budget setting. Although plans and providers may choose different methodologies in their implementation, these guidelines will be used by the State for its analyses of costs and outcomes of VBP arrangements, including the information and data and analytics support disseminated by the State to both MCOs and providers.

In addition, key components of the target budget setting process, including risk adjustment, performance adjustments (from 2017 through 2020), and stimulus adjustments, are directly aligned with how the State pays MCOs (including modifications foreseen for 2017).

Attribution

Medicaid member attribution determines which members a VBP contractor will be responsible for (in terms of quality outcomes and costs). Attribution allows for the calculation of the total costs of care, patient-centered outcomes, and potential shared savings per member or episode of care - measures that are essential for the continual monitoring of VBP arrangements.

a. *Assignment*

- i. The MCO assigned Primary Care Physician (PCP) drives attribution in Total Care for the General Population, Integrated Primary Care with the Chronic Bundle, and the HIV/AIDS subpopulation.
- ii. For non-chronic bundles, the provider delivering the core services that ‘trigger’ the bundle drives attribution. In maternity care, that provider is the obstetric professional delivering the pregnancy care.
- iii. The MCO assigned Health Home drives the attribution for the HARP subpopulation.
- iv. The MLTC assigned home care provider or nursing home (depending on the residential status of the member) drives attribution for the MLTC subpopulation.

An MCO and VBP contractor may deviate from this guideline and agree on a different type of provider to drive the attribution on the condition that the State is adequately notified.³⁰ In most cases, the State will not be able to adapt alternative attribution methods in the information and data it provides to MCOs and VBP contractors. The attribution entity does not need to be the same provider or provider-type as the VBP contractor, but must be part of the VBP arrangement (i.e. a hospital system could be the contractor for a TCGP population while its associated PCPs would drive the attribution). MCOs and providers can utilize multiple factors in establishing attribution.

b. *Timing*

- a. Members are prospectively attributed to a provider through assignment (PCP, Health Home) or start of care (bundle). If the member switches their assigned PCP/Health Home within the first six months of the year, the member will be attributed to the VBP arrangement of the latter

³⁰ For example, in a chronic care episode attribution may be performed by a specialist group rather than a PCP. In this case, cardiologists may be the point of attribution for an arrhythmia bundle.



PCP/Health Home. To reduce complexity and assure predictability for the VBP contractor, the Subcommittee recommends not attempting retrospective reconciliation of members through an analysis of actual PCP or Health Home use.³¹

Through prospective attribution, the State will be able to monitor quality and costs of care, and provide MCOs and VBP contractors with their risk-adjusted and proxy-priced³² costs, real-priced costs, outcomes, target budgets and savings opportunities per VBP arrangement.

Establishing Target Budgets

To determine whether savings or losses are made in Level 1 and 2 arrangements, a ‘virtual budget’ needs to be agreed upon for a bundle or a (sub)population. A well designed target budget continuously incentivizes the improvement of quality and cost effectiveness for both historically high performing and poor performing VBP contractors. The method outlined below is modeled on the Center for Medicare and Medicaid Innovation’s Next Generation ACO approach.³³

- Starting from the VBP contractor’s own historical baseline
- Including risk adjustment to account for differences in patient population between the baseline period and the contract period
- Including ‘performance adjustments’ which account for existing efficiency and quality (or lack thereof)

The latter component is key because realizing shared savings is difficult for those providers who are already highly efficient compared to the State’s average. Likewise, inefficient providers can realize savings relatively easily, and it would be unfair if a VBP methodology punished the former and rewarded the latter. Performance adjustments reward providers who are highly efficient (and of high quality) by adjusting their target budget upwards, thus increasing their potential for shared savings. Vice versa, VBP contractors who deliver much lower value may see their target budgets adjusted downwards.³⁴

In addition to the performance adjustments, the guideline includes ‘stimulus adjustments’ to incentivize VBP contractors to move to higher level VBP contracts. Building on the current quality and efficiency incentives, similar adjustments will become part of the MCO incentive structure from 2017 onwards.³⁵

The method is *prospective*: the target budget is set based on historical performance. The expected PMPM or episode budget is determined at the start of the contract year or the episode – not reassessed during the year/episode. This ensures that an unforeseen shift in population characteristics does not unfairly (dis)advantage the VBP contractor while avoiding gaming and increase predictability.

³¹ The VBP contractor may choose to use a similar approach for downstream contractors joining or leaving at various points of the contract period (joining late or terminating early), as for Medicaid members joining or leaving the attribution pool.

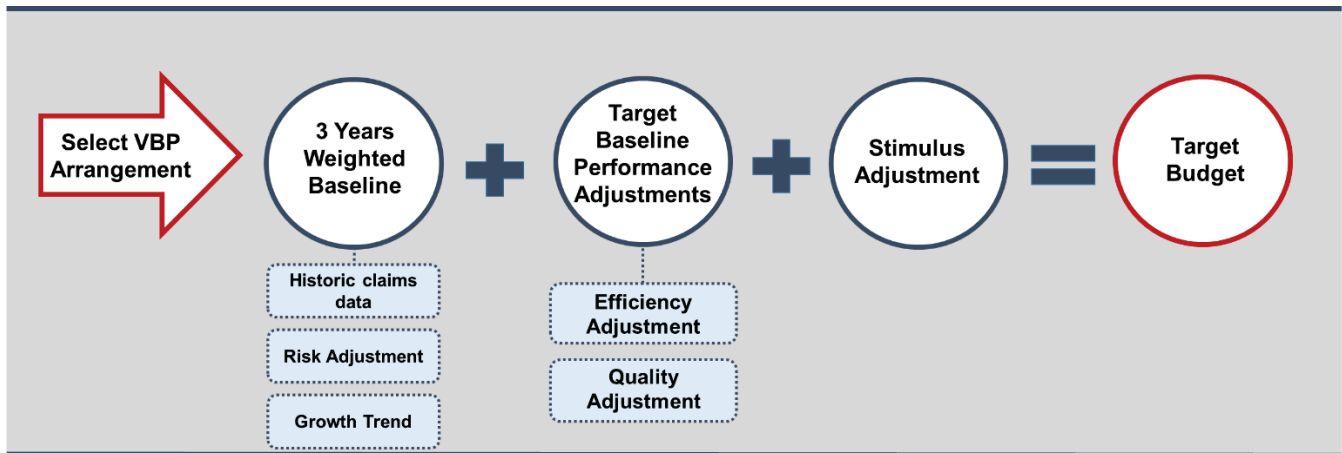
³² Previously called ‘price-standardized’. Both mean that price differences between providers for similar services are excluded from the calculations.

³³ [Innovation.cms.gov/files/x/nextgenacorfa.pdf](https://www.innovation.cms.gov/files/x/nextgenacorfa.pdf)

³⁴ To allow lower value (potential) VBP contractors to improve in time, downward adjustments for VBP contractors are not supposed to be made until 2018.

³⁵ In the guideline created by the Technical Design I subcommittee, the ‘performance adjustments’ were called ‘value modifiers’. The stimulus adjustment as well as some other details were added to this guideline after the subcommittee finished its work to create a stimulus for VBP contractors to further align the guideline with the intentions of the Roadmap and with the adjustments MCOs will receive from the State from 2017 on.

Using this methodology, the MCOs and VBP contractors can negotiate target budgets per arrangement to disincentivize above-average avoidable complication rates, or invest additionally in underserved areas of care.



The Roadmap proposes the following approach to setting up a target budget:

Baseline

- i. The VBP contractor’s own historic claims under the VBP arrangement are aggregated to create the baseline of the target budget and allow for a comparison to prior VBP contractor experience.
- ii. The baseline is calculated on the basis of the most recent three years of claims data, with the latest year weighted at 50% of the baseline and the proceeding years accounting for 35% and 15% respectively.
- iii. To avoid unwarranted rebasing once savings have been made, the historical costs of care of a VBP contractor are calculated *including* the shared savings reimbursed (or losses reclaimed) to the provider.

Growth Trend

- i. The growth trend of costs during the performance period is calculated by averaging the regional growth trend (upstate or downstate) and a VBP contractor-specific growth trend.

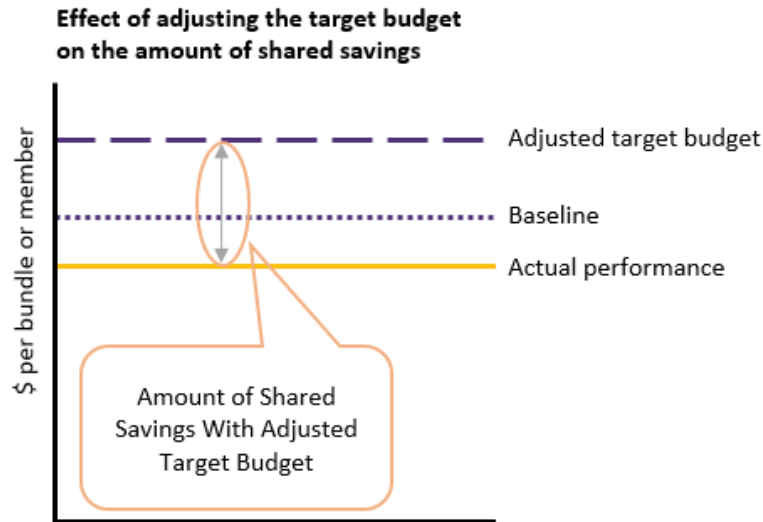
Risk Adjustment

- i. The 3M Clinical Risk Grouping (CRG) methodology is utilized for risk adjustment in TCGP. For the subpopulations, the default is to follow the risk adjustment methodology used for setting the plan’s rates. (The State is currently developing risk adjustment methodologies for both HIV/AIDS and HARP.)
- ii. The most recent HCI3 methodology is utilized for risk adjustment of bundles of care.³⁶
- iii. The target budget is set at the beginning of the contract period for the duration of the bundle or one year. Changes in risk-profile during the contract period do not lead to a change in the target budget.

As adjustment methodologies improve over time (including better sensitivity to pre-existing disparities), the State will adjust accordingly.

³⁶ <http://www.hci3.org/content/ecrs-and-definitions>

Performance Adjustments



- i. After applying the risk adjustment factors, the performance adjustments are applied based on the efficiency and quality of VBP contractors in the most recent year for which claims are available.
 - a. Efficient VBP contractors ranked above the 70th percentile³⁷ in Efficiency receive a 1% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 1.5% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 2% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 0.5% target budget increase
 - b. Highly efficient VBP contractors ranked above the 80th percentile in Efficiency receive a 2% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 3% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 4% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 1% target budget increase
 - c. The most efficient VBP contractors above the 90th percentile in Efficiency receive a 3% target budget increase:

³⁷ Efficiency is measured as the risk-adjusted cost of care per VBP arrangement (per member/episode), using 'proxy-priced' data (proxy-priced data implies that variability in costs due to negotiated prices is excluded from the analysis). The percentile is based on a state-wide ranking of VBP contractors per VBP arrangement. Higher percentiles indicate greater efficiency (lower costs) and higher quality. To emphasize the importance of building out population health, and to stimulate prevention, preventive activities should not be taken into account when comparing efficiency between IPC VBP contractors.



- i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 4.5% increase to their target budget
- ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 6% increase to their target budget
- iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 1.5% target budget increase
- d. If Quality is below the 40th percentile: the VBP contractor will be ineligible for any upward adjustments despite their Efficiency ranking

The State will make funds available to MCOs for these adjustments, and will reward the plans as well. The actual percentages that the State will be able to provide to the MCOs will be determined on a yearly basis by the State.

- ii. At the start of 2018 (giving providers two years to improve and potentially begin earning shared savings), in addition to upwards adjustments, VBP contractors' efficiency and quality may produce target budget decreases:
 - a. VBP contractors below the 30th percentile in Efficiency receive a 1% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 1.5% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 2% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 0.5% target budget decrease
 - b. Inefficient VBP contractors below the 20th percentile in Efficiency receive a 2% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 3% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 4% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 1% target budget decrease
 - c. Highly inefficient VBP contractors below the 10th percentile in Efficiency receive a 3% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 4.5% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 6% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 1.5% target budget decrease
- iii. To prevent unwarranted target budget adjustments, the target budget will not be adjusted when the variability in performance between VBP contractors is below a certain (to be determined) threshold.
- iv. When certain future developments can be foreseen to become relevant in the target year (i.e. pending changes in pharmacy benefits), and of course within the context of the development of MCO rates, MCOs and VBP contractors can adjust the target benchmark accordingly.



Stimulus Adjustment

- i. To stimulate the progress towards Level 2 and higher VBP arrangements, VBP contractors can receive an upwards adjustment to their target budget (for a duration of two years) when moving into a Level 2 VBP arrangement. Similarly, when moving into a Level 3 arrangement, the same adjustment would apply.
- ii. Arrangements that focus on IPC or the Maternity Bundle will receive a higher Stimulus Adjustment (1% upward adjustment of VBP contract's target budget) than Total Cost of Care for the General (Sub)Population (0.5% upward adjustment) because: a) infrastructure costs for these former arrangements will be relatively higher compared to the total dollar amount of the VBP contract and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system will be higher when a more differentiated VBP approach is taken. These Stimulus Adjustments will end in 2020.
- iii. The State will make funds available to MCOs for these adjustments, and will reward the plans as well. The actual percentages that the State will be able to provide to the MCOs will be determined on a yearly basis by the State.
- iv. As explicated in Section 3 of this Roadmap Update, from 2018 on, MCOs may receive a penalty when falling behind the goals of the VBP Roadmap (i.e. when the percentage of value based payments to providers is lagging behind the yearly Roadmap targets). In such situations, it is to be expected that MCOs may pass through such downward adjustments to e.g. inefficient providers who resist entering into VBP arrangements or otherwise work towards reaching their goals.

Future Adjustments

- i. When the price-standardized and risk-adjusted PMPM or episode costs for a specific VBP arrangement start to converge around the State average, that State average can become the starting point for target setting, and these efficiency adjustments would no longer be used. The quality-based performance adjustments would become bonus- and/or malus- payments.

*The State may change the suggested percentages for up- and downward adjustment over time, based on lessons learned, the desire to keep Medicaid dollars maximally available for high value care delivery, as well as the integrity of the Medicaid Global Cap.*³⁸

Transparency of Outcomes and Cost as the Foundation for Value Based Payments

Through its Medicaid Analytics Performance Portal (MAPP), the State has already made it possible for PPSs to use state of the art data and analytics (D&A) tools to explore their performance on key quality measures, identify members, providers or zip-codes responsible for high or low scores, monitor trends, and explore some of the common drivers of better or poorer performance. In the first half of 2016, the State will make the total risk-adjusted cost of care available per PPS and MCO for the total population, as well as per integrated care service delineated above (Maternity Bundle, IPC, HIV/AIDS, HARP). This tool will combine both 3M CRG groupers (for population-based analyses) as well as the HCI3/Prometheus episode grouper, including the appropriate risk-adjustment methodologies. Potential shared savings, estimated, for example, by comparing potentially avoidable complications, will be available at both the total population level and per care bundle and subpopulation. This tool will allow providers and MCOs to have secure, direct analytical access to the

³⁸ If, at any time, the State is on track to exceed the appropriated dollar amount within the Medicaid Global Spending Cap, efforts will be taken by the Health Commissioner to rein in spending and ensure total spending does not exceed the cap.



Medicaid Data Warehouse, including any future data additions (based on e.g. linked clinical registries).

Having these costs and the outcomes of these services available and transparent is crucial for any transformation towards payments based on value rather than volume.³⁹ First and foremost, this tool will provide VBP contractors and MCOs with the same dataset, thus facilitating VBP contracting negotiations. Second, it will help VBP contractors and MCOs start with the required analytical deep-dives in the data without immediate or additional investments in D&A infrastructure. Except for perhaps the smaller MCOs and VBP contractors, most parties will likely want invest in their own D&A infrastructure to facilitate Medicaid VBP contracting over the next several years. In those cases, the State's analytical platform will still be useful to help validate outcomes or allow insight into comparative data that is not available for the MCO or VBP contractor itself.

As stated at the beginning of this section: at any given time, providers and MCOs are free to jointly agree to 'off menu' options of VBP arrangements as long as they support the underlying goals of payment reform and sustain the transparency of value (costs versus outcomes) (see Appendix II for more details).

Current Progress Towards VBP

As has been stated previously, the State's goal is to have 80-90% of total MCO/contractor payments (in terms of total dollars) made using at least Level 1 value based payment methodologies by the end of DSRIP Y5. To optimize the incentives, and allow providers to maximize their shared savings so as to build toward a financially stronger Medicaid delivery system, the State aims to have \geq 50-70% of total managed care payments tied to VBP arrangements at Level 2 or higher. The target here is not to achieve the percentage per se, but rather the underlying goals that the State, the providers, MCOs and members collectively seek to realize through payment reform. The minimum target for the end of DY5 is 35% of total managed care payments (full capitation plans only)⁴⁰ tied to Level 2 or higher.⁴¹

Using the definitions of VBP as set by this Roadmap, the starting point for NYS Medicaid VBP has been calculated through the VBP Baseline Survey. The DOH released the VBP Baseline Survey to Mainstream Managed Care Organizations, Managed Long-Term Care Plans, Medicaid Advantage Plus Plans, and HIV Special Needs Plans in New York State on Friday, February 12th 2016. The survey allows the State to establish statewide and regional baselines for VBP contracting within the Medicaid Managed Care program. The survey includes spending information related to contracting across the VBP Levels and arrangement types established in this Roadmap and further developed by the Clinical Advisory Groups, as well as qualitative questions around the use of quality measures and patient incentives. Results from the survey found that per 2014 data, 25.5% of the respondents' total Medicaid Managed Care payments were in VBP Levels 1-3, with this number rising to 34.5% when including payments in Level 0 with related quality measures.⁴²

³⁹ All comparisons between VBP contractors and MCOs will be made using risk-adjusted, 'proxy-priced' data. 'Proxy-priced' data implies that variability in costs due to negotiated prices is excluded from the analysis. For the risk-adjustment methodologies used see the target budget setting process guideline.

⁴⁰ For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

⁴¹ The State will deduct the total dollar amounts associated with the services and providers that are excluded Statewide (see p. 30 [subsection on 'exclusions']) from the denominator in calculating its progress to the VBP goals.

⁴² These results are inclusive of Mainstream Managed Care Organizations, Managed Long-Term Care Plans, Medicaid Advantage Plus Plans, and HIV Special Needs Plans in NYS.



Exclusions

In principle, the State does not want to wholly exclude any cost categories from the VBP arrangements. Generally speaking, excluding defined services and provider types undermines the principle of value based payment as outlined here. The State must, however, ensure that there are no structural barriers to achieving the statewide goals, and the following narrow list of services and providers either *are* excluded (i.e. they cannot be included) or *may be* excluded by MCOs and VBP contractors. Services not mentioned here or elsewhere in the VBP arrangement definitions, in other words, cannot be excluded.

1. Financially Challenged Providers

To successfully participate in VBP arrangements, particularly those at higher levels of risk sharing, providers need corresponding levels of financial and organizational stability. DOH will exclude specific financially challenged providers (FCP) from being (a parent or risk-carrying member of) a VBP contractor. Payments to providers falling in any of the below categories that are not part of, or contractually related to, VBP contractors according to the guidance above will be excluded from VBP target goal calculations during the planning, restructuring and/or phase-out period.

A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding provider, which is evidenced by the following⁴³:

- Less than 15 days cash and equivalents;
- No assets that can be monetized other than those vital to the operation; and
- The provider has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

Such providers should be in the planning process with DOH to:

- Be absorbed under the umbrella of another health care system,
- Be transitioned to another licensure category/service line, or
- Discontinue operations.

Furthermore, providers who are deemed financially challenged cannot enter a Level 2 or higher VBP arrangement in a VBP contractor role, though they can be part of Level 2 or higher VBP arrangements, as long as they are protected from any downside risk. This exclusion from being a VBP contractor or bearing downside risk under a Level 2 or higher agreement will not apply to FCPs participating in the State's Value Based Payment – Quality Improvement Program (VBP QIP), provided those FCPs comply with all other relevant provisions of VBP QIP.

2. Services to Non-Attributed Members

(Emergency) services performed by a provider for a Medicaid member who is not attributed to a VBP arrangement in which this provider participates will not be seen as costs to that VBP arrangement.

In addition to the services excluded above, which will be excluded as a statewide standard in the VBP calculation, plans and providers have the option to jointly decide to exclude the following:

⁴³ Aligned with the Interim Access Assurance Fund (IAAF) program criteria of severe financial distress.



3. High Cost Specialty Drugs

MCOs and providers may exclude high cost specialty drugs from their VBP arrangements if they so choose, as including specialty drugs may shift too much insurance risk to the provider.

Under Medicare Part D, CMS defines specialty drugs as those costing \$600 or more per month, and has maintained this definition since 2008. This \$600 threshold will also be used for evaluating high cost drugs in Medicaid VBP in order to be aligned with existing CMS definitions.⁴⁴

Should plans and providers decide to include high cost specialty drugs in their VBP arrangements, however, they are able to do so.

4. Transplant Services

MCOs and contractors may choose to exclude the cost of organ transplant services from their arrangements.

Fee-for-Service as Value Based Payment

In addition to the exclusions for VBP described above, the State aims to utilize fee-for-service as a value based payment mechanism for a limited set of preventive care activities, provided that adequate quality measures are included. Especially for the NYS Medicaid population, preventive services need to be stimulated and are broadly underutilized. Since FFS incentivizes volume, paying FFS for high quality preventive services could arguably be seen as paying for value.

As a counterargument, stakeholders argued that many VBP arrangements (such as Total Care for the General Population and Integrated Primary Care with the Chronic Bundle) already incentivize preventive activities, because investing in those will lead to increased quality outcomes and reduced costs when seen at the level of the total costs of care.

Based on the recommendation of the Technical Design II Subcommittee, the State suggests that there are two instances in which the argument for fee-for-service as a VBP model for preventive care still stands:

- 1) Preventive activities to prevent disease that require widespread implementation whose impact will be mid- to long term. (The financial return on investment for a Total Care for the General Population arrangement, for example, could be too remote in such a situation.) These would be limited to the list of preventive activities included in the ACA, and would exclude those preventive activities that are currently not covered by Medicaid. Examples:

Routine childhood preventive activities:

1. Vaccines
2. Measurements, like BP, height and weight
3. Screenings: hearing and vision
4. Developmental/Behavioral assessments, such as autism and depression screening
5. Physical examination
6. Procedures, like newborn screenings, lead screening, STI screening and Pap smears
7. Oral health, like water fluoridation

Routine adult preventive activities:

1. Vaccines
2. Behavioral health screens, like for alcohol use or depression

⁴⁴ With its stakeholders, the State will monitor the pharmaceutical market to prevent an undue financial burden on VBP contractors.



3. Physical health screens, in sub-categories:
 - a. Physical examination related activities, like BP screening
 - b. Lab tests, like diabetes or cholesterol screening
 - c. Cancer screenings, like colonoscopy, Pap smear and mammography
 - d. STI screenings
 - e. Tobacco smoking cessation, behavioral and pharmacotherapy interventions
4. Counseling services, like dietary counseling and tobacco cessation counseling
5. Well visits

Some of these activities (such as blood pressure monitoring, tobacco cessation counseling) can also be part of disease management. In those instances, these activities not considered to be *preventing* disease, but will be included in e.g. the value-based payment arrangement for chronic care.

- 2) Preventive activities that are relatively high cost whose impact may well be felt outside the scope of the VBP contractor. (Similarly, here the financial return on investment may be too uncertain for the VBP contractor to make the investment.) These activities are generally directed at at-risk populations, but cannot meaningfully be included in the value-based payment arrangements for those conditions:
 1. High-cost contraceptive interventions, such as long-acting reversible contraceptive (LARC). (To reduce probability of e.g. low-birth weight neonates)
 2. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
 3. Pre-Exposure Prophylaxis (PrEP) for individuals at risk for HIV/AIDS

The dollars associated with these FFS payments would count towards the statewide goal of 80-90% of payments from MCOs to providers in VBP arrangements. For each suggested preventive service, the State will look at associated quality measures. In the case of LARC, for example, the LARC intervention is not part of the VBP Maternity Bundle (and thus remains FFS), but the intervention is included in the overall quality measure set for the Maternity Bundle. If approved, the State will review its list on an annual basis with CMS. The intent is to keep abreast of the current state of affairs in NYS health care, assessing, for example, the need for more or new immunizations and vaccinations, etc. Priority will be given to the areas where NYS needs improvement according to the Prevention Agenda 2013-2017: New York State's Health Improvement Plan.



2. Ensuring Alignment between DSRIP Goals and Value Based Payment Deployment

Issue 2: How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

Selecting and Defining Integrated Care Services and their Key Quality Measures: the Clinical Advisory Groups (CAGs)

The starting point for this Roadmap is sustaining the achieved DSRIP results. The overall goals of the DSRIP program and payment reform are the same: to improve population health and individual health outcomes and to reward high value care delivery. The selection of the VBP arrangements, and the selection of accompanying quality measures, therefore, needed to be closely aligned.

Engaging the professional community in New York State through Clinical Advisory Groups proved key for this alignment. The task of the CAG was to: review the State's vision for the Roadmap to Value Based Payment, validate the proposed bundle or subpopulation definition and corresponding analysis, and decide upon a set of quality measures for each arrangement. The CAGs met on average three times to discuss each bundle or subpopulation, and will reconvene annually to assess the respective measures. Each CAG is comprised of clinicians and professionals with specific knowledge and industry experience with the condition and/or subpopulation. Members were nominated through recommendations from VBP Steering Committee members, other NY State agencies (such as the AIDS Institute and Office of Mental Health), and other professional groups and associations. Specific consideration was given to the composition of the CAG to ensure that it not only represented geographic diversity (both downstate and upstate), but also the total spectrum care as it related to the specific condition/subpopulation discussed. For example, the Maternity CAG consisted of stakeholders from midwives to neonatologists to health plans.

The following criteria were used to prioritize and select the care bundles and subpopulations (see Appendix V for the quantitative analyses underlying this selection):

1. Large proportion of total Medicaid costs
2. High number of Medicaid members included in these Integrated Care Services
3. Cost Variation
4. Quality Variation (such as variability in potentially avoidable complications)
5. Prioritized within DSRIP

This led to the installation of the following CAGs:

- Maternity Care
- Behavioral Health & Substance Use Disorders (covering HARP and BH/SUD related chronic bundles)
- HIV/AIDS
- Chronic Heart Conditions
- Chronic Pulmonary Conditions
- Diabetes
- Managed Long-Term Care (MLTC)
- Intellectual and/or Developmental Disabilities (I/DD)



There was no CAG created for Integrated Primary Care, as the SHIP workgroup was in the process of developing the structure of Advanced Primary Care (see p. 4, 9) and its related quality measures.

The total dollar amount associated with these care services is \$32.2 billion, thus covering approximately 82% of the total payments between MCOs and PPSs/providers (excluding the Medicare component of the FIDA payments).⁴⁵ When including the Total Care for the General Population VBP arrangement, up to 100% inclusion of MCO payments can be achieved. A small number of CAGs will continue in Year 2, and new CAGs may be formed around additional priorities, such as Special Needs Children. The State is currently investigating whether a specific VBP focus on this population would be beneficial to the value of this care. Next steps will be identified following the conclusion of these efforts. Clinician engagement will, however, remain a hallmark of NYS's approach to VBP throughout the DSRIP period.

Quality Measures

The DSRIP program is geared towards the realization of outcomes (reduced potentially avoidable (re)admissions, visits and complications, better patient experience, reduced number of uninsured and members not using preventive and primary care services). The State's Medicaid Payment Reform strategy embraces these same goals, structurally rewarding outcomes over inputs.

For each prioritized VBP arrangement, the Clinical Advisory Groups began the quality measure selection process using the relevant DSRIP Domain 2 and 3 measures. They also considered applicable NYS Quality Assurance Reporting Requirements (QARR) measures, relevant measures from CMS measure sets, the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), and CAG specific measure sets (e.g. the American Thoracic Society for pulmonary measures and the NYS AIDS Institute's measures for HIV/AIDS). CAG members also suggested measures that were appropriate for review and discussion.

Based on an analysis of clinical relevance, reliability and validity, and feasibility, each CAG ranked their respective measures into one of three categories:

Category 1: Selected by the CAG as clinically relevant, reliable and valid, and feasible.

Category 2: Seen as clinically relevant, valid, and likely reliable, but with problematic feasibility. These measures will be further investigated in the VBP Pilots.

Category 3: Rejected by the CAG on the basis of a lack of relevance, reliability and validity, and/or feasibility.

The Category 1 quality measures identified by each CAG and accepted by the State are to be reported by the VBP contractors. These measures are also intended to be used to determine the amount of shared savings that VBP contractors are eligible for (based on their chosen level of VBP and actual performance; see table "Outcome Targets % Met" p. 20). The State will make the outcomes of these measures transparent to all stakeholders.

The CAGs will reconvene to review measures and discuss whether to include current Category 2 measures in Category 1. The sets will be dynamic: deletions, additions or modifications will be made to optimally capture the key outcomes that matter to members per VBP arrangement. Where quality metrics and reporting imposed by State and Federal policies lack alignment and, in some respects, are in conflict with one another,

⁴⁵ Estimates based on extrapolations to future state MCO coverage; total dollars based on 2012-2014 expenditures. See also Appendix V.



the State will explore in the appropriate CAG a process for improved alignment and elimination of conflict.

One key goal is the inclusion of Patient Reported Outcome Measures (including quality of life metrics), a key missing link in assessing the outcomes of care for many health problems and conditions. Similarly, measures focusing on rehabilitation and individual recovery including housing stability and vocational opportunities, as well as cultural competency and penetration of specific minority groups, are as yet underrepresented (see also further).⁴⁶ Finally, the State will include sufficient measures to assess the competence and stability of the workforce upon which patient access and quality services depends.

List of Prioritized VBP Arrangements

The overview below lists the current set of VBP arrangements, including underlying episodes, if applicable. For every VBP arrangement besides Total Care for the General Population, a Playbook will become available with details on both the definitions of the VBP arrangement and the associated quality measures. These Playbooks will be updated yearly by the CAGs. New CAGs may be convened in 2016 for new VBP arrangements.⁴⁷

VBP Arrangement	Episodes included in the definition	Definition
Total Care for General Population⁴⁸	–	All Medicaid covered services for all members eligible for mainstream managed care and not eligible for one of the subpopulations (excluding duals)
Total Care for HIV/AIDS Subpopulation⁴⁹	–	All Medicaid covered services for all members eligible for HIV/AIDS SNP (excluding duals)
Total Care for HARP Subpopulation⁵⁰	–	All Medicaid covered services for all members eligible for HARP (excluding duals)
Total Care for MLTC Subpopulation	–	All Medicaid covered services for all members eligible for MLTC (including Medicaid component of duals)

⁴⁶ NQF (2013). Patient Reported Outcomes (PROs) in Performance Measurement. For especially the FIDA, HARP, and DISCO subpopulations measures will be developed which reward quality of life and rehabilitation outcomes, and PROs should be considered for broader use within VBP. These measures will help New York State achieve Olmstead, Americans with Disability Act and Home and Community based setting requirements.

⁴⁷ In 2016, CAGs will be set up for three chronic conditions that have been added to the Chronic Bundle after the CAG process had already started: Gastro-esophageal reflux disease (GERD), Osteoarthritis and Lower Back Pain.

⁴⁸ Risk-adjustment and measuring potentially preventable readmissions (PPR) and potentially preventable visits (PPV) for this VBP arrangement is driven using 3M CRG and potentially preventable events (PPE) groupers. Using the HCl3/Prometheus grouper, prevalence and costs of episodes within the Total Care for General Population arrangement can be analyzed by VBP contractors (and MCOs) for purposes of targeting interventions, etc. The State will make these analyses dynamically available to the MCOs and VBP contractors through the MAPP portal in 2016.

⁴⁹ As previously stated, episodes of care are not to be contracted within subpopulations. Using the analytical resources mentioned in the previous footnote, risk adjustment for the HARP and HIV/AIDS subpopulation will be developed. The list of potentially avoidable complications will be further developed for the HARP and HIV/AIDS subpopulations. Prevalence and costs of episodes within especially the HARP and HIV/AIDS subpopulation can be analyzed by VBP contractors (and MCOs) for purposes of for example targeting interventions through the MAPP portal in 2016.

⁵⁰ See previous footnote.



Total Care for I/DD Subpopulation	–	In Development
Maternity Bundle	<u>Episodes:</u> <ul style="list-style-type: none"> ▪ Pregnancy ▪ Vaginal Delivery ▪ C-Section ▪ Newborn 	All Medicaid covered services included in the episodes (following HCI3/Prometheus) for all pregnant women (and their newborns) eligible for mainstream managed care (excluding duals)
Integrated Primary Care with Chronic Bundle⁵¹	<ul style="list-style-type: none"> ▪ Integrated Primary Care (preventive and routine sick care) <u>Episodes in Chronic Bundle:</u> <ul style="list-style-type: none"> ▪ Hypertension ▪ Coronary Artery Disease (CAD) ▪ Arrhythmia, Heart Block and Conductive Disorders ▪ Congestive Heart Failure (CHF) ▪ Asthma ▪ Chronic Obstructive Pulmonary Disease (COPD) ▪ Bipolar Disorder ▪ Depression & Anxiety ▪ Trauma & Stressor ▪ Substance Use Disorder (SUD) ▪ Diabetes ▪ Gastro-esophageal reflux disease ▪ Osteoarthritis ▪ Lower Back Pain 	All members eligible for mainstream managed care (excluding duals) are included. All Medicaid covered services included in preventive and routine sick care are included, as well as all services included in the Chronic Bundle (following HCI3/Prometheus).

⁵¹ To support IPC contracting, the analytical resources mentioned in the previous footnotes will allow MCOs and VBP contractors to analyze/stratify their populations through e.g. CRGs. The HCI3/Prometheus grouper also includes a preventive episode (including a broad range of preventive activities), sick care (including diagnostic and/or therapeutic activities for conditions not leading to a specific diagnosis (headache, fatigue, dizziness, etc.)), and additional minor episodes that could be identified as part of or managed by primary care. This information will be made available to support MCO and IPC decision making, but MCOs and VBP contractors are not required to use these analytical constructs in their IPC contracting.



Contracting Integrated Primary Care with the Chronic Bundle in Practice

Providers, plans and the State have invested significantly in advancing the position and functioning of primary care in New York. Many pay-for-performance, shared-savings and risk-based payment arrangements exist between MCOs and primary care providers. With this Roadmap, NYS wants to build upon and further stimulate what has already been achieved. In the view of NYS Medicaid and the all-payer SHIP Integrated Care workgroup, chronic care and primary care are two sides of the same coin; likewise, physical and behavioral care are (or should be) two sides of the same coin in the primary care setting.

For setting the target budget for Integrated Primary Care with the Chronic Bundle, the guidelines discussed above apply: the historical costs of this care will form the baseline for the target budget going forward. In Level 1 and 2 VBP arrangements, however, this is a virtual budget: nothing needs to change in how the PCPs are paid at this moment. For example, the PCPs as VBP contractors could receive a primary care capitation, primary care FFS, potentially receive a prepaid per member per month (PMPM) amount for the entire IPC, or any of the above combined with a care coordination fee. It is key that during and at the end of the contract year, shared savings are calculated by comparing the actual *overall* costs of IPC care (including all downstream costs that are not included in the PCP payments) to the virtual budget which was agreed upon.

MCOs and providers can then build upon their current contracting arrangements with primary care providers. The State will provide MCOs and providers with standardized information on Medicaid costs and quality metrics related to Integrated Primary Care with the Chronic Bundle (such as claims-based quality measures and total costs of IPC care as defined by the groupers (see footnote 50)).

Contracting for IPC gives the VBP contractor deep insight into overall quality and cost (including the significant costs associated with potentially avoidable complications) for preventive care, routine sick care and chronic care, collectively and per individual condition. This allows for a better understanding of where (which neighborhoods, which subpopulation, which age-group) value-improvements are most needed and possible. In addition, contracting the IPC allows the VBP contractor to realize and receive shared savings across the entire care continuum of the patient for all the episodes included. For primary care-focused VBP contractors considering Level 2 arrangements, IPC allows the contractor to take on risk for those downstream costs that are most within the sphere of influence of the primary care practice. Simply put, contracting IPC is the next step in the development of VBP for primary care, with increased opportunities for shared savings and feasible ways to take on risk. (See p. 13-14 on IPC; see also Appendix X.)



Incentivizing the Member: Value Based Benefit Design

DSRIP aims to transform the Medicaid delivery system in part by becoming more member-focused; population health outcomes can only be improved by supporting and enabling members to access the appropriate levels of care at the right time. Payment reform is, therefore, incomplete without considering financial incentives for Medicaid members regarding both lifestyle choices (affecting future health care costs) and provider choices (choosing higher or lower value providers). Financial incentives for the former (stimulating behavior that will lead to healthier lives) are becoming common, however, incentives to stimulate high value care utilization are less widespread. Yet the problems DSRIP set out to address have their roots in inadequate financial incentives for members as well. Absence of coverage, leading to emergency department use as the only realistic location for care, is the most obvious and is being addressed by New York's Medicaid expansion, among other initiatives. Yet, once a member is enrolled in a Medicaid managed care plan, indiscriminate choices of providers and persistent use of the ED as the first line of care are more often than not similarly covered as judiciously as selecting a PCP and high value care. If providers' *and* members' financial incentives are not fully aligned with the value of health care services, the likelihood that DSRIP will realize (and sustain) its goals will decrease if these behavioral patterns are not adequately addressed. Value based benefit design should thus be a core aspect of any payment reform.⁵²

In the State's Medicaid program, burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option. On the other hand, *positively* incentivizing desired behavior, including allowing access to previous inaccessible high value care benefits can be a very powerful tool. To continue to positively incentivize desired behavior, providers/provider networks and MCOs are encouraged to implement member incentive programs, whose driving purpose should be the well-being of individuals, families and communities. Member incentives should assist and encourage members to make effective choices and address:

- **Member Activation** (e.g. selecting/contracting a primary care provider, engaging with a patient navigator)
- **Proper System Utilization** (e.g. use of "in-network" high value providers)
- **Preventive Care** (e.g. setting health goals, attending workshops and information sessions)
- **Healthy Lifestyles** (e.g. proper nutrition, smoking cessation)
- **Disease Management** (e.g. taking ownership of care, including mental health, palliative/end of life care and transition care)

Learning from the rapidly growing experience in incentivizing members, the State aims to maximally focus on *outcomes* rather than efforts or process steps. With this focus, members could be incentivized, for example through cash payments or subsidies, for making lifestyle choices proven to improve health and reduce downstream costs, or for choosing high value care. While member incentives can be a powerful tool, these programs need to be thoughtfully designed to ensure there are no unintended consequences, for example increasing disparities or limiting access. To this end, the State has developed guidance to encourage all MCOs and providers to take into account the following set of guiding principles in their design and implementation

⁵² Thomson, S., L. Schang and M. E. Chernew (2013). "Value-based cost sharing in the United States and elsewhere can increase patients' use of high value goods and services." *Health Aff (Millwood)* 32(4): 704-712; Choudhry, N. K., M. B. Rosenthal and A. Milstein (2010). "Assessing the evidence for value-based insurance design." *Health affairs (Project Hope)* 29: 1988-1994; Antos, J., K. Baicker, M. Chernew, D. Crippen, D. Cutler, T. Daschle, F. d. Brantes, D. Goldman, G. Hubbard, B. Kocher, M. Leavitt, M. McClellan, P. Orszag, M. Pauly, A. Rivlin, L. Schaeffer, D. Shalala and S. Shortell (2013). *Bending the Curve. Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth.* Washington DC, Brookings Institute.



as building blocks of member incentives:

- a. *Provide information about the program* – Providers will share detailed information with members concerning any incentive program they implement
- b. *Culturally sensitive* – Ensuring cultural sensitivity⁵³ is necessary to provide successful outcomes, as cultural norms differ and may need to be incentivized differently
- c. *Unbiased* – Creating unbiased incentives is necessary to comply with federal laws. Incentives must not leave out any groups on the basis of ethnicity, education, race, social class etc.)
- d. *Possess equity* – Equality is not enough when providing incentives, rather maintaining equity should also be considered (equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone)
- e. *Does not promote negative behavior* – Incentives should not promote behaviors that could harm or have the possibility of producing poor outcomes (e.g. incentivizing members not to use the ED could have negative outcomes if the member has a medical emergency when the ED would be a proper choice for treatment)
- f. *Provide reward as promised in a timely manner from when it is earned* – Members should not have to wait lengthy amounts of time to receive their incentive. Timely reward redemption is critical to success
- g. *Communicated appropriately in a timely manner* – Incorporate the most appropriate and farthest-reaching vehicle to communicate the incentive so as not to exclude members (e.g. lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomes
- h. *Be relevant* – If barriers exist that prevent the members from using the incentive, the incentive will not hold much value (e.g. a member is given a gym membership as an incentive but does not have the transportation to get to the gym)
- i. *Measurable* – Tracking metrics will aid in proving efficacy

The State will make financial incentives available to reward plans and providers who develop and offer member incentive programs. The State also intends to eliminate the \$125 cap for incentive payments in the current NYS Medicaid Managed Care Model Contract. This change will allow for creativity and innovation to further develop and document best practices for member incentives.

Providers will have the flexibility to experiment/test various incentive programs across different member populations and have the ability to opt out of the incentive program if the program does not meet the expected outcomes. Any incentive, regardless of form, should not impact a member's Medicaid or other State Health or Human Service eligibility status (e.g. Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF)) with regards to income or asset thresholds. Rather, this should be a form of 'inclusive shared savings', where members' incentives to choose wisely become fully aligned with professionals and providers aiming to reduce avoidable hospitalizations and improve population health.⁵⁴

It is important to note that the process of designing member incentives is complex and will need to consider

⁵³ Cultural competence is not limited to geographic, linguistic, and normative preferences, but also includes disability status, employment, and transportation needs, for example.

⁵⁴ Thomson et al. op.cit. 38; Schmidt, H. and E. J. Emanuel (2014). "Lowering medical costs through the sharing of savings by physicians and patients: inclusive shared savings." *JAMA Intern Med* 174(12): 2009-2013.



underlying disparities and social determinants of health including community needs, and local planning efforts. Above all, member incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support.

To ensure success and sustainability of the incentive programs, the VBP Pilot sites will consider piloting incentive programs as a way to evaluate and measure the success of improving health outcomes. Given the potential variations of incentive programs, and the need to continue to develop the evidence supporting these efforts, the State will look to analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publically available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design.



Public Health and Social Determinants of Health

The overall well-being of individuals, families, and communities should be the driving purpose of a health care system. Viewed from that lens, addressing social determinants of health (SDH) should come naturally to health care providers. Specific interventions have been shown to improve outcomes for members facing acute and/or chronic health conditions, and even prevent some health conditions before they develop. Since social determinant (SD) interventions are often less costly than medical interventions, which will be necessary as a person’s disease progresses, the benefit of addressing SDs would seem self-evident. However, these

Capturing Savings across all areas of Public Spending

Addressing the social determinants of health is a critical element in successfully meeting the goals of DSRIP and VBP. The State is fully committed to exploring ways to capture savings accrued in other areas of public spending when social determinants are addressed (e.g. reduced recidivism rates). Three mechanisms have been identified by which resources can be leveraged in the context of VBP arrangements to capture savings across the public sector. VBP contractors could:

1. Participate in a co-investing model,
2. Participate in innovative contracting,
3. Invest in social impact bonds.

interventions are traditionally seen as being beyond the scope of health care. The VBP effort by NYS provides a unique opportunity to transform this perception and practice.

At the same time, however, the DSRIP journey has only just begun, and it is in general difficult to truly move the needle on a population-wide basis within a few years. Hence the DSRIP Domain 4 population health measures are Pay for Reporting only. In the near future, though, the State envisions culturally competent community based organizations (CBOs) actively contracting with primary care organizations and health systems to take responsibility for achieving the State’s Prevention Agenda. DSRIP starts to build the infrastructure to take on housing, job placement, community inclusion, and criminal justice alternatives as levers to increase population health. The State foresees that VBP will become a vehicle to maintain this infrastructure.

The core mechanism here is the financial incentive that VBP contractors will have to keep the populations they are responsible for as healthy as possible, to prevent at-risk

populations from becoming chronically ill, and to prevent further morbidity and avoidable complications in members with chronic conditions. Realizing savings and high quality scores in the different NYS VBP arrangements maximally incentivizes providers to focus on the core underlying drivers of poor health outcomes – whether traditionally within the medical realm or not.

Addressing Social Determinants of Health

To stimulate VBP contractors to venture into this crucial domain, VBP contractors in Level 2 or Level 3 agreements will be required, as a statewide standard, to implement at least one social determinant of health intervention. MCOs contracting with VBP Level 2 providers/provider networks will share in the costs and responsibilities associated with the investment, development, and implementation of the intervention(s). Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk. Providers/provider networks/MCOs may also contract with community based organizations to satisfy this recommendation. Contracted CBOs should expect the inclusion of a value based component in the contract, such as pay for performance, and be held to performance measure standards.



The contractors will have the flexibility to decide on the type of intervention (from size to level of investment) that they implement, and several best practice guidelines have been created to support an effective implementation. The guidelines recommend that selection be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources. The contractors should also create a report explaining a measureable reason why the SDH was selected, and identify metrics that will be used to track its success. This could follow a similar process/procedure used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics, and reports back to the State.

Since providers (including CBOs) who successfully address SDH at both member and community levels may not see savings in the short term, they will be incentivized by MCOs upfront to identify one (or multiple) social determinant(s) and be financially rewarded for addressing them. This standard will be included in the Model Contract:

- Level 1 providers will get an additional bonus if they address at least one SDH.
- Level 2 and 3 providers will receive a funding advance (investment or seed money) if they commit to addressing one or more SDs. This funding advance will provide financial assistance to the provider investing in an intervention. The provider may benefit financially if the intervention is successful in lowering the health care costs of its respective members. If the interventions are successful, the savings generated can encourage reinvestment.

Contracting with Community Based Organizations

Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO⁵⁵⁵⁶.

Many CBOs have years of experience improving SDH. This expert understanding of community needs, coupled with support and clinical expertise of a provider network, could make a significant positive impact on population health and generate savings for the entities involved. Providers/provider networks and MCOs should partner with organizations that have objectives aligning with their own, the community needs, and member goals. The CBO should work with the providers/provider networks and MCOs to deliver interventions that support SDH and advance DSRIP goals. After a period of two to three years, the State will create a process, which would include an independent retrospective review of the role of the CBO, to determine if the VBP providers are adequately leveraging community based resources. The review should also identify best practices and determine if further guidance, technical assistance, or other resources are needed to maximize utilization of community resources.

Measuring Program Success

In an effort to ensure sustainability after the next five years, providers and MCOs will be encouraged to

⁵⁵ Tier 1 - Non-profit, non-Medicaid billing, community based social and human service organizations (e.g. housing, social services, religious organizations, food banks). Tier 2 – Non-profit, Medicaid billing, non-clinical service providers (e.g. transportation, care coordination). Tier 3 – Non-profit, Medicaid billing, clinical and clinical support service providers (licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services).

⁵⁶ The State recognizes that CBOs may not exist within a reasonable distance to providers in some regions of New York. In such situations, providers/provider networks can apply to the State for a rural exemption.



measure success of the programs implemented. This may include an assessment tool for VBP contractors and MCOs to measure and (at least) annually report on SDs that affect their members. This helps to track successful interventions and the way in which they are measured. Ultimately, the State will evaluate the feasibility of incorporating SDH measures into Quality Assurance Reporting Requirements (QARR) performance measures. It is also recommended that providers incorporate the patient perspective in quality measurement and improvement, through e.g. Patient Reported Outcome (PRO) measures. This further stimulates providers to become more attuned to members' needs, treatment, and goals. Providers may utilize PRO measures in their practice, using tools to assess the member's symptoms, functional status, and quality of life. The State recognizes that providers may need to incentivize members to complete PRO measure questionnaires as a way to encourage participation and completion of the survey. It is recommended that the current VBP Pilot Programs be used as a vehicle for piloting the use of PRO measures.

The State will monitor progress on the Prevention Agenda targets, including how VBP contractors (aim to) impact these targets. The State intends to introduce a dedicated value based payment arrangement for pilot purposes in 2018 to focus specifically on achieving potentially trailing Prevention Agenda targets through CBO-led community-wide efforts.

Implementation of the VBP Roadmap and the significant delivery system reforms underway in DSRIP requires a thoughtful and strategic approach to communicating to both stakeholders and Medicaid members. Explicit recognition of the rights and role of the individual enrollee is critical throughout the VBP development and implementation process. Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to members. The State utilized the Advocacy and Engagement Subcommittee to develop a plan to identify the most appropriate way to provide information around VBP and the incentives that could impact members. In addition to creating guidelines around what should be communicated to Medicaid members, the State will also update the Managed Care Patient Bill of Rights to include information relevant in the VBP context.



3. Amending Contracts with the MCOs to Realize Payment Reform

Issue 3: How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

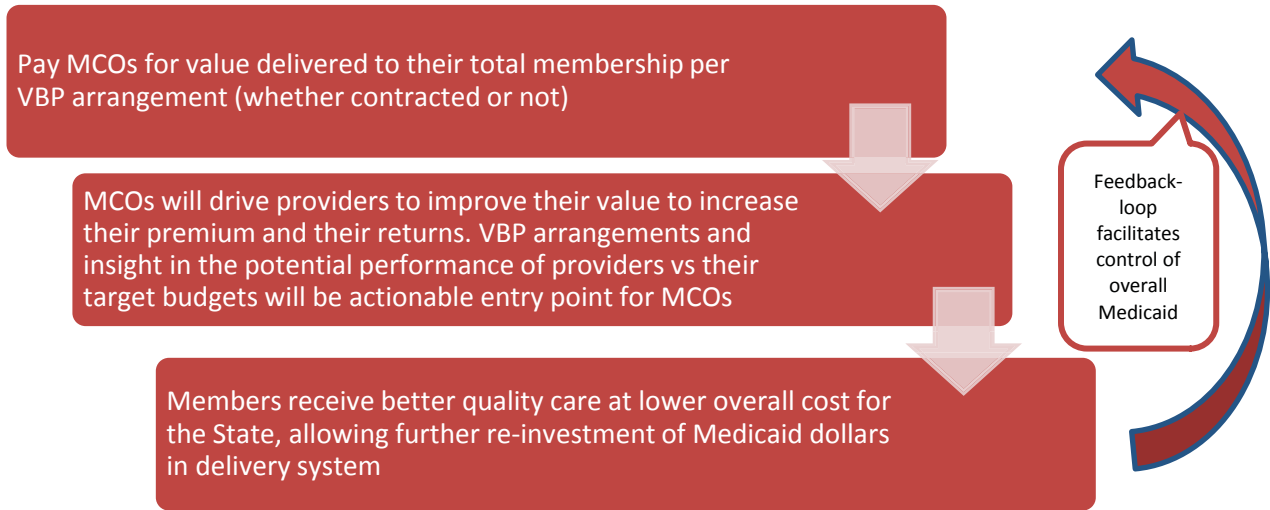
Aligning Incentives

Through updates to the Medicaid Managed Care Model Contract, the State will add the following incentives and regulations in its contracts with MCOs to stimulate their adoption of VBP arrangements:

- The State will implement a Performance Adjustment for MCOs in the 2017 rate setting process so as to maximally align the incentives for MCOs with the incentives for VBP contractors. The Performance Adjustment is a rate adjustment based on the relative efficiency and quality delivered by the MCO per VBP arrangement. For quality, the current QARR methodology will be continued and, where relevant, adapted to optimally align with the quality measures the State has adopted on the basis of the CAG's input.
- Mainstream MCOs will have three main integrated care categories to drive quality and efficiency:
 - Total Care for the General Population⁵⁷
 - Integrated Primary Care with the Chronic Bundle
 - Maternity Care
- Performance (quality and efficiency) of the HIV/AIDS, HARP, MLTC and I/DD VBP arrangements will all be assessed separately as well.⁵⁸
- Performance adjustments will be applied to all MCO members eligible for a particular VBP arrangement, whether part of a VBP contract or not.
- The State will implement a Stimulus Adjustment for MCOs included in the 2018 rate setting process. This will serve to increase the managed care capitation premium for those MCOs that have captured more provider-payment dollars in VBP arrangements at higher levels. This adjustment will be for a duration of two years for MCOs and also mimics the MCO-VBP contractor guidelines. Arrangements that focus on IPC or care bundles will receive a higher Stimulus Adjustment than Total Cost of Care for the General (Sub)Population because: a) infrastructure costs for these former arrangements will be relatively higher compared to the total dollar amount of the VBP contract and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system will be higher when a more differentiated VBP approach is taken. These Stimulus Adjustments will end in 2020.

⁵⁷ To ensure that the adjustments are applied to the total MCO contract value (and not more or less), the 'Total Care for General Population' adjustments will be applied only to the dollars not attributed to the other VBP arrangements

⁵⁸ The I/DD population will only become part of VBP after the transition of the I/DD population to managed care.



- From 2018 on, based on the prior year’s VBP contracts, MCOs that fall behind the goals for VBP contracting as outlined in the Roadmap will receive a penalty⁵⁹:

Year	Penalty
2018	If by 4/1/2018 less than 10% dollars of total MCO expenditure are captured in Level 1 or above VBP contracts, a penalty of 0.5% on the marginal difference between 10% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.
2019	<p>Fully Capitated MCOs: If by 4/1/2019 less than 50% of the of total MCO expenditure is not captured in a Level 1 or higher arrangement, a penalty of 1.0% on the marginal difference between 50% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.</p> <p>If by 4/1/2019 less than 15% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.0% on the marginal difference between 15% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP contracts will be assessed.</p> <p>If both penalties are incurred, then only the larger penalty will be applied.</p> <p>Not Fully Capitated MCOs: If by 4/1/2019 less than 50% of total MCO expenditure is captured in Level 1 or higher contracts, a penalty of 1.0% on the marginal difference between 50% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.</p> <p>If by 4/1/2019 less than 5% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.0% on the marginal difference between 5% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP</p>

⁵⁹ The State will ensure network adequacy and access to care throughout the VBP implementation process.



	<p>contracts will be assessed.</p> <p>If both penalties are incurred, then only the larger penalty will be applied.</p>
2020	<p>Fully Capitated MCOs: If by 4/1/2020 less than 80% of total MCO expenditure is captured in Level 1 or higher contracts, a penalty of 1.0% on the marginal difference between 80% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed</p> <p>If by 4/1/2020 less than 35% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.0% on the marginal difference between 35% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP contracts will be assessed.</p> <p>If both penalties are incurred, then both will be applied.</p> <p>Not Fully Capitated MCOs: If by 4/1/2020 less than 80% of total MCO expenditure is captured in Level 1 or higher contracts, a penalty of 1.5% on the marginal difference between 80% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.</p> <p>If by 4/1/2020 less than 15% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.5% on the marginal difference between 15% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP contracts will be assessed.</p> <p>If both penalties are incurred, then only the larger penalty will be applied.</p>

From 2018 on, when MCOs cannot achieve their VBP goals because providers are unwilling to enter VBP agreements and/or move to higher level VBP agreements, MCOs may pass on such penalties to incentivize providers who can reasonably be expected to make this transition to work with the plans towards realizing these common goals.

The State assures that it will not hold MCOs accountable when providers, to no fault of the MCO, run into financial difficulty because of underperformance on a Level 2 or higher value based contract.

All these changes will be incorporated into the Model Contract 2017.

VBP Innovator and VBP Pilot Programs

In addition to the incentives discussed above, the State will implement a VBP Innovator Program for experienced VBP contractors as a mechanism to allow experienced providers to continue to chart their path into value based payments. The Innovator Program is a voluntary program for VBP contractors prepared for participation in Level 2 (full risk or near full risk) and Level 3 value based arrangements. These providers will be entering into Total Care for General Population and/or Subpopulation arrangements, and will be eligible for up to 95% of the total dollars that have been traditionally paid from the State to the MCO. The Innovator Program is not intended to limit provider networks or member choice. The Department of Health (DOH) will administer the Innovator Program on an open enrollment basis.



The providers must pass a strict set of criteria to be deemed an ‘innovator’ and once they have reached Innovator status, all MCOs will be required to participate in these arrangements. The specifics of the Innovator Program will be outlined in the updated Managed Care Model Contract in 2016.

It is important to note that because IPC and episode-based VBP arrangements cannot readily be translated in a percentage of premium, and because these arrangements would not include significant task-shifting between MCOs and these VBP contractors, these contracts are not included in the Innovator Program. For these arrangements, pilot support and financial rewards will be available in 2016 and 2017.

The Pilot Program is available for all VBP arrangements, and allows contractors to enter into an arrangement at Levels 1, 2 or 3. The VBP Pilot Program will include technical and administrative support for implementing VBP arrangements, along with financial incentives including an MCO incentive bonus, upward adjustments based on performance, and the benefit of no downward adjustments for the first two years of the pilot. A pilot is expected to last for two years, with the commitment to move to (at least) Level 2 by year two. There is also the commitment to share and discuss lessons learned and support the DOH in a webinar after the first year of the pilot. VBP Pilots and the Innovator Program are separate and distinct in two ways:

1. While the Innovator Program provides benefits (90-95% premium pass-through) to the providers and is limited to specific types of arrangements, the pilots do not warrant premium pass-through benefits (though they do receive financial incentives) and are open to all types of arrangements set forth in the VBP Roadmap. The goal of the pilots is to help the State and its participating organizations learn how VBP transformation will work in practice, and to incentivize participants for early adoption of VBP. The goal of the Innovator Program is to recognize those providers who start implementing VBP by contracting high risk, Level 2 or 3 total cost of care for (sub)population arrangements.
2. The Innovator Program is a standard component of the VBP program. In contrast, the VBP Pilot program is only available in State FY 2016. The pilots will run for two years.

The full design of the Innovator Program, including the details below, can be found in Appendix IX:

1. Risk arrangements eligible for the Innovator Program
2. Review/assessment process for the Innovator Program
3. Criteria for participating in the Innovator Program
4. Appeals process for Innovator participation
5. Innovator Program benefits
6. Innovators’ performance
7. Maintenance and contract termination/program exit criteria

Specific Regulatory Amendments

Successful transformation of the existing payment system requires restructuring of contractual arrangements that clearly define metrics and the ability to share savings and risk. Regulatory alignment and streamlining (between providers and MCOs, and between partnering providers) to support VBP models is imperative to facilitate both the clinical and efficiency goals of VBP, freeing resources for member and community needs. Based on the input of the subcommittees and the VBP Workgroup, the existing regulations within the DOH and the DFS have been thoroughly reviewed and are being amended as necessary. Regulatory restructuring will occur through several implementation mechanisms:

[Changes to the Medicaid Managed Care Model Contract and State Provider- Contractor Guidelines](#)

The Medicaid Managed Care Model Contract is a key vehicle for the formal implementation of Medicaid VBP. Changes to the Medicaid Managed Care Model Contract have been proposed and will be edited following a



holistic DOH review. The changes will operationalize recommendations from the subcommittees, as well as additional proposed changes developed through a robust comment period on any existing requirements that may interfere with VBP implementation. There remain a few outstanding considerations that DOH will further evaluate, including contractual safeguards that may need to be included around prompt payment in the VBP environment (as bonus payments, downside reconciliations, and reimbursements of withholds are not specifically addressed in current regulations). The DOH will take the Regulatory Impact Subcommittee comments into account when developing the Medicaid Managed Care contract changes and discuss with the health plan contractors. The documents will reflect and accommodate changes occurring in the new VBP environment, and will be updated in 2016. Additional revisions will be made over the next few years as needed.

Several subcommittee recommendations may also impact the State's MCO-Provider contracting guidelines. The State will take these recommendations into account, along with other comments as it looks to update the State MCO Provider Guidelines⁶⁰. These are formulated as guidelines, as MCOs and VBP contractors are better equipped than the State to take local circumstances and particular challenges of certain populations or provider groups into account. For example, the State will not enforce how MCOs and VBP contractors set the target budgets, what quality measures they reward, and whether they reward actual performance or improvement.

The following key components of the VBP Roadmap are foreseen to be included in the Model Contract 2016:

- The definitions of the VBP arrangements and outcome measures (p. 12-15 and further and the forthcoming Playbooks per VBP arrangement)
- The definitions of the VBP Levels (see Appendix X)
- Definition of what can be included in 'off menu' VBP arrangements (p. 12, Appendix II).
- Contract risk review process (see p. 21-22)
- The VBP Innovator Program (see p. 46-47)

In 2017, the following additional components are foreseen to be included in the Model Contract:

- VBP reporting requirements
- MCO VBP incentives (see p. 44)
- Additional

DOH will negotiate these proposed changes with the health plans, and the updated Model Contract document will be posted on the DOH public website once approved by CMS.

Proposed Changes to New York State Law

Alignment of Federal and State Stark Laws and Anti-kickback Statutes

In order to give providers increased flexibility for forming networks and entering into VBP contracts with MCOs, the State will propose amending its Stark Law and Anti-kickback Statute to fully align with federal provisions. Changes to State law should include language that incorporate future amendments to federal laws and regulations.

Stark Law (Self-Referral)

⁶⁰ https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf



Federal and State laws prohibit physicians from referring patients for certain designated health services if the physician (or immediate family member) has a financial interest. A violation can be triggered through prohibited referral arrangements, splitting of fees, leases of office space, as well as other ownership and compensation arrangements. The federal rules apply to physicians only, and allow for several exceptions. NYS's version of the federal law broadens it to different provider types, all payers, and does not include several exceptions that are in federal law. Aligning the NYS regulation to fully align with federal Stark rules will allow for more flexibility for providers to engage in VBP contracting.

Anti-kickback Statute

Federal Anti-kickback statute (AKS) prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals (including self-referrals) or generate federal health care program business. Unlike Stark law, AKS is intent-based and can carry both civil and criminal penalties. Federal and State AKS laws are largely similar (unlike Stark law). The State law is broader and has a lack of safe harbors (exemptions) or exceptions to the general prohibitions. There are several 'safe harbors' that act as exemption to AKS, but VBP arrangements are not currently included at either the federal or State level. Fully aligning NYS law to federal AKS laws would also allow for more flexibility for providers to engage in VBP contracting.

Changes to Laws Related to Professional Service Entities

Currently, there are some obstacles to collaboration for some clinical groups in New York State. The current Business laws and Corporate Practice of Medicine (CPOM) laws present the following barriers in a value based payment setting:

- Restrictions regarding which professionals can have ownership interests in professional entities;
- Constraints on how medical professionals structure their corporate entities to optimize VBP implementation; and
- Limitations on which professionals and entities can split fees (e.g. bundled payments for services including physicians and non-physicians).

These limitations may prevent different types of providers from collaborating and integrating in the spirit of the DSRIP program, and inhibit the implementation of the NYS Value Based Payment Roadmap. A bill has been introduced (S.5862/A.8153) in June of 2015 that addresses several of the Business Law issues mentioned above.

Although these proposed legislative changes will help the NYS Medicaid VBP program, potential delays in realizing these changes will not impede its successful implementation.

Updates to Physician-Pharmacist Collaboration Laws

Current NYS Public Health laws and regulations allow a certain degree of collaboration between the physicians and pharmacists, however, they do not provide for the full spectrum of benefits that patients (including Medicaid members) could realize in terms of improving their health and quality of services received. By allowing a higher degree of collaboration⁶¹ between physicians and pharmacists on Comprehensive Medication Management (CMM), the State would be able to achieve an enhanced service integration environment that will result in reduction of hospitalization rates in NYS, thus helping achieve the goals of the

⁶¹ Currently, collaboration is already permitted in all hospitals and limited nursing home settings in New York. This recommendation promotes voluntary collaboration in community practice settings as well.



Payment Reform, and the DSRIP program overall.

The Public Health Law should be amended to create a *voluntary* program for collaboration between qualified pharmacists⁶² and physicians ruled by a written protocol that would enable physicians to refer certain patients with chronic conditions who (1) have not met the goals of therapy, (2) are at risk for hospitalization or (3) are otherwise considered to be in need of CMM services, to qualified pharmacists.

The written protocols would describe the nature and scope of services to be provided; they would be made available to the Department of Health (DOH) for review to ensure compliance with the requirements in the law. Such protocols could cover services including but not limited to the following:

- ongoing evaluation of a patient's condition and medication adherence, including ordering/performing routine patient monitoring functions;
- adjusting or managing a drug regimen of a patient;
- accessing the patient's medical records;
- other.

Further, the pharmacist would be required to notify the treating physician in a timely manner of the recommendations made to the patient, and of any adjustments made to the patient's prescribed medications.

Ongoing Regulatory Review

One or more workgroups will be established to address the following topics:

HIPAA and State Privacy Laws

Current New York State (NYS) privacy laws and regulations are more restrictive and provide less flexibility than federal HIPAA laws and regulations. These additional restrictions may prevent providers from sharing information for the purpose of coordinating care and evaluating the outcome of care, both of which are critical to successful VBP arrangements (see Appendix VII for scenarios and options to be considered).

Program Integrity

As VBP will fundamentally change the way health care services are delivered, paid, and measured, the guiding principles underlying NYS's Medicaid Program Integrity strategy (Program Integrity) must also change. Many of the foundational activities and strategies in a fee-for-service environment to ensure that quality health care is delivered at a reasonable cost while protecting stakeholders may not be effective in VBP. As the payment model shifts from FFS to value based, so too will the avenues of fraud, waste, and abuse (FW&A) in the system. The workgroup(s) will work to conceptualize which avenues of fraud will be implicated, and consider future safeguards.

Improving integrity at all levels of health care delivery will be considered. Questions raised will include considerations of where current FW&A issues fall in a VBP environment, what new fraudulent incentives can/will arise amidst a shift to VBP, and deliberation on how FW&A can be meaningfully quantified and measured in a VBP environment. Recommendations may come in the form of changes to State laws and regulations, contracting requirements between the State and MCOs or providers, and

⁶² Qualified pharmacists would be pharmacists who hold an unrestricted license and have completed accredited programs in the management of chronic disease(s). Their qualifying credentials would be reviewed by physicians who are interested in CMM programs offered by qualified pharmacists to which they could refer selected patients.



other contracting guidelines between parties. Using these recommendations as a framework, a robust plan for Program Integrity in the move toward VPB must be developed proactively to minimize risks and monitor compliance. It is essential that this plan be in place at the outset of VBP contracting arrangements.

Regulatory Reform

Current NYS health care regulations were created to safeguard the legitimate interests of the State, providers, payers, and especially Medicaid members in a fee-for-service environment. Implementing the DSRIP program and moving to VBP introduces new methods of collaboration, contracting, and delivery of health care services that may be at odds with existing regulations. Similarly, certain regulations may no longer be required in a context where VBP contractors assume responsibility for the entire cycle of care.

Regulatory hurdles will be evaluated and changes proposed changes to the State. In addition, as currently exists in the DSRIP program, the DOH will create a formal process where MCOs and (potential) VBP contractors can submit written requests to the DOH for the waiving of regulations that hinder VBP contracting. The workgroup(s) will help design that process and provide recommendations to the State.



4. Amending Contracts with the MCOs: Collection and Reporting of Objectives and Measures

Issue 4: How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

The State currently includes quality and efficiency incentives in contracting with MCOs that are directly aligned with DSRIP. Many of its Quality Assurance Reporting Requirements (QARR) metrics, for example, are identical to the metrics selected for DSRIP. 2015 was the first year that the State incorporated efficiency measures for MCOs, aimed at reducing ED visits and avoidable admissions through the same measures used within DSRIP. Such changes further align MCO's incentives with DSRIP's desire to realize a lasting, sustainable transformation of the safety net system.

As is noted in the previous section (Section 3), the DOH is amending the Model Contract before contracting year 2017 to reflect changes to MCO reporting requirements. The VBP contractors will also be obligated to report on a standard set of quality measures as recommended by the Clinical Advisory groups. Where discrepancies exist between the QARR measure set and the VBP arrangement specific measures, the State may modify the QARR measure set to optimally align how MCOs are scored in terms of performance with how VBP contractors' performance is measured.

As part of the reform, the State will provide VBP contractors and MCOs with a dynamic data and analytics tool that provides cost and outcome information of the different VBP arrangements, by MCO, by geography and by provider(s), including potentially shared savings (p. 28). This will support MCOs and (emerging) VBP contractors to start negotiating VBP contracts, and to identify areas for improvement.

Finally, the State will work with stakeholders to improve the quality of encounter data provided by providers to plans and from plans to the State as this data is foundational for the measurement of quality and costs. Poor quality data delivery may be financially penalized.



5. Creating Synergy between DSRIP Objectives and Measures and MCO Efforts

Issue 5: How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

Currently, the base administrative PMPM amounts are calculated for each of the State's nine managed care rating regions using plan Medicaid Managed Care Operating Reports (MMCORs). The regional PMPM amounts are calculated by dividing the total allowable administrative cost for each plan in a given region by the plan reported member months. Each plan PMPM amount is then subject to the Department's administrative PMPM cap and adjusted downward if necessary. Additionally, the Department of Health also incorporates an administrative component into capitated premiums for all new populations and benefits moving into the benefits that are not reflected in the two year MMCOR base. This additional administrative component is developed by the State's actuary. The administration component is then adjusted by a plan specific risk score (see Section 7). The Performance and Stimulus Adjustments, as well as potential penalties (see Section 3), will be incorporated in this process from 2017 on.

As with all new requirements, the Department and its actuary will review what will be expected of plans under DSRIP with regards to providing technical assistance/support, new activities, workforce development, etc. to achieve waiver goals. This analysis will also take into consideration activities already accounted for in plan premiums to ensure duplication of payment is avoided. Ultimately, the State's actuary will certify an actuarially sound premium range that takes into account the factors above which the State will pay for within the range to meet federal requirements (see Section 8).

New requirements under DSRIP may result in additional administrative costs for plans and providers which will need to be evaluated by the State and its actuary. Two specific areas where this will likely occur are: 1) workforce planning where, under the waiver, plans are responsible for developing and implementing various workforce strategies; and 2) value based payment requirements which will necessitate plan/provider contract modifications. While there will likely be increases for these items, the Department believes they will not be excessive as it intends to set benchmark payment levels for use by plan/provider that recognize these additional costs. Further, it is not the intention of the State to exclude plans (or providers) that have been proactive and have already made investments to develop VBP from this additional support.

Maximum alignment between DSRIP and VBP is achieved, first and foremost, by the fact that the activities required by providers to be successful in DSRIP or VBP are two sides of the same coin. Because the outcome measures of the VBP arrangements and the DSRIP program will overlap to a large extent, and the VBP contractor is responsible for reporting the measures, additional administrative efforts are minimized here as well. Finally, the State will provide providers and MCOs with data and cost and outcome information of the different VBP arrangements, by MCO, by geography and by provider(s), including potentially shared savings, thus reducing the need for MCOs and providers to immediately duplicate these efforts.



6. Assuring that Providers Successful in DSRIP are included in Networks

Issue 6: How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks

VBP is *not* designed to limit member options or to lock providers out of the system. The State will maintain current managed care network requirements, which ensures both adequate member choice and provider inclusion. Within DSRIP, PPSs have and will continue to have opportunities to enhance their networks as needed to ensure that all vital providers are included, particularly community based behavioral health and social service providers who have been previously excluded from the formal Medicaid payment system. While there is no requirement for a provider to join a PPS network, these networks have been growing extensively since DSRIP Year 0. This growth will help to ensure that VBP is applied widely.

Because high performing (combinations of) providers will be visible to providers, MCOs and the public alike, and MCOs will be financially incentivized to contract with high value providers, it is highly unlikely that providers who are successful in delivering high value care would not be contracted by MCOs. The State will monitor this development and, where necessary, develop additional approaches to ensure the inclusion of providers who demonstrate successful performance.

It is likely that some providers may need assistance engaging in VBP. Smaller, less prepared providers may need access to resources and support to develop the sophistication to succeed, and DSRIP funds are explicitly intended to facilitate this progress. These providers may include community and home based organizations who may have challenges related to infrastructure, technology, and workforce. To support the integration of community based organizations into VBP and as VBP contractors, the State has adapted several standards, recommendations and guidelines to assist CBOs. These recommendations include: creating a self-assessment process for groups to assess their readiness for VBP participation; State funding and the creation of additional workgroups to address the capacity, monetary, and infrastructure deficits impacting numerous organizations; convening a team of experts with whom CBOs could consult on VBP participation; and evaluating the feasibility of creating a bi-directional system for provider/provider network and CBO communication. The subcommittees created robust guidelines for the implementation of VBP that are important for all stakeholders. A full set of the recommendations made by these subcommittees throughout this process can be accessed online.⁶³

VBP contracts between the providers and MCOs provide a strong incentive for the MCOs to offer technical support, given the potential financial benefit to both parties. In addition to the support that MCOs can provide, health care providers participating in DSRIP have the ability to use program funds to employ third party services for further education and technical support on VBP arrangements. Providers may also seek assistance within their PPS. The State, MCOs and providers will collectively monitor whether in later years additional support for low performing providers within VBP arrangements is necessary.

Large scale VBP Pilots will start in 2016 to create momentum and provide learning opportunities for the providers and MCOs involved, but also for other potential VBP contractors in the State. The State will actively support these pilots in 2016. Finally, the State will organize statewide 'VBP bootcamps' for both providers and MCOs to provide further opportunities for learning.

⁶³ https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf



7. Amending Contracts with the MCOs: Adjusting Managed Care Premiums to Improve Population Health and Care Utilization Patterns

Issue 7: How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development

Under the Department's Mainstream Managed Care risk adjusted capitation premium methodology, all plans are paid at the same regional average premium, adjusted by a plan specific risk adjustment factor that accounts for differences in enrollee acuity across plans. The regional premiums are developed using two years of plan reported MMCOR data (as described in Section 5). Using collected encounter data, risk scores are calculated using 3M's CRG model and cost weights developed by the Department. In simple terms, these two pieces are multiplied together to get plan specific risk adjusted premiums. The Department and its actuary incorporate changes in case mix, utilization and cost of care on an annual basis as the data becomes available to incorporate in premium development. The inclusion of DSRIP into this process will be a continuation and expansion of the work being done. Furthermore, as the Department implements its *Care Management for All* initiative and new populations and services (especially for chronic conditions including the MLTC, behavioral health and intellectually and/or developmentally disabled populations) move into managed care, it has engaged 3M and plans to make refinements to the current risk adjustment methodology. This effort is also a significant element of the FIDA demonstration. Ultimately, the goal is to have one risk adjustment system that incorporates the needs of the entire Medicaid managed care population.



8. Amending Contracts with the MCOs: Ensuring Alignment between DSRIP Objectives and Measures and MCO Premium Setting

Issue 8: How actuarially sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g. MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

As discussed in Sections 5 and 7, making appropriate rate adjustments to account for VBP expectations in New York's program will be dependent on many things, but none more critical than (i) flexibility within the current (and even proposed) Federal regulatory framework, and (ii) accurate and complete data to support the multitude of different VBP arrangements that are possible between the health plans and providers.

Under current Federal managed care regulations and Actuarial Standard of Practice No. 49, actuaries may only include costs for expenditures associated with services defined in the State's approved Medicaid State plan that are covered under the contract. With rates being based solely on encounters or claims, the payment to the health plan is not likely to adequately recognize the State's policy goal to pay for high-quality and cost-efficient care achieved through system transformation, clinical improvement and population health improvement.

While the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on June 1, 2015 identified VBP arrangements as an allowable strategy in a managed care contract, it currently does not provide detailed guidance regarding how the value of VBP arrangements should be reflected in plan payment rates and actuarially sound rate ranges. Indeed, the NPRM increases the requirements that rates be built off of historical utilization (volume) and cost (not value). The NPRM also proposes to remove the current flexibility in certifying to rate ranges by proposing that states provide a certification of a specific rate for each rate cell. Because VBP arrangements are expected to evolve at a different pace by health plan and provider, certifying a specific rate for each rate cell may be difficult. There will likely be a need to widen rate ranges (at least during the developmental period of VBP initiatives) in order to be able to reasonably capture additional variations in experience from plan-to-plan within regions. These issues illustrate the concern that the NPRM will not provide the necessary flexibility to permit rate-setting to account for value instead of volume.

Some states have already experienced difficulty in developing rates that utilize global budget strategies that retain savings for reinvestment by providers in the health care system. While arguably existing frameworks could be used to estimate savings (e.g. the framework used for efficiency adjustments), it is unclear if these models can be sufficiently tailored to measure value. It is also unclear if there are expectations about how savings estimates are determined in VBP arrangements and/or the documentation that should be provided.

In changing the framework from counting "volume" to "value", it will be necessary to collect additional data from the health plans and providers. Encounter data will continue to be important, but additional information to capture the cost of total cost of care arrangements, episodic bundles, integrated primary care models, special needs subpopulation arrangements and any off-menu VBP arrangements will be critical. When the VBP arrangements are embedded in data used to establish rate-setting based data, it will also be necessary to determine what costs need to be included – and how that differs for each VBP arrangement.

As VBP strategies are evolving, (i) flexibility within the current (and even proposed) Federal regulatory framework, and (ii) accurate and complete data to support the multitude of different VBP arrangements that



are possible between the health plans and providers will be critical, as well as continued guidance from CMS. To that end, support from CMS for aligning other State health initiatives, such as SIM, APC, and VBP QIP will also help ensure that the State has the flexibility to adapt VBP implementation as needed over the life of the waiver.

Stakeholder Engagement

Since 2014, New York State has been working diligently on involving various stakeholder groups in the policy development, design and implementation of VBP as outlined in this Roadmap. The level of engagement has been unprecedented; over 500 stakeholders across the State participated in the 16 subcommittees and Clinical Advisory Groups held in 2015. Stakeholders will continue to be closely involved with the VBP implementation process in 2016, as their participation is a critical component and a hallmark of the Medicaid Redesign Team tradition. Stakeholders engaged included: New York State health plans, managed care organizations, representative organizations including the health plan associations, professional associations, hospital associations, legal firms specializing in health care contracting, New York State Health and Human Services agencies, community based providers, patient advocates, Performing Provider Systems and other industry and VBP experts. These stakeholders have been critical to the design of VBP in New York State, and contributed through their active participation over the past two years.

The State is committed to supporting the Medicaid health care system on the path to payment reform and ensuring the sustainability of the DSRIP program. The input that the stakeholders provided to date has been invaluable, and crucial to not only developing the plan to transition from fee-for-service to value based payment, but most importantly, the way to improve health care delivery to over six million individuals in NYS. Recognizing the value of continuous stakeholder input, the State will continue to rely on the VBP Workgroup as well as the formed Subcommittees and Clinical Advisory Groups at any time, for additional support or when guidance is needed to meet VBP goals, further enforcing the overall commitment to the Program's success.



Next Steps

This Roadmap has been conceived as a living document. It is not a blueprint; but rather an attempt to demonstrate the State's ambition and to outline what the State and its stakeholders consider the payment reforms required for a high quality, financially sustainable Medicaid delivery system.

The updates to this Roadmap reflect the significant work and accomplishment over the course of the last year related to moving VBP closer to implementation. The next year will hold the same promise, with a focus on moving from concept into actual implementation and statewide focus on reaching our VBP goals. The work for the next year is outlined below and includes:

1. *VBP Pilot Implementation*: The State has invited providers and MCOs to test the VBP arrangements (outlined in this Roadmap) through a VBP Pilot Program. The State aims to launch an estimated 15 pilots throughout 2016:
 - a. Total Care for the General Population (2-3 pilots)
 - b. Integrated Primary Care with the Chronic Bundle (2-3 pilots)
 - c. Maternity Care (2-3 pilots)
 - d. HIV/AIDS (1-2 pilots)
 - e. Health and Recovery Plans (1-2 pilots)

Due to the need for integrated Medicare and Medicaid data (planned to be operational later this calendar year), the MLTC pilots will likely not start before 2017. Similarly, an I/DD pilot will not start until this care has been transitioned into managed care.

These pilots will be aligned with the arrangements detailed by the Clinical Advisory Groups, and will receive technical assistance from the State on design and analytics to support VBP implementation. In addition, all pilot participants (plans and providers) agree to participate in a learning diffusion process where they commit to assist in developing lessons learned for VBP implementation and reengagement with the CAGs as needed.

2. *Statewide Readiness Preparations (VBP Bootcamps)*: In order to both support and promote a smooth and transparent shift to VBP, the State will also be running an educational series for providers and plans across the State. These trainings or 'boot camps' will help ensure that the health care community is educated on the details of the VBP design that were developed throughout 2015. Other relevant topics, including risk management and contracting for VBP, will also be included. Learnings from the VBP Pilot participants and leading providers and plans engaging in VBP will be leveraged and shared by the Department of Health, promoting transparency and operational support on the VBP implementation process.
3. *Mid-Point Assessment Planning*: The State will collaborate with the VBP Workgroup to define the details of an assessment of VBP progress, based in part on the output for the Baseline Assessment completed in early 2016.
4. *Implementation of Workgroup Recommendations*: To fully implement the required changes identified by the VBP Workgroup, the Medicaid Model Contract and Provider Contract guidelines will be updated to reflect many of the technical design and regulatory recommendations developed throughout 2015. Numerous State agencies, such as the Department of Health and the Department of Financial Services, will make updates to their internal policies and help support legislative changes within the State. Additionally, analytics and performance tools have been updated to support access to relevant data and further



transparency for providers and MCOs. This focus on data transparency will be critical for successful implementation of VBP and is a cornerstone of the State's vision for the future of Medicaid.

5. *Ongoing Clinical Advisory Groups:* Clinical Advisory Groups are in various stages of completion, with the goal of finalizing all quality and clinical measures by mid-2016. While the majority of the CAGs are complete (Maternity, Chronic Heart, Diabetes, Pulmonary, HIV/AIDS, Integrated Primary Care), some CAGs that will continue through mid-2016 (Behavioral Health and Managed Long-Term Care). The Behavioral Health CAG, which has reviewed the HARP subpopulation and Bipolar Disorder, has been extended to accommodate enhancements to specific bundles (such as Depression and Anxiety) and develop additional ones (Trauma and Stressors, Substance Use Disorder). In addition to the continuation of certain CAGs, CAGs for Managed Long-Term Care and the Intellectually and/or Developmentally Disabled have begun in 2016. As discussed, additional CAGs will be launched as needed to address the remaining Medicaid population.

Formation of New Workgroups: Recommendations of the Regulatory Impact Subcommittee and the Advocacy and Engagement and Social Determinants of Health Subcommittees included requests for the development of new workgroups to continue and deepen the work charged to the subcommittees. Additional regulatory workgroups will be formed around HIPAA and State Privacy Laws, Program Integrity, and Regulatory Reform. These proposed workgroups will focus on staying abreast of any unanticipated regulatory challenges to VBP implementation, and ensuring that the appropriate safeguards for members, plans and providers are in place. The output of these workgroups will be findings and recommendations, which will be submitted to the VBP Workgroup for approval.

The Advocacy and Engagement and Social Determinants of Health Subcommittees also recommended the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: a taskforce focused on children and adolescents in the context of VBP; a taskforce to identify standard data sources and data points for reliable tracking of social determinant-related metrics; a workgroup to review the opportunity for development of a communication system for providers and CBOs to better address members' SDH needs; and workgroups to update the current Managed Care Patient Bill of Rights to include information relevant to VBP and provide information on VBP to Medicaid members.



Timeline

The core goals of VBP implementation and the DSRIP program, as well as the speed of implementation remain unchanged. The timeline has been updated to reflect the changing role of the Performing Provider System, which may, but is not required, to be the entity contracting VBP arrangements.

In DY 2 (April 1st, 2016 – April 1st, 2017), PPSs will be requested to submit a growth plan outlining the path of their network towards 90% value based payments. All growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population).

End of DY 3 (April 1st, 2018), at least 10% dollars of total MCO expenditure are captured in Level 1 or above.⁶⁴

End of DY 4 (April 1st, 2019), at least 50% of total MCO expenditure will be contracted through Level 1 VBPs or above. At least 15% of total payments contracted through Level 2 VBPs or higher (full capitation plans only)⁶⁵.

End of DY 5 (April 1st, 2020), 80-90% of total MCO expenditure (in terms of total dollars) will have to be captured in at least Level 1 VBPs. At least 35% of total payments contracted through Level 2 VBPs or higher for fully capitated plans and 15% contracted in Level 2 or higher for not fully capitated plans.⁶⁶

⁶⁴ This goal was rephrased to make the target more measurable.

⁶⁵ For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans, from this minimum target.

⁶⁶ The State's ambition is to stimulate MCOs and VBP contractors to move to Level 2 contracting as soon as possible, because it is at Level 2 (or 3) that the most impact on outcomes is seen. Even more important, however, is the need to ensure that VBP contractors are ready to assume risk, especially in a system with safety net functions and providers who often start from a financially fragile position.



Coordination with Medicare

In October 2015, the State submitted a Medicare Alignment proposal to CMS that outlined the State's efforts to maximally align CMS payment reform efforts for Medicare to the NYS Medicaid Payment Reform Roadmap. Alignment between Medicare and Medicaid is beneficial for members, providers, the State and CMS alike. The significant benefits of this alignment are focused on important outcomes such as: increasing opportunities to create shared savings for NYS providers; a reduction of risk of divergence and distraction caused by diverging payment models and incentives; thoroughly reducing administrative burden; reducing barriers and increasing incentives to 'make the jump' to a new business model for providers; increasing opportunities for stabilization of the safety net, especially upstate; increasing overall value delivered to members and payers, including Medicaid; and increasing value delivered, especially to the dual eligible population.

The Alignment proposal was drafted with the support of the VBP Workgroup, and was posted for a public comment period. The State has had preliminary discussions with CMS, and is committed to continuing to maximize synergy and benefit between the programs and minimize complexity for members, providers and plans. The Medicare Alignment proposal requests that the State receive approval to: 1) allow its providers and Managed Care Organizations on a voluntary basis to include Medicaid members in CMS innovative payment models (these have already been included in the Roadmap as off-menu options that would be automatically accepted as valid Level 1 or higher VBP arrangements); and 2) in parallel, NYS requests that CMS allow NYS providers on a voluntary basis to include Medicare FFS members in the VBP arrangements outlined in the NYS Payment Reform Roadmap.

In January 2016, the Health Care Payment and Learning Network (initiated in 2015 by DHHS), published its new Alternative Payment Model (APM) Framework⁶⁷, which distinguishes four categories of health care payments:

Category 1: Fee-for-service with no link of payment to quality

Category 2: Fee-for-service with a link of payment to quality

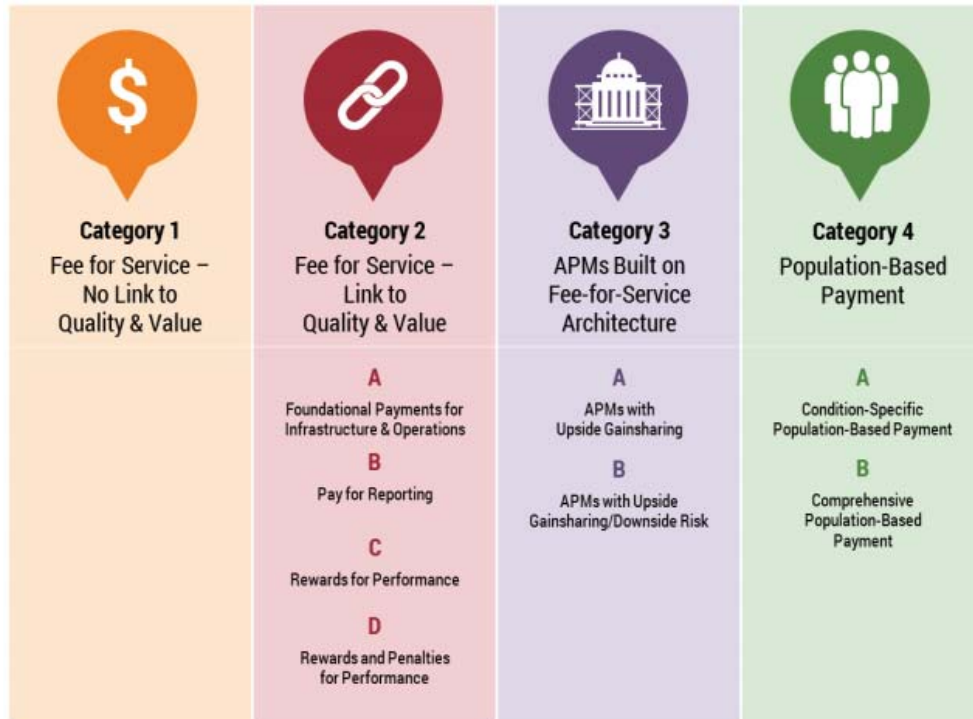
Category 3: Alternative payment models built on fee-for-service architecture

- a) APMs with upside gainsharing
- b) APMs with upside gainsharing and downside risk

Category 4: Population-based payment

- a) Condition specific population-based payment
- b) Comprehensive population-based payment

⁶⁷ <https://hcp-lan.org/groups/apm-fpt/apm-framework/>



This new APM Framework is fully aligned with the NYS Roadmap:

HCPLAN APM Framework	NYS Roadmap
Category 1	FFS
Category 2	Level 0
Category 3a	Level 1
Category 3b	Level 2
Category 4	Level 3

CMS has announced the goal of having 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018 (Category 2). Perhaps even more important, the CMS target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018 (Category 3 or 4).⁶⁸

As CMS embarks down the path of VBP for Medicare with explicit goals for alternative payment models and value based payments, New York State is committed to ensuring alignment of the goals between both VBP programs by mapping the DHHS goals to the NYS Medicaid levels. New York State Medicaid will also continue to be a national leader by committing to meeting or surpassing the DHHS goals as defined under the Health Care Learning and Action Network.

⁶⁸ Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS Fact Sheet, 01-25-2015. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>.



Conclusion

The recommendations for VBP implementation captured in this Year 2: 2016 Annual VBP Roadmap Update have been made based on significant stakeholder input and engagement. Through the implementation process, providers and PPSs in successful DSRIP programs will see a significant shift in reimbursement dollars. DSRIP funds will allow them to compensate for lost revenues while investing in new infrastructure. Similarly, DSRIP funds will be used to pay for care activities that are currently not funded or underfunded, especially important as innovative, outpatient and community-focused care models are being introduced. As quality outcomes improve, and avoidable admissions and visits are reduced, the current fee-for-service model will be increasingly ill-fitted to sustain the new delivery models. After five years, when the DSRIP funding stops, gains realized will be impossible to maintain unless significant steps are made to align payment mechanisms with these new care models. Importantly, without payment reform, improved outcomes and efficiency will lead to reduced reimbursements, and a downward rebasing of MCO premiums, reducing Medicaid dollars and weakening rather than improving the viability of the safety net.

Building upon the infrastructure that DSRIP will help put in place, this Roadmap outlines a transformation towards payment reform which:

- Aligns the payment incentives with the aims and goals of DSRIP and population health management;
- Rewards value over volume;
- Ensures reinvestment of potential savings in the delivery system;
- Allows for reimbursement of innovative care models not currently funded or underfunded;
- Allows for increased margins for providers when delivering value and an increased viability of the State's safety net;
- Allows for more sustainable workforce strategies; and
- Reduces the percentage of overall Medicaid dollars spent on administration rather than care.

The State realizes that this plan is ambitious. Yet without this ambition, these aims, vital to members, the provider and plan communities, and the Medicaid delivery system as a whole, cannot be realized. It is encouraging to see this plan's ambitions reflected in the broad and extensive stakeholder participation and the Medicaid community's commitment to realizing this plan over the next five years.



Appendix I: T&Cs Par. 39

In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the State's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid members through comprehensive payment reform, strengthened provider networks and care coordination, the State must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the State submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the State must submit a roadmap for how they will amend contract terms Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the State may claim FFP for managed care contracts for the 2015 State fiscal year. The State shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its stated goal of 90% of managed care payments to providers using value based payment methodologies.

How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

How the State will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.

How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.

How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the State will use benchmark measures (such as the MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for State review and approval by January 31 of each calendar year.

How the State will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.



Appendix II: Criteria for ‘Off-Menu’ Options

‘Off-menu’ options will have to be initiatives embraced by both the MCO and the involved providers. In addition, they have to fulfill certain criteria to be considered (at least) Level 1: they must reflect the underlying goals of payment reform as outlined in this Roadmap and sustain the transparency of costs versus outcomes. ‘Off-menu’ approaches also, at a minimum, must meet DHHS’ definitions of Alternative Payments Models (APMs). The following outlines the criteria the State will use when it assesses whether off menu options reflect the goals of Medicaid VBP reform.

VBP models work only if the ‘value’ at heart of the model can be measured objectively and compared with other providers/MCOs. To allow transparency and proper benchmarking, then, calculations of ‘costs’ and ‘outcomes’ require a certain level of statewide standardization. If provider-MCO combinations define similar bundles or (sub)populations differently, the current inability to compare costs and outcomes across meaningful units of care would simply have been replaced by a similarly opaque situation, and the State would be hampered in its responsibility to monitor the value of care delivered to its most vulnerable populations.⁸⁰ In addition, standard VBP arrangement definitions significantly reduce the administrative burden for both MCOs and providers. Especially for smaller providers, varying definitions of a VBP arrangement between MCOs and/or differences in outcome measures to report would cripple their ability to fulfill their role.

This implies the following criteria:

1) Off-menu VBP arrangements that focus on conditions and subpopulations that address community needs but that are not otherwise addressed by VBP arrangement in the Roadmap

MCOs and VBP contractors are invited to focus on conditions and subpopulations that are locally highly relevant yet not identified as such by the VBP Roadmap. ‘Off-menu’ arrangements are not intended to be used for making variations to the VBP arrangements that have been prioritized by the State.

Example of an acceptable ‘Off-Menu’ option:

- An arrangement that focuses on a bundle or subpopulation that the Roadmap and the State are not supporting analytically, but that has significant local impact would satisfy this criteria. For example, a cancer treatment arrangement in an area with poor outcomes for cancer patients would constitute a potentially acceptable ‘Off-Menu’ arrangement.

2) Off-menu VBP arrangements should be member centric

The delivery of such care services will almost always require different provider types working together. All VBP arrangements should be member centric and span the full continuum of care as appropriate for the target condition or subpopulation. The VBP arrangements outlined in the Roadmap offer clear examples. ‘Costs’ and ‘outcomes’ are measured across the entire spectrum of the care services.

Example of an acceptable ‘Off-Menu’ option:

- A TCGP arrangement that excludes dental services but that does include the continuum of covered services for all members eligible for mainstream managed care would satisfy this criteria, as dental services are outside of the set of covered services for these members.

Examples of an unacceptable ‘Off-Menu’ option:

⁸⁰ To maximize alignment across payers, the State will except certain alternative models such as Medicare ACOs and Medicare BCPI (Bundled Payments for Care Improvement) bundles; see further.



- A TCGP arrangement that excludes hospital costs would not satisfy this criteria. Urgent and tertiary care services are a necessary component of the continuum of care for the general Medicaid population due to the variability and unpredictability of medical needs.
- A Maternity Bundle arrangement that excluded obstetric services would fail this criteria. Obstetric services are a core component of the support provided to this cohort, and an arrangement that omitted these services would be unable to provide adequate care to its members.

3) Through sharing savings and/or losses, off-menu VBP arrangements should include a focus on both components of 'value': the quality and cost of the care delivered

VBP contractors take responsibility for the total costs and quality delivered to the patient included in the APM. These total costs as well as the quality-based outcome measures need to be clearly defined; both the VBP arrangement definition as well as the outcomes need to be publically available so as to stimulate uptake by other providers and MCOs if desired. VBP contractors will need to publish their scores on the quality metrics as is the case for on-menu VBP arrangements.

Every VBP arrangement must satisfy this criteria through focusing on both cost and quality.

4) 'Off-Menu' VBP arrangements should utilize standard definitions and quality measures from the Roadmap where possible

The arrangement definitions and quality measures appearing in the Roadmap have been carefully developed by the CAGs and represent a highly collaborative and evidence-based approach to policy development. As such it is important for them to be implemented consistently across the state to enhance the ability for all stakeholders to monitor progress and success across the state.

Variations on the defined arrangements may be allowable, but will be reviewed and approved by the Department. These variations may include adjustments to target population parameters, covered services, or performance measures.

Examples of a potentially acceptable 'Off-Menu' option:

- An arrangement that proposes carving out one or more conditions from the Chronic Bundle in the short term in order to expedite their ability to implement a VBP contract for IPC.
Note: the integration of primary care and behavioral health care is core to the aims of enhanced patient-centered care and therefore the separation of primary care and behavioral health will not be an acceptable example of a carve out for the IPC arrangement
- A HARP arrangement that includes new quality measures that have been developed after the HARP CAG report was published and that will assist the VBP contractor in monitoring outcomes in an enhanced manner.
Note: the consistency of quality measures across similar arrangements state-wide is an important aspect of monitoring the progress and results of the VBP program. VBP Arrangements should not omit quality measures recommended by the CAGs. Alternative quality measures outside of those recommended by the CAGs will be considered as long as they are consistent with the aims of the VBP program and are supported by a compelling argument for their use.

Examples of a potentially unacceptable 'Off-Menu' option:

- An IPC arrangement that carves out the depression and anxiety episode.
- An arrangement that omits CAG-recommended quality measures without approved rationale and/or inclusion of approved alternatives.



Appendix III: Criteria for Shared Savings in IPC and TCGP Contracting

To clearly define the expected level of cooperation between professional-led VBP contractors and downstream hospitals, three main criteria (listed below) have been identified. These criteria will serve as a statewide standard in determining equitable shared savings in IPC and TCGP VBP arrangements.⁸¹ To provide flexibility, hospitals and professional-led VBP contractors may agree to alternative sub-criteria measures and specifics where appropriate, provided the State is notified and the MCO contracting the Level 1 and/or 2 VBP arrangements agrees. They may also include more detailed criteria than those listed below. It is the responsibility of the contractor to notify downstream hospitals of its intent to negotiate value based arrangements with an MCO. Subsequently, it is the responsibility of the hospital to initiate conversations with the VBP contractor based on a plan created by the hospital conforming to the statewide standard.

If a Level 1 arrangement is contracted, the hospitals qualify for 50% of the savings realized by the professional-led practice. If a Level 2 arrangement is contracted, the hospitals will qualify for 25% of the savings; 75% will remain with the professional-led practice (as the VBP contractor) as it has now accepted downside risk.⁸²

The criteria for determining that hospitals have sufficiently demonstrated their cooperation in Level 1 and 2 IPC arrangements are separated into three categories: 1) Data Management and Data Sharing, 2) Innovation and Care Redesign, and 3) Quality and Engagement. If the hospitals meet all of the three criteria and savings are generated in the VBP arrangements, the hospitals will receive 50% or 25% of the savings depending on the arrangement VBP Level. Hospitals must meet all three criteria in order to receive savings. Partially met criteria will not result in shared savings for the hospital. The DOH will work closely with stakeholders to monitor the implementation of these criteria.

1) Data Management and Data Sharing

Provide real time direct data feeds to professional-led VBP contractors for emergency room utilization, admissions, and discharges (including behavioral health and substance use).

⁸¹ Clarification: the amount of savings subject to an equitable split with hospitals does not include the MCO share of the total savings. In addition, a downstream hospital only shares in the savings proportionally to its loss of revenue (i.e., the amount in which savings generated by the professional-led contractor were based on lost revenue to the hospital). For downstream hospitals to share in the savings, no causal relation between the VBP contract and the revenue loss has to be established.

⁸² Costs for risk-mitigation such as reinsurance to prevent excessive insurance risk may be subtracted from 'VBP contractor's shared savings' before the 25% calculation is applied.



<p>2) Innovation and Care Redesign</p>	<p>Fulfill at least one of the three following measures:</p> <ol style="list-style-type: none"> 1) Develop standardized care plans based on evidenced-based guidelines and practices to reduce inappropriate variation in the organization for at least one of the following service areas: high cost imaging, emergency room care, oncology treatment, diagnostic testing, behavioral health treatment, substance use treatment, etc. 2) Enhance care transitions to post-acute settings such as mental health treatment facilities, substance use disorder treatment facilities, Skilled Nursing Facilities, home, etc. to reduce readmission rates and potential complications. 3) Implementation of palliative care and collaboration with hospice.
<p>3) Quality and Engagement</p>	<p>Collaborate with professional-led VBP contractors on DSRIP Domain 2 and 3 metrics quality indicators affecting population health⁸³.</p>

Disagreement between the hospital and the professional-led VBP contractor will not prevent the MCO and the VBP contractor from moving forward with the contract. When disagreement on the interpretation of the criteria or disagreement on whether a hospital has met the criteria persists, the parties may choose to solicit assistance from the Department of Health during this mediation process. During the first year of VBP implementation (CY 2016), the State and the VBP Workgroup will continue to monitor these situations closely to validate the need for an appeals process.

⁸³ See Appendix A of DSRIP Measure Specification and Reporting Manual for the extract of Domain 2 and 3 DSRIP measures. https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/dsrp_specif_report_manual.pdf



Appendix IV: Value Based Payments and the Forestland PPS in 2019

During the DSRIP application process, the State facilitated the creation of a Prototype application, designed to provide emerging PPSs with an example of what a successful DSRIP application would look like. To create this prototype a fictional PPS “Forestland” was created. Building upon this narrative, the following provides an example of what the future state of VBP in the fictional Forestland PPS could look like. (It is not necessary to have read these earlier Forestland materials).

The Forestland PPS has been a successful PPS. It has met the bulk of its performance targets over the DSRIP years, and has been one of the State’s most successful PPSs in addressing diabetes and cardiovascular disease related hospital admissions, leading to several high-performance fund payments. While thinking through its Value Based Payment strategy in 2015, the Executive Body of the Forestland Health Provider Partnership (FHPP, the NewCo created during those last hectic months of 2014) decided that it would not attempt to create one integrated contracting entity for the total PPS. Big is not always beautiful, they had argued. Their MCOs, with whom they had always had a good relationship, had also been clearly concerned about having to negotiate with such a unified group of providers. In addition, there had always been a natural distinction in culture, focus and also patient populations between the east and the west parts of the Forestland providers.

In East Forestland, home of the poorer parts of this geographical area and two of the PPSs three hospital systems, the providers and MCOs had decided during 2016 to focus on their significant HARP and MLTC/FIDA populations for value based payments. Analysis of the outcome versus cost measures (that had become available and comparable statewide that year as part of the State’s VBP Roadmap) had shown them that potential improvements in both quality and overall costs were significant. Maternity care, on the other hand, was selected because their outcome versus cost measures showed what they had thought all along: they were one of the best performers statewide. In the FFS system, however, they were still losing money on maternity care, and a contract that focused on value could be the solution.

The pre-existing Health Home had linked up with the other Advanced Primary Care initiatives that were expanding in the region, and had proposed to contract Integrated Primary Care with the Chronic Bundle throughout most of East Forestland. They had been impressed with the potential reduction in potentially avoidable complications that the data had shown, especially with those patients who weren’t quite HARP eligible, but whose combinations of behavioral and physical chronic conditions led to poor outcomes overall.

For Maternity Care, the two hospitals joined forces with the obstetricians and community based providers, and opted for a Level 1 arrangement in 2017. This increased the dollar amount available for this care (based on their high performance statewide, and on the State’s incentive for MCOs and providers to move to higher levels of VBP arrangements). Because this bundle also included the care and costs of the first month of the baby, significant savings were realized by a further reduction of the already low NICU admission rates.

With the 50% of these savings that the MCO returned to them based on the Level 1 contract, improvements were made in the ability of community based providers to reach out to the most underserved populations, which helped reduce smoking and other substance abuse during pregnancy. The shared savings helped the hospital as well, and was a welcome addition to the obstetricians’ income.



Inspired by this result, they agreed to move to Level 2 in 2018 so as to be able to capture 100% of the shared savings, and profit from the further increase in VBP incentive dollars). The hospitals and the obstetricians formed a Maternity Care IPA, aimed at ultimately taking full risk. The obstetricians pushed to hire midwives to further decrease overall cost of care, safely increase the percentage of homebirths, and increasing the overall hands-on time that delivering mothers would experience. Increased patient satisfaction led to an influx of patients from the wider region, which further helped stabilize the financial results for the hospital, which was now receiving its maternity care related income through a contract with the Maternity Care IPA. Sensing the alignment of their own professional drives with the new financial incentives, and witnessing the disappearance of prior authorizations and MCO's utilization reviews, morale surged amongst the staff members.

The Health Home and other Advanced Primary Care practices had realized that if they would maximally strengthen the synergies between the different projects they had selected (IDS (2.a.i), medical village (2.a.iv), ED (2.b.ii), readmission reduction (2.b.iv), their 'project 11' (2.d.i), and their Domain 3 and 4 projects), all these projects would help drive the same results: an improved focus on housing, adequate nutrition, smoking cessation and obesity prevention throughout the community, improved adequate utilization of primary and preventive care, improved disease management and care coordination. One of their magic bullets, they had decided, was to build upon the success of their Health Home. Its focus on and infrastructure for care management and physical and behavioral care integration was the platform upon which they rolled out their approach to first the HARP population and subsequently the broader at-risk population. A second magic bullet had been the idea to work closely together with the home health care and visiting nurse providers, which greatly improved their ability to be pro-active in terms of addressing patients' problems and allow these patients to live more independently, reduce hospital use, and overall consume less costly care resources. This cooperation subsequently proved highly successful for the FIDA population as well, reducing the need for inpatient long term care, and improving quality of life.

They moved to Level 1 for Integrated Primary Care with the Chronic Bundle in 2017 and Level 1 TCGP for the HARP population as well. Getting a good grip on the HARP population proved harder than expected, and not much difference in outcomes or costs was realized in 2017. Their integrated approach, however, was highly successful in reducing admissions for especially diabetes and all cardiovascular chronic conditions that were being measured statewide: hypertension, angina/coronary artery disease, chronic heart failure (CHF), and arrhythmia. Contrary to their expectations, 2017 saw a drop not only in the admissions for CHF and uncontrolled diabetes, but also in long-term complications: diabetic lower-limb amputations and cardiovascular events, especially myocardial infarctions and strokes.

The savings resulting from fewer potentially avoidable complications were significant. Following the State's guidelines, they had agreed to split these savings 50/50 with the hospitals within their PPS, helping them further reduce inpatient capacity to the newly modeled demand. For the Health Home and the Advanced Primary Care practices, even 50% of 50% of savings amounted to a significant increase in revenue. They used this revenue increase to make several improvements: increase payment levels for the primary care docs and the home care organizations; expand their use of visiting nurses to further prevent hospitalizations in at-risk individuals; invest in new staff across all levels (some of whom were transferred from inpatient care organizations through the DSRIP workforce retraining programs they had put in place). Building upon the DSRIP programs, they paid much attention to ensuring cultural competency within their staff, adequately reflecting the cultural and ethnic diversity of the populations they served.



They moved to Level 2 in 2018 for IPC, with an increased stop-loss provision just to “get used to the risk”, as they called it. They moved to Level 1 for the MLTC population that year, and remained in Level 1 for the HARP population. When their interventions for the HARP populations seemed to bear fruit throughout 2018, they shifted to Level 2 for that population as well. For the remainder of the care within the PPS, a Level 1 Total Cost for the General Population arrangement was agreed upon in 2018 that would suffice until further notice. There was no risk involved in such an arrangement, and the MCOs had agreed to simply distribute potential savings (according to overall involved Medicaid dollars) amongst the East Forestland PPS providers, with the option to negotiate different arrangements in the future.

In West Forestland, the Forestland Hospital Center and its neurologists had realized its potential to be an early adopter of integrated Stroke care. It had long been a center of excellence for stroke care, and its own analyses showed that optimizing the acute phase of stroke care, starting rehabilitation during day one, and working with a select group of specialized post-acute rehabilitation and home care providers would yield significant improvements in mortality and long term outcomes. They were aware that the bulk of stroke care costs, when seen across the total cycle of care, were long term care costs. Improving quality of acute stroke care, they were convinced, would improve the number of stroke patients recovering fully and thus reduce the number of patients left with impairments and corresponding life-long care dependency. Their own analyses had shown them that much of these potentially avoidable downstream costs were incurred outside of their PPS: nursing homes, other post-acute care providers and hospitals that were not part of their PPS.

They decided to opt in the VBP Innovator Program, moving immediately to a fully-fledged Level 2 model. The incentive associated with this Innovator Program was significant, but – as they had predicted – the savings that they were able to realize, largely without impacting any of their PPS provider colleagues, were greater. The public attention their work received led to an increase of patients being brought to them for acute stroke care, including Medicare and commercial patients. In 2018, Forestland Hospital Center was the first organization in the State to enroll in the aligned Medicaid-Medicare stroke bundle, which extended the rules of engagement of the Medicaid bundle to the duals and the Medicare FFS population. This was part of a broader alignment between CMS and New York State on the Medicaid and Medicare payment reform, which allowed for adaptation of New York State’s Medicaid VBP models in Medicare, and selected Medicare Innovation Models within Medicaid.

Contrary to East Forestland, there initially was not much focus on value based payment arrangements in the remainder of the West Forestland provider community. Triggered by the success of the Stroke Program, and the bristling of activities in their sibling ‘hub’ within the PPS, they decided to try out a Level 1 Total Care for the General Population program in 2018 (which excluded only stroke care). Because they were successful in meeting most of their DSRIP goals, overall costs of care dropped somewhat, which became an unexpected source of additional revenue (they had booked a significant sum of lost revenue compensation within the DSRIP funds for 2018). Emboldened by that result, and perhaps also somewhat driven by competition with the West Forestlanders, they moved to Level 2 in 2019, while planning to realize an integrated Medicaid-Medicare ACO in 2020.



Appendix V: Quantitative Analysis per Integrated Care Service

The following table gives an estimate of total dollar amounts per integrated care service. Dual eligible members are included only for the MLTC and the I/DD population (total Medicaid costs only). The cost categories below are mutually exclusive (i.e., the ‘chronic care’ costs for people within the HARP population are included in the HARP total cost of care; not also in the Chronic Bundle). The total dollar amount associated with these care services is 32.2 billion dollars, thus covering approximately 82% of the total payments between MCOs and providers (excluding the Medicare component of the FIDA payments).⁷³ The remainder are costs incurred for members that are not included in one of the four subpopulations, for conditions that are not part of primary care nor of the bundles discussed here. (These costs include e.g. cancer care, acute trauma care, and other specialty care with a relatively low prevalence in the Medicaid only population.) Providers contracting Total Care for the General Population can achieve up to 100% inclusion of MCO payments.

VBP Arrangement	Dollars (billions)	% of Total MCO-Provider Dollars
<ul style="list-style-type: none"> - Mutually exclusive - Unless explicitly stated otherwise, dual eligible members excluded 		
Special Needs Subpopulations	22.26	56.7%
MLTC (incl. Duals)	11.02	28.1%
I/DD (incl. Duals)	8.05	20.5%
HARP	1.52	3.9%
HIV/AIDS	1.67	4.3%
Mainstream Managed Care	9.89	25.2%
Primary Care	3.43	8.8%
Chronic Bundle	4.92	12.5%
Maternity Bundle (incl. first 60 days of newborn)	1.53	3.9%
Total Covered	32.23	82.0%
Unbundled / Not in Any Arrangement (General Population)	7.08	18.0%

Zooming in on Chronic Care, for example, the graph below illustrates three of the criteria mentioned in Section 2 of the Roadmap (p. 33) used to select care bundles or subpopulations:

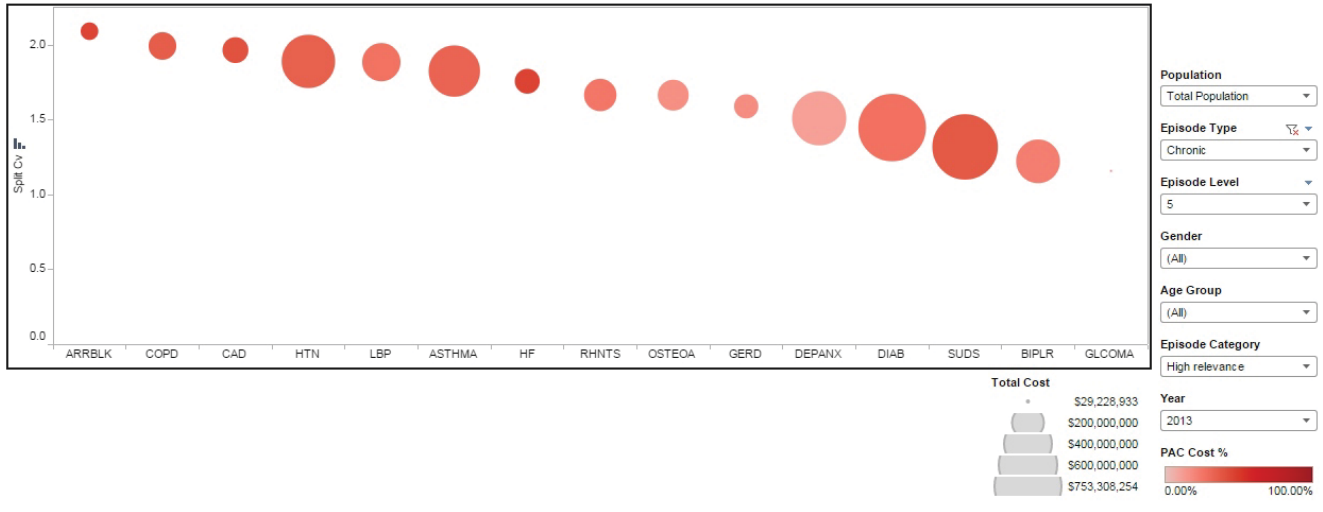
- Proportion of total Medicaid costs (size of the bubble)
- Variability in costs (Y axis)
- Rates of potentially avoidable complications (color of the bubble)

⁷³ Estimates based on extrapolations to future state MCO coverage; total dollars based on 2012-2014 expenditures.



Cost, PACs and Variation

This page is designed to find improvement opportunities. The best episodes to look at are those with a high volume, a high PAC % and with a large variation in PAC costs. Volume is shown by the size of the bubbles, PAC % by color and variation by placement on the y-axis. The largest opportunities for improvement can hence be found by searching for large and dark red bubbles in the left upper corner.



More detailed analyses of improvement potential and baseline situation per subpopulation and selected bundle, as well as progress of performance over time will be included in later updates.

Appendix VI: Contract Risk Review Process

Figure A

The flowchart below illustrates the contract review process:

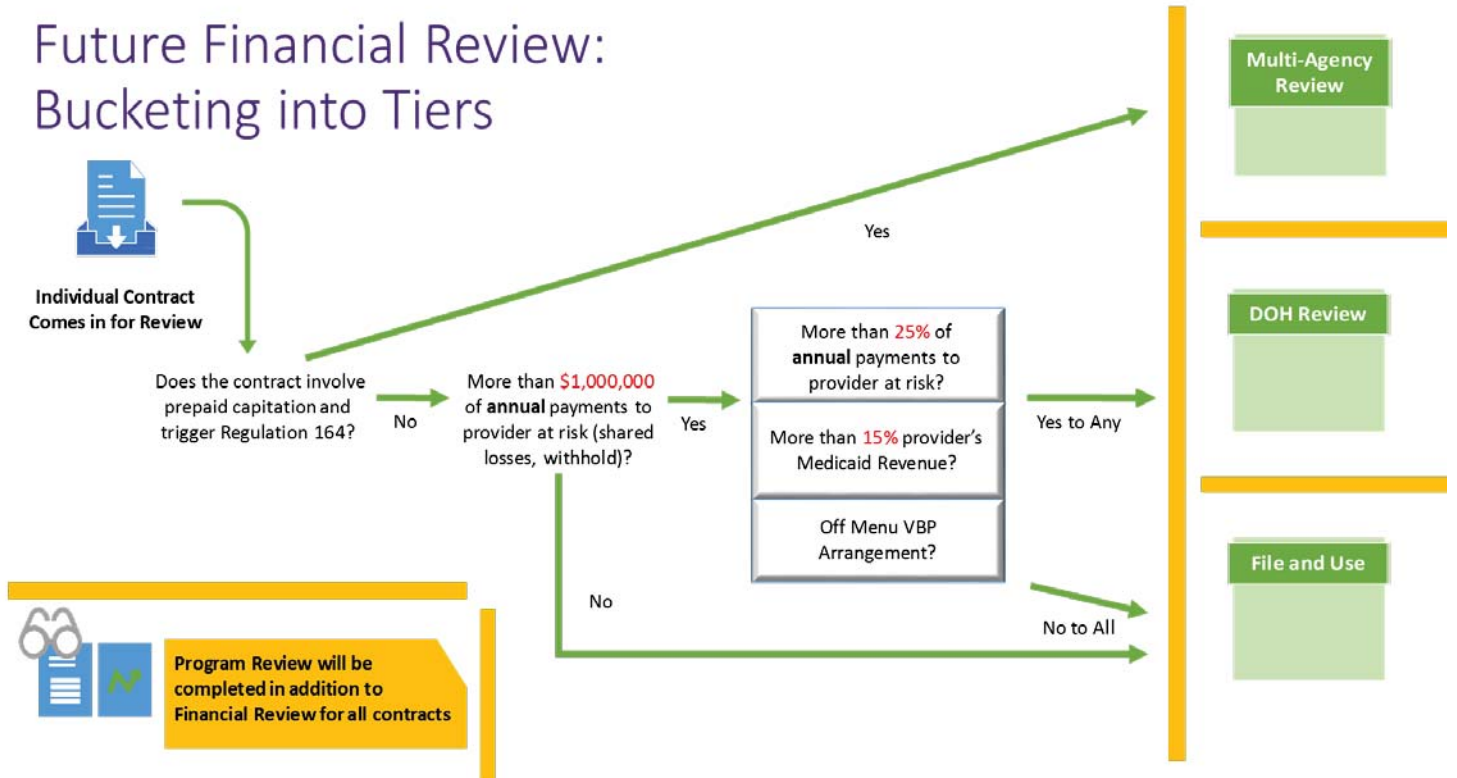


Figure B

- **This \$1,000,000 annual payment threshold is applied to:**

- Only the individual contract that is coming in for review
- Medicaid Managed Care components of the contracts only

- **This 25% payment threshold is applied to:**
 - Only the individual contract that is coming in for review
 - Medicaid Managed Care components of the contracts only
- The ratio is expressed as:

$$\frac{\text{Annual Medicaid Payments at Risk for this Contract}}{\text{Total Value of All Medicaid Contracts between this MCO and Provider}}$$

- **This 15% revenue threshold is applied to:**
 - All MCOs that contract with the provider
 - All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts
- The ratio is expressed as:

$$\frac{\text{Value of This Contract's Projected Medicaid Revenue}}{\text{Total Projected Annual Medicaid Revenue for Provider}}$$



Appendix VII: HIPAA and State Privacy Laws Brief

HIPAA and State Patient Privacy: Options and Considerations

Executive Summary

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related NYS privacy laws and regulations are key components of value based payment arrangements. The Regulatory Impact Subcommittee (Subcommittee) is tasked with providing recommendations regarding the policy question and related policy options discussed below which deal with the regulatory and procedural framework surrounding HIPAA and NYS privacy and security.

Current NYS privacy laws and regulations are more restrictive and provide less flexibility than federal HIPAA laws and regulations. These additional restrictions may prevent providers from sharing information for the purpose of coordinating care and evaluating the outcome of care, both of which are critical to successful VBP arrangements.

In some cases, the recommended method will be to align NYS and federal policies while maintaining sufficient protections to prevent the unnecessary sharing of individuals' Protected Health Information (PHI). Furthermore, there may need to be additional training for providers on any changes to the laws in order to support appropriate information sharing for the purpose of coordinating care while still protecting the confidentiality of this information. In other cases, the recommendation may be to retain NYS laws and regulations due to state policy reasons, yet create specific exceptions or alternative processes to accomplish the purposes of VBP.

Policy Question: *Should NYS privacy laws be amended to more fully align (harmonize) with federal HIPAA and the goals of VBP?*

A thorough review of the five scenarios below depict various VBP challenges under current NYS law. The scenarios describe examples of the significant data privacy issues that may arise in a VBP setting. Each scenario depicts situations in which providers may need additional data in order to be more proactive and successful in VBP while continuing to acknowledge members' individual privacy needs.⁷⁴

Each of the five scenarios described in this brief should be considered on an individual basis with at least the three options described here (suggestions for alternative options are encouraged). The options below attempt to take into account potential changes in Medicaid members' rights for each scenario, particularly in the areas of behavioral health, substance abuse, HIV/AIDS, reproductive care, and for minors. The three options for each scenario are as follows:

- **Option 1:** Align NYS law with federal HIPAA protocol. Because NYS must already abide by HIPAA, this option provides a less restrictive and more updated alternative to many potential data privacy issues while maintaining a baseline privacy and security protocol; however, a broad alignment may not take into account various NYS specific policies regarding patient confidentiality.

⁷⁴ The five scenarios are not meant to be exhaustive. Even with consensus for these scenarios, there will likely be specific data privacy questions and uncertainties that arise in which interpretation of consents, opt outs, and state laws and regulations will be necessary.



- **Option 2:** Create specific exceptions to the NYS laws in an effort to accommodate the shift from a fee-for-service system to VBP. This option would help mold NYS law to accommodate VBP, but the layering of exceptions may become cumbersome to address all relevant privacy and confidentiality laws.
- **Option 3:** Replace/rewrite existing NYS privacy laws and regulations in an effort to accommodate the shift from a fee-for-service system to VBP. This option would generally require the greatest degree of legal work; however, it may provide a balanced solution that maintains NYS policy concerns, takes into consideration the existing federal law, and accommodates VBP.

In considering these options, the Subcommittee should also recommend the degree of State involvement required and related considerations and regulatory impacts associated with each option. Further, the Subcommittee should consider whether a data privacy and security workgroup should be developed to follow up on the recommendations and future data and privacy issues that arise over the course of VBP implementation.

Below are five scenarios in which current NYS laws and regulations present challenges to VBP. While these scenarios provide five strong examples of potential data sharing issues under VBP, they do not encompass every potential issue.

Scenario 1 – DSRIP Opt Out and DEAA Processes:

The DSRIP Opt Out and DEAA processes are limited to NYS provided data. The DEAA process only applies to downstream transactions and does not apply to non-state provided data. There is currently uncertainty on upstream sharing of data and data sharing from provider-to-provider for purposes of VBP.

Example: PPSs, IPAs, and ACOs may need to compare the quality of different providers to evaluate performance. This may require use of PHI (upstream or provider-to-provider) to determine shared savings and losses. Requiring distinct opt out processes per PPS or provider or requiring additional consents for each transaction would be burdensome and may cause delays in review processes and timing of payments.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Clarify that the data sharing for purposes of VBP constitutes health care operations consistent with HIPAA and NYS law.	This may eliminate the need for additional opt outs and consents specific to data sharing for purposes of DSRIP and related VBP transactions.
2. Create Exceptions to NYS Law	Create specific exceptions/state interpretation to allow for both upstream and provider-to-provider sharing of data for purposes of VBP.	Relatively efficient solution, but would not necessarily eliminate the need for all DEAAs and opt outs for purposes of DSRIP and VBP.
3. Replace existing NYS law	Replace/rewrite existing law to allow for both upstream and provider-to-provider sharing of data for purposes of VBP.	Would require a great amount of legal work to rewrite NYS law, but would allow for an updated law taking into account VBP with relevant policy considerations built into the law.



Scenario 2 – Care Management:

There is lack of clarity in the application of state confidentiality laws related to the disclosure of PHI for the purposes of care management organizations. Care management organizations may be neither covered entities nor providers, but may require access to PHI. There is also a lot of confusion about the appropriate sharing of information with and by care management agencies (including health homes) which leads to burdensome and unnecessarily complex consent processes that are not clearly communicated to consumers. If care management facilities such as Health Homes are one of the potential points of attribution in a VBP environment, these issues need to be clarified and addressed.

Example: Care Management organizations and health homes may need access to PHI to gather all necessary information to create a care management plan to better coordinate patient care. Currently, specific patient consent (in addition to current opt-out or treatment consent) may be needed for providers to disclose PHI to each entity or vendor. The consent process may delay, or in some cases deny, the care management entity’s access to patient information.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Align the application of state confidentiality laws related to disclosure of PHI for purposes of care management organizations to the goals of VBP (health care operations).	Also add more resources to support training, tools, development of standardized consents and clearer guidelines for care management agencies and providers.
2. Create Exceptions to NYS Law	Draft exceptions to the relevant Public Health Law, Mental Hygiene, and related laws on a case by case basis.	This would require consideration and cross reference of multiple laws and regulations.
3. Replace existing NYS law	Draft specific laws or regulations to govern the access and security of PHI for care management organizations.	Would require a new NYS law or regulation, but would allow for an updated law taking into account VBP with relevant policy considerations built into the law.



Scenario 3 – RHIO and SHIN-NY Data:

The RHIO and SHIN-NY data may be incomplete due to NYS patient confidentiality laws (e.g., Public Health Law §2782) which limit provider-to-provider data access. If data access is for non-treatment purposes, it is not clear what would constitute “minimally necessary” standard for health care operations. Other issues include minor consent laws, which may create a gap for 12-17 year old patient info; HIV/AIDS; mental health; and maternity and reproductive health confidentiality laws which are more restrictive than HIPAA.

Example: When a minor provides the consent for treatment, only that minor may provide consent to release the medical records or other PHI related to that visit. The RHIO opt-out and SHIN-NY opt-in do not necessarily include the consent of minor patients. Providers are therefore reluctant to provide access to minor patients’ data through the RHIOs and SHIN-NY.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Allow data sharing consistent with HIPAA (e.g., health care operations).	Does not fully solve the issue. Certain state restrictions (e.g., minor consent laws) are important to the State’s policy interests. HIPAA does not account for minor confidentiality, maternity, HIV/AIDS, and related NYS policy considerations.
2. Create Exceptions to NYS Law	Create exceptions to allow for providers to disclose and access PHI through the RHIOs and SHIN-NY to accommodate VBP.	Exceptions can be made to all or some of the following restrictions to: minor consent, HIV, mental health, and maternity confidentiality laws. This requires analysis and evaluation including an update on how the RHIOs are functioning and what protections are currently in place. This requires further discussion and a deeper understanding of the RHIO and SHIN-NY networks and scope of data access.
3. Replace existing NYS law	Replace existing NYS law to allow for providers to disclose and access PHI through the RHIOs and SHIN-NY to accommodate VBP.	This approach will require a great deal of legal work and time. However, replacing existing, pre-HIPAA law would provide the State with an opportunity to customize laws and regulations to accommodate VBP while maintaining critical policy interests.



Scenario 4 – Scope and Medicaid Consent:

The Medicaid consent form seems to allow disclosure for health care operations, but DOH legal takes a strict view of the scope of this consent. There is uncertainty among providers regarding the scope of the Medicaid consent which may lead to missing data and delays in data reporting.

Example: There is a lack of guidance on when opt-in/outs are necessary in light of the exception for health care operations contained in the Medicaid consent form. Some PPSs fear they need their own opt-out or alternative consent process to receive data from downstream providers.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Clarify that the exception for health care operations is consistent with definition and scope contained in HIPAA.	Does not solve issue if the more restrictive NYS laws and regulations remain in place.
2. Create Exceptions to NYS Law	Clarify the scope of the Medicaid consent form and create legal exceptions, as needed, to allow alternative means of data sharing for purposes of VBP.	Would require case by case analysis of each use of Medicaid member PHI to determine whether the Medicaid consent is sufficient in scope and what exceptions to specific NYS law and regulations is required.
3. Replace existing NYS law	Replace/amend existing law to add law or regulation that addresses the scope of the Medicaid consent form to allow alternative means of data sharing for purposes of VBP.	Could require a great amount of legal work as option 2 above, but would allow for an opportunity to customize the laws and regulations to accommodate VBP while maintaining critical policy interests.



Scenario 5 – Vital Statistics (VS):

Vital Statistics have unique restrictions which render them unusable with Medicaid members. New York state regulation 10 NYCRR 400.22 suggests that only state employees may access VS. There are no exceptions or consent processes available to providers, PPSs, and NYS contractors (there are limited exceptions for non-Medicaid members).

Example: When a baby is born, it is not immediately assigned a Medicaid ID, and costs related to the birth are attributed to the mother. Once the baby receives a Medicaid ID, costs are then attributed to the baby. In some cases, the identity of the mother may be unknown (e.g., homelessness) and it is not possible to create this link. Access to VS records (collection of blood records, SSN, etc.) would help to create the mom-baby link and supplement the medical record.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	N/A. There is no HIPAA equivalent.	This is a NYS specific regulation that is analyzed separately from other data privacy categories.
2. Create Exceptions to NYS Law	Create an exception to allow for access to mom-baby VS data with a DEAA or related consent process (similar to HIV, and other PHI) for limited purposes.	This may be the easiest solution, but would require additional analysis on the policy reasons behind the Medicaid restriction in the current regulation.
3. Replace existing NYS law	Replace/rewrite the existing regulation.	VS data is state collected information; this option would require coordination of multiple departments to determine the policy considerations and may be beyond what is necessary to effectuate purpose of this scenario.

Other Considerations

In addition to the scenarios and options presented above, the Subcommittee should also consider:

- (1) Other potential scenarios and options regarding patient data privacy and security; and
- (2) Whether it would be prudent for the DOH to establish a data privacy and security work group comprised of various NYS departments and stakeholders to follow these issues and implement recommendations throughout the development of VBP on a case by case basis.



Appendix VIII: Criteria for Quality Measure Selection

Criterion	Description
Clinical Relevance	<ol style="list-style-type: none"> 1. Focused on key outcomes of integrated care process I.e. outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e. the quality of one type of professional’s care); 2. For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcomes measured; 3. Existing variability in performance and/or possibility for improvement.
Reliability and Validity	<ol style="list-style-type: none"> 1. Measure is well established by reputable organization <i>By focusing on established measures (owned by e.g. NYS Office of Patient Quality and Safety (OQPS), endorsed by the National Quality Forum (NQF), Healthcare Effectiveness Data and Information Set (HEDIS) measures and/or measures owned by organizations such as the National Committee for Quality Assurance (NCQA);</i> 2. Outcome measures are adequately risk-adjusted <i>Measures without adequate risk adjustment make it impossible to compare outcomes between providers.</i>
Feasibility	<ol style="list-style-type: none"> 1. Claims-based measures are preferred over non-claims based measures (clinical data, surveys); <i>I.e. ease of data collection data is important and measure information should not add unnecessary burden for data collection;</i> 2. When clinical data or surveys are required, existing sources must be available <i>I.e. the link between the Medicaid claims data and this clinical registry is already established, or data elements are available in EHRs in an adequately standardized way</i> 3. Data sources preferably are be patient-level data <i>Measures that require random samples (e.g. sampling patient records or using surveys) are less ideal because they do not allow drill-down to patient level and/or adequate risk-adjustment, and may add to the burden of data collection. An exception is made for such measures that are part of DSRIP/QARR;</i> 4. Data sources must be available without significant delay <i>I.e. data sources should not have a lag longer than the claims-based measures (which have a lag of six months).</i>



Appendix IX: Innovator Program

1. Risk arrangements eligible for the Innovator Program

VBP contractors who aim to engage in Level 2 (full risk or near full risk) and Level 3 TCGP and subpopulation arrangements will be eligible to apply for the Innovator Program, provided they pass the tiered contract review process. Level 2 contracts are only be considered eligible if the total risk assumed by the provider (and therefore also the potential savings) is comparable to a Level 3 arrangement level of risk.⁷⁵ It will be possible for a VBP contractor to enroll in the Innovator Program with a slightly lower risk Level 2 contract, as long as the contractor demonstrates that it will be ready to transition to the required Level 3 (or high-risk Level 2) the following year.

2. Review/assessment process for the Innovator Program

The assessment process for entering into the Innovator Program will be aligned with the aforementioned contract review process detailed on page 21. This process focuses on ensuring that VBP contractors can safely take on higher levels of risk, and on the alignment of the VBP arrangements with the Roadmap.

3. Criteria for participating in the Innovator Program

In order for VBP contractors to participate in the Innovator Program, they should meet the following four criteria (at a minimum):

1. Meet health plan network adequacy requirements based on the appropriate provisions of NYS laws and regulations.
2. Demonstrate proven success in VBP contracting for TCGP and subpopulations, determined during the review process on a case by case basis.
3. To ensure impact as well as reasonable size to be able to assume significant risk⁷⁶, the VBP contractors should have a minimum number of 25,000 Medicaid members (excluding dual eligible members) attributed for a TCGP contract, or 5,000 Medicaid members (excluding dual eligible members) attributed for a total care for a subpopulation contract. For the MLTC subpopulation contract, the minimum number of dually eligible members is recommended to be 5,000. Providers and MCOs should be cognizant of the number of Medicaid members served in the Program – it should be large enough to justify the investments and make substantial positive impact on population health.
4. Be financially solvent and have appropriate net worth as per the DOH analysis.

4. Appeals process

VBP contractors will be unable to appeal their Innovator status. Decisions on acceptance into the Innovator Program will be based on the DOH/DFS review process. The State will monitor whether the need for a comprehensive appeals process becomes necessary in the future.

⁷⁵ To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the provider with a low quality score is 40%, with a maximum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on. To be considered a high risk Level 2 arrangement, the minimum percentage of potential losses to be allocated to the provider with a low quality score is 60%, with a minimum cap of 35% of the target budget.

⁷⁶ With low numbers of attributed lives, chance determines financial outcomes more than actual performance.



5. Innovator Program benefits

The Innovator Program rewards providers with up to 95% of premium pass-through for total risk arrangements as the prime Program benefit. The pass-through percentage will be determined by analyzing the amount of the risk and administrative tasks taken on by the providers: more delegation results in higher percentage of premium (between 90% and 95%).

Delegable functions include the following: utilization review, utilization and care management, drug utilization review, appeals and grievances, quality, claims administration, member/customer service, network management, risk adjustment and reinsurance, disease management, member/provider services, provider relations, and credentialing. Additional functions, which are unlikely to be delegated, include member enrollment/advertising, fraud, waste and abuse, legal, and compliance. In addition, some tasks may still require some sign off or have other process limitations from MCOs, while the providers can be responsible for the majority of the actual work. The resulting list of administrative functions that can be fully or partially delegated, as well as those that cannot be delegated, is displayed below.

To be eligible for 90% premium pass-through, functions 1, 2 and 10, listed in the table below for reference, should be fully delegated to the provider, while at least half of the tasks listed as "shared" should be partially delegated. To be eligible for the 95% premium, tasks 1, 2, 6, 10 and 13 should be fully delegated to the provider, while all the other tasks should be delegated to the maximum amount possible. Percentages may be set between 90 and 95% depending on the exact delegation of tasks negotiated.

#	MCO Administrative Functions*	Optimum	
		MCO	Provider
1	Utilization Review (UR)		
2	Utilization and Care Management (UM)		
3	Drug Utilization Reviews (DUR)		
4	Appeals and Grievances		
5	Quality		
6	Claims Administration		
7	Member/Customer Service		
8	Network Management		
9	Risk Adjustment & Reinsurance		
10	Disease Management		
11	Provider Services Helpdesk		
12	Provider Relations		
13	Credentialing		
14	Data Sharing		
15	Member Enrollment/Advertising		
16	Fraud, Waste and Abuse		
17	Legal		
18	Compliance		

Legend	
	Sole Responsibility
	Shared Responsibility
	Can't be delegated

It is important to note that this Program does not imply any changes to the current NYS law and regulations with respect to any licensing or certification requirements.



6. Innovators' performance

Innovator Program will be required to comply with the relevant VBP measures, which are based on the current DSRIP and QARR measures. No specific Innovator Program measures will be created. Innovators will be asked to report on these measures and cannot perform below average (compared to the performance of comparable VBP contractors, or, when not available, to PPSs) in order to maintain their Innovator status. The performance measures of the VBP arrangements that pertain to the Innovator Program will become available as soon as they have been approved by the VBP Workgroup.

7. Maintenance and contract termination/program exit criteria

If performance measurements are below average, or if the MCOs are concerned about the financial stability of the VBP contractor or if it faces operational challenges, the MCO may consider contacting the State (after having informed the VBP contractor) to assess whether the Innovator should be placed on probation. In case of probation, a 6 – 12 month timeline to improve performance with no surplus payments to the Innovator will be applied, until the measurements are above average again. In a Level 3 arrangement, the VBP contractor will share in any costs or penalties imposed on the health plan, if the contractor's failure to meet quality standards negatively affects the health plan's quality scores. If a provider operates at a loss so that the costs exceed the percent of premium paid by a health plan, the provider will not have any recourse against the health plan or any of its members.

Should Innovators need to exit the program (for reasons surrounding mergers and acquisitions, or failure to improve, other reasons), it is recommended that a transition period be included in the contract. This will be a set period of time during which the provider and respective MCO ensure a smooth transition out of the Innovator Program.



Appendix X: Definitions of Level 1, 2 and 3 VBP Arrangements

Level 1: FFS with Retrospective Reconciliation - Upside Only

A Level 1 VBP arrangement continues the existing FFS payment⁷⁷ methodology from MCO to providers, but allows the VBP contractor to receive shared savings based on a ‘target budget’ set for the VBP arrangement. When the total spend on the services included in the VBP arrangement remain below the target budget, these savings are shared between MCO and VBP contractor. To be counted as a Level 1 VBP agreement, the minimum percentage of potential savings to be allocated to the VBP contractor with a high quality score is 40%.

Level 2: FFS with Retrospective Reconciliation – Up- and Downside

A Level 2 VBP arrangement also continues the existing (usually FFS) payment methodology from MCO to providers, but allows the VBP contractor to receive more shared savings than in a Level 1 arrangement, because the VBP contractor also shares in potential losses. To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the provider with a low quality score is 20%, with a maximum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on.^{78,79}

Below these levels, the VBP arrangement is counted as a Level 1 arrangement.

Level 3: Prospective Payments (PMPM or Bundled Payments)

Level 3 arrangements are fully capitated PMPM arrangements or prospectively paid bundles. The presence of risk-mitigation strategies (stop-loss, risk-corridors etc.) does not affect the Level 3 classification.

The difference between Level 2 and Level 3 is the way the payment is effectuated: continuation of current payment mechanisms (with or without additional payments for e.g. coordination activities that do not currently have an existing billing code) versus prepaid payment arrangements. In terms of assuming risk by the VBP contractor, a Level 2 arrangement can be equal to a Level 3 arrangement.

⁷⁷ For purposes of the NYS VBP program, the existing payment mechanisms referenced here include Diagnosis Related Groups and Enhanced Ambulatory Patient Groups.

⁷⁸ For Level 2, certain situations may warrant a lower cap, as in the case of an Integrated Primary Care arrangement or Chronic Care Bundles where the VBP contractor may be PCPs or FQHCs or other providers with an operating budget that may be significantly smaller than the total downstream costs they are held to account for. In those cases, the cap set should be proportional to the overall budget of the PCP / FQHC. Minimally, for PCPs or FQHCs engaged in Level 2 IPC or Chronic Care arrangements that have received shared savings in year t should be able to lose the same amount of dollars in year t+1.

⁷⁹ VBP contractors may re-insure against potential losses, which will not affect the categorization as Level 2 as long as the costs for that re-insurance are born by the VBP contractor. (I.e. if the MCO pays for the re-insurance, that will be interpreted as reducing the risk born by the VBP contractor and may thus prevent the VBP arrangements to be classified as Level 2.)



Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

REPORT TO CONGRESS

DECEMBER 2014

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The Center for Medicare and Medicaid Innovation

REPORT TO CONGRESS

1. Executive Summary

The Center for Medicare and Medicaid Innovation (referred to herein as “the CMS Innovation Center”) was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures... while preserving or enhancing the quality of care” provided to those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. The CMS Innovation Center’s mandate gives it flexibility within the parameters of section 1115A to select and test the most promising innovative payment and service delivery models. Section 1115A provides a total of \$10 billion in direct funding for these purposes over the fiscal years 2011 through 2019.

Section 1115A requires the Secretary of the Department of Health and Human Services to submit to Congress a report on the CMS Innovation Center’s activities under section 1115A at least once every other year beginning in 2012. This is the second report to Congress, and it focuses on activities between November 1, 2012 and September 30, 2014. As of September 30, 2014, the CMS Innovation Center has launched 22 payment and service delivery initiatives under section 1115A authority (Appendix).¹ There has been significant interest in these initiatives and a high level of public and provider engagement.

The CMS Innovation Center’s portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serves Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. We estimate that over 2.5 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by the more than 60,000 providers participating in CMS Innovation Center payment and service delivery models. Beyond the impact for these beneficiaries, CMS Innovation Center models are impacting tens of millions of additional Americans by engaging thousands of other providers, payers, and states in model tests and through quality improvement efforts that extend across the country. As required by section 1115A, these models are expected to reduce program expenditures in Medicare, Medicaid, and CHIP, while preserving or enhancing the quality of care received by beneficiaries.

Since its inception in 2010, the CMS Innovation Center has partnered with stakeholders across the country, other federal agencies, and Centers for Medicare & Medicaid Services

¹ This number includes only activities that are considered payment or delivery system initiatives. Bundled Payments for Care Improvement represents four separate models; Health Care Innovation Awards and State Innovation Models are each considered two separate models. Million Hearts®, Strong Start Strategy One, and the Innovation Accelerator are not included in this count.

(CMS) components, including the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Financial Alignment Initiative), the Office of Financial Management (for the Prior Authorization models), and the Center for Clinical Standards and Quality (for the Partnership for Patients), to enable our health system to achieve better health, improved care, and lower costs.

CMS Innovation Center models have supported providers and health care organizations in the testing of alternative care delivery and payment models. These models focus on three core strategies for improving our health system: improving the way providers are paid, improving the way care is delivered, and increasing the availability of information to guide decision-making. Several of the models being tested include other payers in order to align financial incentives across payers when possible. The participation of multiple payers in alternative delivery and payment models increases support for delivery system transformation and encourages efficiencies for health care organizations.

Rates of some hospital-acquired conditions and hospital readmission rates have declined meaningfully. These improvements reflect policies and an unprecedented public-private collaboration made possible by the Affordable Care Act. Two of the first models launched by the CMS Innovation Center, Pioneer Accountable Care Organizations and Partnership for Patients, have released early findings showing favorable impacts on cost and quality. These findings are detailed later in this report.

This report conforms to the requirements of section 1115A and describes the models launched under this authority. Any legislative recommendations related to CMS programs, including the CMS Innovation Center, would typically be included in the President's budget request.

2. Introduction

The CMS Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. The statute provided the Secretary of the Department of Health and Human Services (HHS) with the authority under section 1115A(c) to expand through rulemaking the duration and scope of a model being tested or a demonstration project under section 1866C, including implementation on a nationwide basis. In order for the Secretary to exercise this authority, an expansion must either reduce spending without reducing quality of care or improve quality of care without increasing spending, CMS’ Chief Actuary must certify that expansion of the model would reduce (or not increase) net program spending, and the model must not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP. The Secretary’s expansion determinations are made based on evaluations performed by CMS under section 1115A(b)(4).

The law also requires that the Secretary terminate or modify models tested under section 1115A, at any time after testing has begun and before completion, unless the Secretary determines that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing quality of care, or improve quality of care and reduce spending. The CMS Chief Actuary must make a certification in support of the Secretary’s determinations with respect to spending.

The CMS Innovation Center is organized to support the development and testing of new payment and service delivery models, as well as to support demonstrations and other projects. To better coordinate these models and demonstration projects and to avoid duplication of effort and expense, the former Office of Research, Development and Information was merged with the CMS Innovation Center in early 2011. As a result, the CMS Innovation Center oversees not only initiatives that are authorized under section 1115A, but also activities under several other authorities, including other provisions of the Affordable Care Act and other laws and certain projects authorized by section 402 of the Social Security Amendments of 1967 as amended. Managing these varied responsibilities as part of a single portfolio of activity allows for better coordination and more efficient operations. However, each demonstration or model is associated with its own funding stream, as appropriate. For example, demonstrations authorized by section 402 of the Social Security Amendments of 1967 as amended are not funded under section 1115A.

The CMS Innovation Center works directly with other CMS components and with colleagues throughout the federal government in developing and testing new payment and service delivery models. The CMS Innovation Center has partnered with the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Financial Alignment Initiative), the Office of Financial Management (for the Prior

Authorization Models), and the Center for Clinical Standards and Quality (for Partnership for Patients) for the joint development and administration of these models. Other CMS components, and other federal agencies such as the Centers for Disease Control and Prevention, Health Resources and Services Administration, Agency for Healthcare Research and Quality, Office of the National Coordinator of Health Information Technology, Administration for Community Living, Department of Housing and Urban Development, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration, have assisted in design and testing activities for multiple models. These collaborations help the CMS Innovation Center effectively test new models and execute mandated demonstrations.

CMS Innovation Center Priorities: 2011 - 2014

CMS published a Statement of Organization, Functions, and Delegations of Authority for the CMS Innovation Center in the November 17, 2010 *Federal Register* (75 FR 70274). Since that time, the CMS Innovation Center has focused on four main priorities as it carries out its statutory responsibilities:

- a. testing new payment and service delivery models,
- b. conducting congressionally mandated or authorized demonstrations and related activities,
- c. evaluating results and advancing best practices, and
- d. engaging stakeholders.

a. Testing New Payment and Service Delivery Models

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A and in consideration of the opportunities and factors set forth in section 1115A(b)(2) of the Act. During the development of models, the CMS Innovation Center builds on ideas received from stakeholders and consults with clinical and analytical experts, as well as with representatives of relevant federal and state agencies. For example, as is typical in other projects, during the development, announcement, and solicitation phases of the Comprehensive End-Stage Renal Disease (ESRD) Care Model, the CMS Innovation Center

- held open door phone calls with small dialysis organizations, large dialysis organizations, nephrologists, ESRD advocacy groups, and other interested stakeholders;
- consulted with representatives from other federal agencies,
- assembled and consulted a technical expert panel;
- staged webinars on the Request for Application, Building Effective Partnerships, and Making the Accountable Care Organization Business Case; and
- posted proposed quality measures for public consideration and comment.

The CMS Innovation Center solicits organizations to participate in model tests through an open process that includes competitive Funding Opportunity Announcements and Requests for Applications. The selection process follows established protocols to ensure that it is fair and transparent, provides opportunities for potential partners to ask questions regarding the CMS Innovation Center's expectations, and takes into account stakeholder input to inform selection of the most qualified partners. The CMS Innovation Center does not fund unsolicited proposals, but does use ideas from partners and stakeholders to inform model development.

b. Conducting Congressionally Mandated or Authorized Demonstrations and Related Activities

The CMS Innovation Center has taken on responsibility for implementing a number of specific demonstration projects authorized and funded by statute. For example, the Independence at Home Demonstration was authorized by section 3024 of the Affordable Care Act and the Medicaid Emergency Psychiatric Demonstration was authorized by section 2707 of the Affordable Care Act. The findings from these demonstrations will inform possible changes in health care payment and policy, as well as the development and testing of new models, if appropriate.

The CMS Innovation Center has managed 20 demonstrations authorized by statute (in addition to the 22 authorized under section 1115A authority) during the period between November 1, 2012 and September 30, 2014. A list of all demonstrations active during this time period is included in the Appendix.

c. Evaluating Results and Advancing Best Practices

Section 1115A(b)(4) requires the CMS Innovation Center to conduct an evaluation of each new model. Section 1115A(b)(4) also specifies that each evaluation must include an analysis of the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria, as well as changes in spending. As noted above, the Secretary shall take the evaluation into account in decisions to expand the duration and scope of a model or demonstration project under section 1866C.

The CMS Innovation Center's Research and Rapid Cycle Evaluation Group assesses routinely and rigorously the impact of each model on quality and cost. To evaluate models, the evaluation group employs advanced statistical methods and carefully defines and selects comparison groups, as appropriate, to ensure that programs deemed to be successful represent high-value investments of taxpayer dollars.

Central to this evaluation approach is the recognition that evaluators must not only assess results, but also understand the context that allows for those results. For each model, the CMS Innovation Center collects qualitative information about provider practices, organizational characteristics, and their systems of practice. This information also includes participants' perceptions regarding the opportunities and challenges they have faced and their experiences in addressing them. These data are merged with performance metrics to allow evaluators to assess which features of interventions are associated with

successful outcomes. The CMS Innovation Center also provides data to states to help its state partners monitor outcomes and facilitate care coordination for Medicare-Medicaid enrollees.

Learning and adaptation are essential to enable providers and health systems to achieve the greatest efficiencies and improvements possible in each new model. In addition to the rigorous evaluation of the impact of each model on outcomes of interest, the CMS Innovation Center supports continuous quality improvement by providing frequent feedback to model participants. The CMS Innovation Center leverages claims data to deliver actionable feedback to providers about their performance and encourages participating providers to use their own performance data to drive continuous improvement in their outcomes.

Every test of a new service delivery or payment model developed by the CMS Innovation Center also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible to support improvement for both public programs and the health care system at large. The CMS Innovation Center has created learning collaboratives for providers in our models that promote broad and rapid dissemination of evidence-based best practices that have the potential to deliver higher quality and lower cost care for Medicare, Medicaid, and CHIP beneficiaries.

d. Engaging Stakeholders

Since its inception, the CMS Innovation Center has actively sought input from a broad array of stakeholders across the country to identify promising new payment and delivery models. The CMS Innovation Center has held regional meetings and frequent “listening sessions,” engaging thousands of innovators from around the country. In addition, hundreds of ideas for improving health care have been shared through the CMS Innovation Center website. The result is a growing portfolio of innovative payment and service delivery models.

The CMS Innovation Center invites input in the design of individual models using vehicles that are open to all stakeholders, including Requests for Information (RFI), surveys, and “open door” phone conferences. Guidance from leading authorities is also sought through interviews, consultation, and technical evaluation panels.

Requests for Information and comments issued in the past two years:

From 2013 to 2014, the CMS Innovation Center issued four RFIs seeking input from stakeholders on possible models and initiatives under consideration. Information collected through these RFIs may be used to test new payment and service delivery models. CMS also requested comments on a model through the CY 2015 proposed rule for the Medicare Home Health Prospective Payment System.

Accountable Care Organizations (ACOs)

On December 20, 2013, the CMS Innovation Center issued an RFI to obtain input on policy considerations for the next generation of ACO initiatives. Topics of particular

interest included approaches for increasing participation in the current Pioneer ACO model through a second round of applications, and suggestions for new ACO models that encourage greater care integration and financial accountability. The submission period for the RFI concluded on March 1, 2014.

Specialty Practitioner Payment Model Opportunities

On February 11, 2014, the CMS Innovation Center issued an RFI seeking information in relation to the development of models that will focus on specific diseases, patient populations, and specialty practitioners in the outpatient setting to incentivize improved care, better health, and lower costs. The submission period for the RFI concluded April 10, 2014.

Transforming Clinical Practice Initiative

On March 5, 2014, the CMS Innovation center issued an RFI to obtain input on policy considerations related to large-scale transformation of clinician practices to accomplish the aims of better care and better health at lower costs. The submission period for the RFI concluded on April 8, 2014. The CMS Innovation Center has used this input in the design and development of an initiative supporting large-scale transformation of clinical practices and, as of September 30, 2014, anticipates the release of a Funding Opportunity Announcement.

Beneficiary Engagement Model Opportunities

On August 15, 2014, the CMS Innovation Center issued an RFI to seek input from stakeholders on the possibility of testing innovative models to increase the engagement of Medicare beneficiaries, Medicaid beneficiaries, Medicare-Medicaid enrollees, and/or CHIP beneficiaries in their health and health care. The submission period for the RFI concluded on September 22, 2014.

Home Health Value-Based Purchasing

In the CY 2015 proposed rule for the Home Health Prospective Payment System issued in July 2014 (79 FR 38408-38409), CMS requested comments regarding a possible Home Health Agency Value-Based Purchasing (HHA VBP) model that would build on other related demonstrations and programs, including the Hospital Value-Based Purchasing (HVBP) program.² The model presents an opportunity to test whether larger incentives than have been previously tested will lead to even greater improvement in the quality of care furnished to beneficiaries. CMS will consider the comments it received as it makes further decisions about implementing an HHA VBP model in CY 2016. If CMS decides to move forward with the implementation of an HHA VBP model in CY 2016, it intends to invite additional comments on a more detailed model proposal to be included in future rulemaking.

² The Medicare Home Health Prospective Payment System final rule released in October 2014 summarizes these comments (79 FR 66105-66106)

RFIs Under Consideration

In April 2014, the Advance Notice of Methodological Changes for CY 2015 Call Letter signaled CMS' interest in partnering with private payers to test innovations in health plan design for CMS beneficiaries, including but not limited to value-based arrangements, beneficiary engagement and incentives, and/or care coordination. The Call Letter also indicated CMS' intent to issue a formal RFI in the coming months.

Stakeholder solicitations and communications:

In addition, the CMS Innovation Center has conducted hundreds of interviews and consultations with technical experts and leading providers, payers, and researchers to learn from their innovations and experiences, and has held scores of webinars each year to announce and explain initiatives and increase stakeholder engagement.

In designing the Comprehensive Primary Care initiative, for example, the CMS Innovation Center solicited input from numerous provider organizations, primary care thought leaders, payers, and advocacy groups. In the design of the Medicare Care Choices Model, CMS held an open door call for providers, beneficiary advocacy groups, and other interested parties and engaged stakeholders from the National Hospice and Palliative Care Organization and representatives from leading palliative care programs.

The CMS Innovation Center interacts with people across the country interested in service delivery and payment innovation through its website, social media outreach, and an e-mail listserv. Since 2012, the listserv audience has grown from 30,000 to over 55,000 and Twitter followers have increased from 5,000 to 16,000. The CMS Innovation Center website and listserv continually update innovators in the field on new funding and learning opportunities. The site includes search-driven interactive maps that allow state-level views of organizations participating in CMS Innovation Center models.

The CMS Innovation Center has also developed an online network that supports collaboration among awardees, grant recipients, and other CMS Innovation Center partners. The site allows CMS Innovation Center partners to share documents and tools and to interact online. The network is used by participants in various CMS Innovation Center models, including Accountable Care Organizations, the Comprehensive Primary Care initiative, and the Health Care Innovation Awards. There are currently 8,000 registered users and more than 50 active affinity groups collaborating on improvement activities on topics such as pediatric asthma, community health workers, and the care of complex patients. The site is a key tool in the CMS Innovation Center's efforts to capture and disseminate lessons learned to accelerate the spread of innovations that enhance care, improve health, and lower costs.

3. Review of CMS Innovation Center Activities

During the past 4 years, the CMS Innovation Center has launched 22 new payment and service delivery initiatives aimed at reducing expenditures under Medicare, Medicaid, and CHIP and enhancing the quality of care that beneficiaries receive. Collectively these initiatives are providing services to Medicare, Medicaid, and/or CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. The CMS Innovation Center's portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders.

The CMS Innovation Center estimates that over 2.5 million beneficiaries are or soon will be receiving care furnished by the more than 60,000 providers participating in these CMS Innovation Center models. Millions of additional Americans are or will be receiving care from the CMS Innovation Center's models through multi-payer model tests such as the Comprehensive Primary Care initiative, the Pioneer ACOs, and the Health Care Innovation Awards, and through quality improvement initiatives like Partnership for Patients and Million Hearts[®]. These other engagements also reach thousands of other health care providers. Comprehensive state health care transformation efforts driven by the State Innovation Models (SIM) initiative are affecting a steadily increasing percentage of providers nationwide. The states engaged in SIM represent over half of the U.S. population.

Model participants and partners include a broad cross section of health care providers, health organizations and systems, state and local governmental entities, academic institutions, and nonprofit and community organizations engaged in health system transformation. CMS Innovation Center models are testing approaches to improve outcomes and lower costs across the care continuum from prenatal to palliative care and from acute care to community settings. Under each CMS Innovation Center model, beneficiaries retain access to their regular Medicare, Medicaid, and CHIP benefits and the right to select the providers and services of their choice.

CMS Innovation Center models focus on improving care delivery and on realigning financial incentives so they reward providers and provider organizations who deliver better care at lower cost. These models also offer providers the financial support, skills, and information they need to improve the care of individual beneficiaries and the health of populations. The CMS Innovation Center has engaged private and other governmental payers in testing new care delivery and payment models. CMS Innovation Center models also support delivery system transformation at the state level.

The initiatives highlighted in this section include only models authorized and funded by section 1115A of the Social Security Act.³ However, the CMS Innovation Center will implement and thoroughly evaluate both the section 1115A models and initiatives authorized under other authorities to determine their impact on quality and costs. A table

³ Million Hearts is authorized by section 1115A of the Social Security Act, but has not received direct funding from the CMS Innovation Center.

identifying all of the activities under the purview of the CMS Innovation Center and their specific statutory authority is provided in the Appendix.

CMS Innovation Center initiatives are grouped into the following categories:

- Primary Care Transformation,
- Accountable Care ,
- Bundled Payments for Care Improvement,
- Initiatives Focused on Medicaid and CHIP Populations,
- Initiatives Focused on Medicare-Medicaid Enrollees,
- Initiatives to Speed the Adoption of Best Practices, and
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models.

Primary Care Transformation

Primary care serves as an entry point and coordinating mechanism for many patients, including those with chronic illness. Achieving better outcomes and lower costs across the health care system requires more efficient and effective models for delivering and paying for primary care. New approaches, including enhanced primary care and the patient-centered medical home, are expanding the capacities needed to allow primary care to manage the health of populations, to coordinate care, and to integrate health information technology within the practice. Under its section 1115A authority, the CMS Innovation Center is testing two primary care transformation models employing these new approaches: the Comprehensive Primary Care initiative and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration.

Comprehensive Primary Care Initiative

The Comprehensive Primary Care (CPC) initiative is a multi-payer collaboration between public and private health care payers to strengthen primary care. As of September 30, 2014, 2,528 providers are serving an estimated 396,000 Medicare beneficiaries at 483 practice sites. Of the initially selected 502 practices, 96 percent continued into the second year of the model, a highly favorable persistency rate. The CPC practice sites are distributed across seven regional or statewide markets:

- Arkansas: statewide
- Colorado: statewide
- New Jersey: statewide
- New York: Capital District-Hudson Valley Region
- Ohio/Kentucky: Cincinnati-Dayton Region
- Oklahoma: Greater Tulsa Region
- Oregon: statewide

The CPC model period of performance began in October 2012 and will end in December 2016. The CPC initiative tests whether multi-payer participation in a payment model

encompassing upfront care management fees and potential shared savings can result in primary care practices delivering better care.

The initiative includes both a new delivery and a new payment model designed to support improved care, better health for populations, and lower costs through the provision of a core set of five “comprehensive” primary care functions. The functions are: 1) risk-stratified care management; 2) access and continuity; 3) planned care for chronic conditions and preventive care; 4) patient and caregiver engagement; and 5) coordination of care across the medical neighborhood. The initiative is testing whether these functions, coupled with payment reform, the use of data to guide improvement, and meaningful use of health information technology, can achieve better care, improved health, and reduced costs and can inform future Medicare and Medicaid policy.

The seven CPC regions were chosen after soliciting interest from payers nationally. Regions with the highest collective market penetration of payers willing to align their payment models to support the five CPC functions were selected. The seven regions encompass 38 public and private payers spanning commercial, Medicare Advantage, Medicaid managed care, and Third Party Administrator/Administrator Services Only lines of business, as well as four state fee-for-service (FFS) Medicaid agencies (Arkansas, Colorado, Ohio, and Oregon). The CMS Innovation Center is funding the enhanced payment models offered by state FFS Medicaid agencies. Other CPC payers receive no payment from the CMS Innovation Center for participation in the model.

CPC practices were selected through a competitive process in each designated region. Participating practices receive a monthly care management fee for each Medicare FFS beneficiary and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary. Practices also receive monthly fees from other participating CPC payers and are expected to combine CPC revenues across payers to develop a whole-practice transformation strategy.

The CMS Innovation Center guides development of the five CPC functions through a framework of Milestones, including the provision of care management for high-risk patients, 24/7 access to medical records, assessment and improvement of patient experience of care, the use of data to guide improvement, and improvement in patient shared decision-making capacity. CPC aligns with the Office of the National Coordinator of Health Information Technology (ONC) by requiring providers to achieve Meaningful Use standards and to use ONC-certified electronic health records in their quality measurement and improvement activities. Practices routinely report their progress through a web portal. The CMS Innovation Center supports practices in attaining the CPC Milestones through national and regional learning networks, online collaboration opportunities, and access to local academic and clinical faculty under contract with CMS, who provide hands-on assistance. To support learning across payers, the CMS Innovation Center convenes CPC payers on both a regional and national basis to review and discuss data, trends, and strategies for improvement.

The evaluation plan for the Comprehensive Primary Care initiative has been designed to provide a robust assessment of implementation and impacts using mixed-methods techniques. The evaluation will use site visits, key informant interviews, observations of technical assistance, surveys, and program data to establish how the intervention was implemented and received. Building on this analysis, the evaluation will use additional survey data and administrative claims to analyze the intervention's impact on beneficiaries and the primary care workforce. Key outcome and quality measures will include total Medicare and Medicaid expenditures per beneficiary, hospitalization rates, emergency department visit rates, claims-based process of care outcomes, readmission rates, beneficiary experience of care, and beneficiary health-related quality of life. These analyses will be performed at the program and regional level, looking at both the entire beneficiary population attributed, as well as key subgroups, such as Medicare-Medicaid enrollees. Finally, the impact and implementation analyses will be synthesized to attempt to identify the key factors that drive positive impacts.

Federally Qualified Health Center Advanced Primary Care Practice Demonstration

The Federally Qualified Health Center Advanced Primary Care Practice Demonstration (FQHC APCP) tests both the feasibility of incentivizing the adoption of National Committee of Quality Assurance (NCQA) Level 3 Patient Centered Medical Home (PCMH) standards within FQHCs and whether the application of these standards ultimately improves quality of care and reduces costs for Medicare beneficiaries. As of May 2014, FQHCs operating under the demonstration had provided services to more than 207,000 Medicare FFS beneficiaries and had received approximately \$45 million in care management fees from CMS. CMS collaborates with the Health Resources and Services Administration to assist participating FQHCs in achieving Level 3 NCQA recognition as a PCMH. 73 percent of FQHCs participating in the demonstration have achieved NCQA Level 3 PCMH recognition, with large increases in final quarters. The demonstration is a 3-year model that began on November 1, 2011 and concludes on October 31, 2014. The original goal was to have 90 percent of participating FQHCs achieve PCMH recognition by the end of the demonstration.

A PCMH is a patient-centered or community-centered model of primary care that delivers accessible, comprehensive, and coordinated care using a systems-based approach to quality and safety. FQHCs that have achieved PCMH recognition provide enhanced services to patients through the following:

- team-based care that maximizes efficiency and quality,
- improved access to care that both attracts new patients and retains current patients,
- use of Electronic Health Record systems to facilitate the coordination and continuity of care,
- a systematic approach to medication management and reconciliation with the goal of reducing adverse drug events and unnecessary readmissions,
- adherence to documented policies and evidenced-based procedures to ensure quality, and
- improved staff retention to prevent practice disruption.

The goals of the FQHC evaluation are to assess the impact of the demonstration on FQHCs' attainment of NCQA Level 3 PCMH recognition, to determine whether the rate of PCMH recognition accelerated under the model, and to assess whether there were resulting improvements on a range of quality, utilization, and cost outcomes for Medicare beneficiaries seeking care at demonstration FQHCs. The evaluation will also examine the impact of the model on beneficiary experience. The final evaluation report will include analyses based on linked Medicare data files and the use of beneficiary-level information to assess impact on quality, utilization, and spending.

Accountable Care

The CMS Innovation Center is currently testing three Accountable Care Organization (ACO) models: the Pioneer ACO, Advance Payment ACO, and Comprehensive End Stage Renal Disease Care Model. These models were developed to incentivize health care providers to become accountable for the quality and cost of care for an entire patient population and to invest in infrastructure and redesigned care processes that achieve high-quality and efficient service delivery.

Pioneer ACO Model

The Pioneer Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. The Pioneer ACO Model was launched in 2012 with 32 ACOs. Organizations agree to an initial 3-year performance period with the option to extend for 2 additional option years. At present, 19 Pioneer ACOs are participating and plan to enter their fourth performance year in 2015. Of those Pioneer ACOs that made the decision to exit the model, each organization did so based on its particular business priorities and concerns. Three of the withdrawing organizations generated shared losses. Other Pioneer ACOs that generated losses made the decision to remain in the model and a number of others transitioned into the Medicare Shared Savings Program to continue healthcare transformation with a slower transition to downside risk. More than 625,000 Medicare beneficiaries are aligned to Pioneer ACOs. The model has reported favorable results on both cost and quality measures for its first 2 performance years. It is scheduled to end in February 2017.

The model tests payment arrangements that hold providers accountable for cost, quality, and patient experience outcomes for a defined population of beneficiaries. It uses a shared savings payment methodology with generally higher levels of shared savings and risk than levels currently in use in the Medicare Shared Savings Program and is assessing the ability of hospital and physician organizations experienced in care and risk management to achieve savings for Medicare while sustaining or improving the quality of care for beneficiaries. Pioneer ACOs that demonstrated savings during the first 2 performance years and met other criteria are able to transition to a monthly population-based payment starting in performance year 3. The performance of Pioneer ACOs on both financial and quality metrics, including patient experience ratings, is publicly reported by CMS.

On July 16, 2013, CMS announced positive results indicating higher quality of care from the first performance year of the Pioneer ACO Model

(<http://innovation.cms.gov/Files/x/PioneerACOqualmsrpy1.pdf>). Financial results, including lower Medicare expenditures, were discussed in a subsequently released report (<http://innovation.cms.gov/files/reports/pioneeracoevalreport1.pdf>).

Quality of Care and Patient Experience:

- All 32 Pioneer ACOs that participated in the first year achieved the maximum reporting rate in their first year and eligible professionals participating in the ACOs earned incentive payments for successfully reporting quality measures. Overall, Pioneer ACOs performed better than comparable providers in Medicare FFS on all 15 clinical quality measures for which comparable data are available.

Medicare Expenditures and Savings:

- Pioneer ACOs generated total program savings of \$87 million in their first year of operation with savings to the Medicare Trust Funds of nearly \$33 million.
- According to an independent evaluation, on average, Medicare spending per beneficiary per month was about \$20 less than if beneficiaries had not been aligned with an ACO in their market.
- 13 Pioneer ACOs earned shared savings and one generated shared losses which were paid to CMS. The rest of the Pioneer ACOs generated neither savings nor losses.

After the first performance year, nine ACOs withdrew from the model. Of those nine ACOs, seven transitioned to the Medicare Shared Savings Program and their organizations continue to invest in care delivery and intervention strategies for accountable care.

Preliminary results for the second performance year of the Pioneer ACO Model were released on September 16, 2014

(<http://innovation.cms.gov/Files/x/PioneerACOqualmsrpy2.pdf>, <http://innovation.cms.gov/Files/x/PioneerACO-FncI-PY1PY2.pdf>) and showed higher quality of care and lower Medicare expenditures.

Quality of Care and Patient Experience:

- The mean quality score among Pioneer ACOs increased from 71.8 percent in 2012 to 85.2 percent in 2013.
- The organizations showed improvements over 2012 in 28 of the 33 quality measures and experienced average improvements of 14.8 percent across all quality measures. These measures included screening for future fall risk, screening for tobacco use and cessation, patient experience in health promotion and education, and controlling high blood pressure.

The Pioneer ACOs improved the average performance score for patient and caregiver experience in six out of seven measures compared with 2012. These results suggest that Medicare beneficiaries who obtain care from a provider participating in Pioneer ACOs report a positive patient and caregiver experience.

Medicare Expenditures and Savings:

- In the second performance year, there were 23 Pioneer ACOs. During the second performance year, Pioneer ACOs generated estimated total model savings of over \$96 million and savings to the Medicare Trust Funds of approximately \$41 million. Model savings and other financial results are based on preliminary results and are subject to revision.
- Pioneer ACOs achieved lower per capita growth in spending for the Medicare program at 1.4 percent, which is about 0.45 percent lower than Medicare FFS per capita growth.
- 11 Pioneer ACOs earned shared savings, three generated shared losses, and three elected to defer reconciliation until after the completion of performance year three. The remaining six Pioneer ACOs did not earn shared savings or generate losses.

Four Pioneer ACOs withdrew from the model after the second performance year. Of the Pioneer ACOs that withdrew, two are transitioning into the Medicare Shared Savings program.

While it is too early to draw conclusions about the success of the Pioneer ACO Model in its ability to improve beneficiary quality and reduce Medicare costs, several insights have begun to emerge. ACOs that showed savings more often had higher expenditures than their local markets in the year before the model began. In addition, ACOs with diverse organizational arrangements and incentive structures for physicians achieved savings in the first 2 years, suggesting that many different types of ACOs are capable of high performance. An independent evaluation for the first 2 performance years is being undertaken.

Advance Payment ACO Model

In the Medicare Shared Savings Program, groups of providers and suppliers meeting criteria specified by the Secretary may form ACOs to improve care management for beneficiaries. ACOs participating in the Advance Payment Model receive an upfront payment and ongoing monthly payments which they can use to make important investments in their care management infrastructure. The Advance Payment ACO Model is testing whether pre-paying a portion of future shared savings allows more entities to participate successfully in the Medicare Shared Savings Program and generate savings for Medicare.

The Advance Payment ACO Model was designed to help entities such as smaller ACOs with less access to capital participate in the Medicare Shared Savings Program, in which ACOs are eligible to share in savings as long as they meet or exceed quality and financial

performance standards. The CMS Innovation Center developed the Advance Payment ACO Model in response to input received from stakeholders on the proposed rule for the Shared Savings Program and comments received on its initial Funding Opportunity Announcement in May 2010. There are currently 35 Advance Payment ACOs encompassing a total of 301,000 aligned Medicare beneficiaries. Five ACOs began participation in April 2012, 15 joined in July 2012, and 16 more were added in January 2013. All but one of these ACOs, which voluntarily terminated because of an organizational buyout, are still in the Advance Payment Model and will complete their initial period of performance in the Medicare Shared Savings Program on December 31, 2015. All Advance Payment ACOs had a minimum 3-year performance period and early starters had additional months in their first performance “year”.

Advance payments are structured to acknowledge that new ACOs will have both fixed and variable start-up costs. ACOs receive three types of advance payments during their agreement period:

- *An upfront, fixed payment:* each ACO receives a fixed payment.
- *An upfront, variable payment:* each ACO receives a payment based on the number of beneficiaries prospectively assigned to it on a preliminary basis.
- *A monthly payment of varying amounts depending on the size of the ACO:* each ACO receives a monthly payment based on the number of beneficiaries prospectively assigned to it on a preliminary basis.

The Medicare Shared Savings Program has released financial and quality data for the first performance year (<https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt>). Nine Advance Payment ACOs earned gross savings. Eight of the nine Advance Payment ACOs that earned gross savings successfully reported quality data and earned shared savings sufficient to fully repay the funds received from the Advance Payment Model. Overall, 33 of the 36 Advance Payment ACOs submitted quality data. Results showing year-over-year performance on financial and quality measures will be reported after completion of the second performance year.

As of June 2014, the Advance Payment Model completed its disbursement of advance payments to participating ACOs. The model will continue to provide trainings and forums for Advance Payment ACOs to identify and share best practices and lessons learned that will contribute to their success until the model ends on December 31, 2015.

Comprehensive End Stage Renal Disease Care Model

The purpose of the Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model is to improve outcomes for Medicare beneficiaries with ESRD and reduce per capita Medicare expenditures. Under the CEC Model, CMS will partner with ESRD Seamless Care Organizations (ESCOs)—accountable care collaborations of dialysis facilities, nephrologists, and other providers and suppliers—to address the needs of beneficiaries with ESRD and complex medical needs.

The Request for Applications to participate in the CEC Model was issued in the spring of 2014 and included two application rounds. The first application round for ESCOs

included Large Dialysis Organizations (LDOs), defined as organizations with more than 200 dialysis facilities, closed in June 2014. It is expected that these LDO ESCOs will begin their initial 3-year period of performance in July 2015. The second application round for ESCOs focused on non-LDOs; it closed in September 2014. The 3-year period of performance for these non-LDO ESCOs is also expected to begin in July 2015. An additional 2 performance years may be offered, subject in part to the ESCOs meeting financial and quality performance targets.

The CMS Innovation Center expects a total of 10 to 15 unique ESCOs to participate in the CEC Model, with broad representation from dialysis facilities, and geographic areas. An ESCO is required to have a minimum of 350 matched beneficiaries to qualify for the model. Medicare beneficiaries will be prospectively matched to the ESCO if they meet the eligibility requirements and receive dialysis services from a dialysis facility participating in the ESCO. The model will be implemented as a 3-year agreement with 2 option years for each ESCO, contingent on performance.

This model is based on the hypothesis that appropriately aligned financial incentives will encourage providers to work together and improve care coordination for ESRD beneficiaries, resulting in improved health, better health care, and lower expenditures. Specifically, the CMS Innovation Center is testing whether this model will:

- improve key care processes such as chronic disease management;
- improve clinical outcomes, including transplantation rates, mortality rates, and disease complications;
- improve beneficiary experiences of care, quality of life, and functional status;
- improve management of care transitions;
- reduce excess utilization of services such as emergency department visits; hospitalizations, and readmissions; and
- reduce total Medicare Parts A and B per capita expenditures.

The core operational elements of the model are:

- respect for Medicare FFS beneficiaries' freedom to continue to seek the services and providers of their choice;
- selection of a diverse group of ESCOs willing to commit to transformation of their business and care delivery models;
- payment arrangements that, over time, escalate the degree of the ESCO's financial accountability;
- standardized quality performance metrics and other parameters across ESCOs to allow for rigorous evaluation;
- provision of monthly and quarterly data reports to ESCOs for purposes of supporting care improvement;
- strong beneficiary protections and comprehensive and frequent monitoring;
- formative and summative evaluation; and
- shared learning that is continuous and data-driven.

The quality measure set for the CEC Model was developed in collaboration with CMS Innovation Center partners with input from stakeholders. The CMS Innovation Center developed its approach working with the Center for Clinical Standards and Quality and with the input of the CMS Quality Measures Taskforce. A preliminary set of measures was reviewed and evaluated by a Technical Expert Panel and released for Public Comment in February 2014. The measure set will be made available to participants in November 2014.

The CMS Innovation Center will closely monitor the utilization of services for beneficiaries through data analysis and the use of audits and other actions as necessary. Beneficiaries will be surveyed each year to assess their experience with the model.

The evaluation for the CEC Model will identify comparison groups and assess the impact of the initiative on the quality of care, health outcomes, and Medicare expenditures of beneficiaries with ESRD. The evaluator will perform rigorous quantitative analysis of claims, clinical, and survey data to determine if the CEC Model resulted in improvements in care, health outcomes and cost. The evaluation will also include qualitative analyses to capture participant, provider, and beneficiary perceptions, key success factors, and lessons learned.

Bundled Payments for Care Improvement

The Bundled Payments for Care Improvement (BPCI) initiative was announced in August 2011. Currently, it tests four models for bundling payment for acute and/or post-acute care by episode of care. The four models offer participating organizations options for the clinical conditions to be tested, the length and composition of an episode, and the level of financial risk. The initiative is projected to serve 130,000 Medicare beneficiaries.

The four BPCI models are the following:

Retrospective Acute Care Hospital Stay Only (Model 1): Under this model, the episode of care is the acute inpatient stay. Hospitals are permitted to “gainshare” savings from coordinating and improving care, if quality targets and certain other conditions are met. All Medicare FFS beneficiaries admitted to a participating acute care hospital initiate an episode regardless of the Medicare Severity Diagnosis Related Group (MS-DRG). Beginning 6 months after the start of the performance period, Medicare pays a discounted amount based on payment rates established under the Inpatient Prospective Payment System.

Retrospective Acute Care Hospital Stay Plus Post-Acute Care (Model 2): This model extends the episode of care beyond the acute care inpatient hospitalization to include care in a post-acute period that is clinically related to the hospitalization. The episode of care is specific to the clinical condition being treated; each beneficiary who is assigned a selected MS-DRG will initiate an episode. The episode includes services furnished by the hospital, physicians, and post-acute care providers as well as other Medicare-covered items and services furnished during the inpatient hospital

stay and during the post-acute period following discharge. Awardees must offer Medicare a discount based on the episode's historical cost, which is used to determine a target price for the episode.

After the episode of care concludes, the aggregate Medicare FFS expenditures for items and services included in the episode are reconciled against the predetermined target price for the episode. If aggregate Medicare FFS expenditures are less than the target price, Medicare pays the difference to the awardee. Gains may be shared among participating providers if quality targets and certain other conditions are met. If aggregate Medicare FFS expenditures for items and services included in the episode exceed the target price, the awardee must repay Medicare. Medicare performs reconciliation for each performance quarter during which awardees bear risk in BPCI. Recent changes to the program have limited the range of awardee payments/repayments to +/- 20 percent of the sum of the target price and Medicare discount, aggregated across all episodes of care that initiate for the awardee in each performance quarter. In addition, Medicare waived the requirement to repay negative amounts at the episode initiator level for the fourth quarter of 2013 and all four quarters of 2014.

Retrospective Post-Acute Care (Model 3): Under this model, an episode of care consists of services furnished in a post-acute care period following an acute care inpatient hospitalization. The initial inpatient hospital stay is not included. The episode begins with the initiation of post-acute care services following discharge from an acute care hospital for selected MS-DRGs. The episode of care includes physician services, hospital readmissions, services furnished by post-acute care providers, and other Medicare-covered items and services during the episode. Awardees must offer Medicare a discount based on the episode's historical cost, which is used to determine a target price for the episode.

As with Model 2, after the episode concludes, the aggregate Medicare FFS expenditures for items and services included in the episode are reconciled against the predetermined target price for the episode, and gains may be shared if quality targets and other conditions are met.

Prospective Acute Care Inpatient Hospital Stay Only (Model 4): The episode of care in this model covers all acute care inpatient hospital and physician services provided during the hospital stay. It also includes all acute care hospital and physician services provided during clinically related readmissions for a period after an initial hospitalization for beneficiaries assigned the selected MS-DRGs. CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services and incorporates a discount. In most cases, physicians and other practitioners are not paid directly by Medicare for covered services furnished as part of the episode, but are paid directly by the hospital from the bundled payment. Participants are permitted to share gains derived from better coordination of care, provided quality targets and certain other conditions are met.

Models 1–3 are administered retrospectively with Medicare continuing to pay each provider participating in the episode under the applicable FFS payment system. Model 4 is administered prospectively with Medicare making a single bundled payment.

For Model 1, interested providers were invited to apply in late 2011. Selected providers began participation in April 2013. There was also an additional application period in mid-2013, which resulted in one additional provider joining the model in January 2014. In total, 14 hospitals are currently participating in Model 1.

For Models 2–4, the initial application period was in 2012, with additional open periods for new providers to join in late 2013 and early 2014. Subsequent submissions expanded the current BPCI participants and added new entities representing approximately 4,000 additional hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long term care hospitals, physician group practices, and convening organizations.

Models 2–4 are structured in two phases. Phase 1 is a preparation period, in which model participants receive additional data from CMS and prepare to assume financial risk. In Phase 2, entities that are offered an agreement by CMS fully participate in the model and bear financial risk. As of October 2014, 220 awardees, concentrated in Models 2 and 3, have shifted at least one episode to Phase 2 and begun a period of performance in BPCI. There are over 6,500 entities currently in the preparatory phase—Phase 1. These may enter the risk-bearing phase if offered an agreement with CMS. The transition period to the risk-bearing phase will conclude in October 2015. At that point, all episodes remaining in BPCI must be in Phase 2. The table below summarizes the entities by model type, entering Phase 2 as of October 2014.

Table 1: As of October 2014, bundled payment entities starting to assume risk.

BUNDLED PAYMENT ENTITIES STARTING TO ASSUME RISK		
<i>Data from October 2014</i>	Entities in Phase 1 (Preparatory Phase) Only	Entities Shifting at Least One Episode to Phase 2 (Risk Bearing Phase)
Model 2	2,046	117
Model 3	4,637	94
Model 4	8	9

Awardees that entered into agreements with the CMS Innovation Center between October 2013 and January 2014 have begun the risk-bearing phase for some or all of their episodes. In BPCI, the period of performance is at the episode level for 3 years. Awardees may move episodes into a period of performance on a quarterly basis, and not all episodes selected by an Awardee will have the same performance period.

Participating entities continue to receive significant technical and educational support, along with Medicare patient data to support successful transition to the risk bearing phase. Participants are monitored for adverse outcomes, including stinting of necessary patient care.

Each of the four bundled payment models will be rigorously evaluated for its impact on total cost and quality of care. The evaluation and monitoring plan for BPCI is designed to guide the implementation, monitoring, and summative evaluation of the initiative. The goals of the evaluation are to assess the initiative's impact on a range of quality, utilization, and cost outcomes. The evaluation will also examine the impact of the initiative on beneficiary experience including access to care and functional outcomes. The evaluation plan includes monitoring the implementation of the initiative to identify any unintended consequences, such as reduced quality and patient or cost shifting. Results will be examined during the period of time covered by the defined episode as well as within a more extended window to assess possible cost shifting and outcomes. Annual and quarterly reports will include analyses based on a combination of qualitative and quantitative sources including Medicare and Medicaid claims, patient surveys, awardee reports, interviews, and site visits.

Initiatives Focused on Medicaid and Children's Health Insurance Program Populations

Strong Start for Mothers and Newborns

The Strong Start for Mothers and Newborns initiative (Strong Start) was announced in February 2012 and is serving Medicaid and CHIP enrollees in sites across 20 states and the District of Columbia, and Puerto Rico. The initiative uses two complementary strategies to improve birth outcomes.

Strategy 1 builds on the work of Partnership for Patients (detailed later in this report) and tests a learning collaborative model to encourage the adoption of best practices to reduce early elective deliveries prior to 39 weeks.

Preterm birth—defined as a gestational age of less than 37 weeks—is a growing public health problem with significant health and financial consequences for families. Nationwide, approximately 12 percent of infants are preterm, a 36 percent increase over the last 20 years. Despite long-established evidence that delivery prior to full term (defined as 39 weeks to 40 weeks, 6 days) significantly increases the risk of complications, up to 15 percent of all babies are electively delivered prior to full term without medical indication. To address these risks, Strategy 1 uses three distinct activities: spreading best practices, increasing awareness, and promoting transparency.

To expedite the adoption of best practices that reduce early elective deliveries, Strong Start builds on the efforts and infrastructure of the Partnership for Patients initiative, including the engagement of nearly 4,000 participating institutions. The CMS Innovation Center has worked with the Partnership for Patients' 26 Hospital Engagement Networks to establish and report progress towards measurable goals for participating hospitals, and is providing technical assistance to implement proven strategies and practices for reducing early elective deliveries.

The CMS Innovation Center is also supporting broad-based awareness efforts for Strong Start through visible partnerships with leading organizations that share its goals, including the March of Dimes and the American Congress of Obstetricians and Gynecologists, as well as other professional and advocacy organizations. In addition to supporting industry efforts to develop and publish data on early elective deliveries, the Hospital Engagement Networks are reinforcing participating hospitals' efforts to collect data, measure success, and promote quality improvement and transparency. In May 2014 a reduction of 64.5 percent in early elective deliveries (using a standard Joint Commission measure) was announced (in conjunction with other improvements in Partnership for Patients measures), reflecting the collaborative efforts of providers, private sector organizations, and government toward the shared goal of improved birth outcomes.

Strategy 2 tests three enhanced prenatal care interventions to reduce preterm births for women covered by Medicaid or CHIP who are at high risk for preterm birth. In February 2013, CMS awarded 27 cooperative agreements to test approaches to enhanced prenatal care under Strategy 2. Awarded sites are located in Alabama, Arizona, California, District of Columbia, Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, New Jersey, Nevada, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Puerto Rico.

Awardees and sites began enrolling women in Year 2 of the initiative, with large enrollment increases reported in the second quarter. Through June 2014, cumulative enrollment for all three models in Strong Start Strategy 2 is estimated at 11,108 with a total of 1,725 live births. Because women are enrolled early in their pregnancy, a similar increase in births, reflective of the Year 2 enrollment increase, is anticipated by the end of 2014. Awardees comprise a wide range of providers and organizations, across rural and urban areas, including university systems, hospital systems, community health centers, and nonprofit health organizations. Awards are for a 4-year performance period, with continuation contingent upon awardee performance and demonstrated progress toward reducing preterm births.

Strategy 2 provides an opportunity for funding to obstetric providers to test three specific, evidence-based maternity care interventions in the Medicaid program that have shown the potential to reduce preterm birth:

- Enhanced Prenatal Care through Centering/Group Visits: Group prenatal care that incorporates peer-to-peer interaction in a facilitated setting for health assessment, education, and additional psycho-social support.
- Enhanced Prenatal Care at Birth Centers: Comprehensive prenatal care facilitated by teams of health professionals, including allied health professionals and peer counselors. Services include collaborative care, intensive case management, counseling, and psycho-social support.
- Enhanced Prenatal Care at Maternity Care Homes: Comprehensive prenatal care emphasizing care coordination and management that includes psycho-social support, education, and health promotion in addition to traditional prenatal care. This intervention offers expanded access to care, improved care coordination, and a broader array of health services.

An evaluation will assess the impact of Strong Start programs and models of care provided to Medicaid and CHIP beneficiaries on pregnancy outcomes (particularly gestational age at birth and birth weight) and health costs for mother and infant in the year following birth. The evaluation will have three components: case studies of all awardees, participant level data as measured through three surveys and clinical reports, and an impact analysis based on Medicaid/CHIP claims and vital records data. The analysis will be conducted at the site and awardee level—by model, by services provided, by risk levels, and by demographic characteristics of sites and participants.

While findings will be based on the evaluation, the CMS Innovation Center has identified several lessons learned during the first year of implementation of the Strategy 2 enhanced prenatal care approaches. These include: the effectiveness of electronic medical records in identifying women at high risk for preterm birth early in pregnancy; the value of creating and utilizing “opt out” policies to facilitate program participation and retention; and the need for award recipients to establish program policies and infrastructure that facilitate program startup and operations. These lessons learned are informing the technical assistance provided to award recipients and will be used for future program operations and infrastructure planning.

Initiatives Focused on Medicare-Medicaid Enrollees

The Medicare and Medicaid programs were designed to serve distinct purposes. As a result, there are often barriers that prevent beneficiaries enrolled in both programs (often called dual eligible or Medicare-Medicaid enrollees) from receiving coordinated, high-quality, and cost-efficient care. Currently, there are over 10 million low-income seniors and people with disabilities who are Medicare-Medicaid enrollees. These individuals must deal with multiple rules, benefits, providers, and insurance cards to access care across the different parts of the Medicare and Medicaid programs. Many of these beneficiaries have complex health care needs and, as a result, account for a disproportionate share of the programs’ expenditures.

Opportunities exist to enhance the Medicare and Medicaid programs for enrollees who are dually eligible. A fully integrated, person-centered system of care that ensures all of a beneficiary’s needs are met—primary, acute, long-term care, prescription drug,

behavioral, and social—could serve this population in an improved, high-quality, and cost-effective manner.

Section 2602 of the Affordable Care Act established the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid Coordination Office) to integrate program benefits more effectively and improve coordination between the federal government and states for Medicare-Medicaid enrollees. Working together, the CMS Innovation Center and the Medicare-Medicaid Coordination Office have created new opportunities to develop and test innovative care models for the Medicare-Medicaid enrollee population.

The Medicare-Medicaid Coordination Office Fiscal Year 2013 Report to Congress provides additional detail on the Office's efforts to develop policies, programs, and initiatives that promote coordinated, high-quality, cost-effective care for all Medicare-Medicaid enrollees (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>). The Financial Alignment Initiative and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents are designed to reduce inefficiencies in care delivery and improve both the coordination of services and overall experience of care for Medicare-Medicaid enrollees.

Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals

In July 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative to establish innovative models of care for Medicare-Medicaid enrollees. Under this initiative and through related work, CMS is partnering with states to test both a capitated model and a managed fee-for-service (MFFS) model. Under the capitated model, the state and CMS enter into a three-way contract with a health plan, which receives a prospective blended payment to provide comprehensive, coordinated care. Under the MFFS model, the state and CMS enter into an agreement by which the state may benefit from a portion of savings from initiatives that improve quality and reduce costs in the FFS delivery system. Although the approaches differ in each state demonstration, beneficiaries are eligible to receive all the standard Medicare and Medicaid services and benefits that they are entitled to, as well as additional care coordination, beneficiary protections, and access to enhanced services. As of October 2014, approximately 200,000 beneficiaries are currently enrolled in the combined Financial Alignment Initiative & State Demonstrations to Integrate Care for Dual Eligible Individuals. Model tests are operated in 11 states.

The Financial Alignment Initiative builds upon and, for some states, incorporates funding from its precursor, the State Demonstrations to Integrate Care for Dual Eligible Individuals, through which CMS awarded design contracts to 15 states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin) in April 2011 to design new approaches to better coordinate care for beneficiaries enrolled in both the Medicare and Medicaid programs.

Eight of these states are now part of the Financial Alignment Initiative, but continue to receive implementation funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals. Seven of these eight states have signed Memoranda of Understanding (MOUs) to test new models under the Financial Alignment Initiative. In Minnesota, the eighth state from the State Demonstrations, CMS has signed an MOU to test an alternative model, building on the longstanding Minnesota Senior Health Options program.

As of September 2014, under the Financial Alignment Initiative, CMS has entered into MOUs with a total of 11 states: seven states that received awards from the State Demonstrations (California, Colorado, Massachusetts, Michigan, New York, South Carolina, and Washington) and four additional states (Illinois, Ohio, Texas, and Virginia) to integrate care for Medicare-Medicaid enrollees. Nine of these states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia) are implementing capitated model demonstrations. Colorado is implementing a MFFS model demonstration and Washington is implementing both a MFFS model and a capitated model demonstration in separate regions of the state. Each model is scheduled to serve beneficiaries for approximately 3 years.

Approved demonstrations are at different stages of implementation. The Washington and Colorado MFFS demonstrations began in July 2013 and September 2014, respectively. The Minnesota demonstration became effective in September 2013. Medicare-Medicaid Plans (MMPs) in Massachusetts started serving beneficiaries in October 2013. Plans participating in the Illinois demonstration began beneficiary services in March 2014; plans in California and Virginia initiated services in April 2014; and MMPs in Ohio began in May 2014. In other states with signed MOUs, beneficiary enrollment will begin at various times in early 2015.

As more demonstrations move toward implementation, CMS and the states have invested in new monitoring and oversight activities designed to protect beneficiary rights and maximize the benefits of integrated care. These activities include the following:

- *Readiness Reviews:* Plans participating in capitated model demonstrations and states participating in MFFS model demonstrations must complete readiness reviews prior to the start of the demonstration. These comprehensive reviews help ensure that each plan or state is ready to accept enrollments, provide the required continuity of care, ensure access to the full spectrum of providers, and fully meet the diverse needs of the Medicare-Medicaid population.
- *Implementation Funding:* States that previously received design contracts for a Demonstration to Integrate Care for Dual Eligible Individuals and also have signed an MOU for demonstrations are eligible for additional funding for implementation activities, especially those activities that promote beneficiary engagement and the protection of beneficiary rights. As of September 2014, CMS had made such awards to California, Colorado, Massachusetts, Michigan, Minnesota, New York, South Carolina, and Washington.

- *Contract Management Teams:* For each capitated model demonstration, CMS and the state establish a joint Contract Management Team (CMT), which monitors plan compliance with a three-way contract. The CMT is responsible for day-to-day monitoring of the demonstration and conducts contract management activities related to access, beneficiary protections, quality, program integrity, and financial solvency.
- *Funding for Ombudsman Services:* Through funding from CMS and technical support from the Administration for Community Living, the Demonstration Ombudsman Programs do the following: 1) provide beneficiaries in states with approved Financial Alignment demonstrations with access to person-centered assistance in answering questions and resolving issues; 2) monitor the beneficiary experience; and 3) offer recommendations to CMS, the states, and participating plans. As of September 2014, CMS had made awards to California, Colorado, Illinois, Massachusetts, Ohio, Virginia, and Washington through this funding opportunity.
- *Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs):* This funding supports local SHIPs and ADRCs in providing beneficiary outreach and one-on-one “options counseling” to states participating in the demonstrations. As of September 2014, CMS had made awards to California, Illinois, Massachusetts, Virginia, and Washington.

An aggregate evaluation plan has been designed to guide the overall evaluation and individual state evaluation plans are in development. The goals of the evaluation are to monitor demonstration implementation in each state and assess the demonstration’s impact on a range of quality, utilization (including changes in the balance between home and community-based services and nursing facility use), and cost outcomes. Evaluations will also examine the impact of the demonstrations on the beneficiary experience. Results will be measured for the eligible populations as a whole and for subpopulations of interest in each demonstration (such as persons with mental and/or substance use disorders or long term services and supports recipients). The final state-specific reports and the final aggregate evaluation report will include analyses based on linked Medicare and Medicaid data files to provide beneficiary-level information on total Medicare and Medicaid quality, utilization, and spending.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

Under the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, seven organizations operating under cooperative agreements are partnering with approximately 146 nursing facilities in seven states. Focused on improving the quality of care in nursing facilities by reducing avoidable hospitalizations, the initiative has served an estimated 24,000 Medicare-Medicaid enrollees each year.

Nursing facility residents are subject to frequent avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities. Approximately 45 percent of hospitalizations

among Medicare-Medicaid enrollees are avoidable, costing the federal government billions in unnecessary expenditures each year.

To address this situation, the CMS Innovation Center launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents in March 2012. Under this initiative, CMS has entered into cooperative agreements with seven organizations functioning as Enhanced Care and Coordination Providers (ECCPs) to test strategies to reduce unnecessary hospitalizations of Medicare-Medicaid enrollees who are long-stay residents of nursing facilities, while at the same time maintaining or improving quality of care. The selected organizations and their partners will test evidence-based interventions designed to accomplish this goal. They will implement and operate these interventions over a 4-year performance period. The model began serving Medicare-Medicaid enrollees in February 2013.

Implementation of the project was staggered, starting in February 2013 and continuing until September 2013, by which time the ECCPs had started operations at all participating nursing facilities under the terms of the model test. During the fourth quarter of 2013, the population served by the model included 15,946 long-stay nursing facility residents in the intervention group. The CMS Innovation Center has worked closely with the participating organizations to support and monitor implementation of the model, providing learning and diffusion activities that facilitate collaboration between model participants and carefully tracking beneficiaries' experience of care.

An independent evaluator is monitoring each ECCP's implementation of the interventions and will evaluate the impact of interventions after they have been operational for several years. The independent evaluator is using comparison groups located in close proximity to partnering nursing facilities in each state to assess the effectiveness of the overall initiative and of the separate components of each ECCP intervention.

Initiatives to Speed the Adoption of Best Practices

Partnership for Patients

In April 2011, CMS announced the Partnership for Patients, an initiative designed to make hospital care safer, more reliable, and less costly. The program contracts were awarded in December 2011, and the period of performance includes a 2-year base period and a 1-year option period. The option period was exercised and the contracts end in December 2014. The Partnership for Patients has two goals:

Making Care Safer: By the end of 2014, decrease preventable hospital-acquired conditions by 40 percent compared to 2010. This decrease would represent approximately 1.8 million fewer injuries to patients.

Improving Care Transitions: By the end of 2014, decrease preventable complications during a transition from one care setting to another so that all hospital readmissions would be reduced by 20 percent as compared to 2010. Achieving this goal would mean

that more than 1.6 million patients will recover from illness without suffering a preventable complication requiring readmission within 30 days of discharge.

Preliminary data for Partnership for Patients show positive results on measures of reduced harm and readmissions. Although the precise causes of the decline in patient harm are not fully determined, the increase in safety has occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events, spurred in part by Medicare payment incentives, and catalyzed by HHS' Partnership for Patients initiative that is led by CMS.⁴

- For example, based on 2011 and 2012 data from the independent National Scorecard Evaluation, conducted by the Agency for Healthcare Research and Quality (AHRQ), there has been a 9 percent reduction since 2010 in overall harm rates. The reduction in harm rates equates to preventing an estimated 560,000 harms to patients and averting more than 15,000 deaths. The estimated cost savings from these reductions are approximately \$4 billion for 2011 and 2012 combined. These preliminary results and estimated cost savings do not yet include the impact of work in 2013 and 2014. The preliminary quarterly data from the AHRQ National Scorecard continues to trend significantly in the direction of further decreases in harm.
- There has been an 8 percent reduction in the Medicare FFS all-cause, 30-day readmission rate, which represents 150,000 fewer hospital readmissions between January 2012 and December 2013.
- Data from other national leading indicator datasets and from a preliminary independent evaluation provide further evidence of significant national improvements. In the preliminary evaluation report, posted on the CMS Innovation Center website in July 2014 (<http://innovation.cms.gov/Files/reports/PFPEvalProgRpt.pdf>), five areas of focus are showing clear evidence of improvement; Ventilator Associated Pneumonia (VAP), reduction in Early Elective Deliveries (EED), Adverse Drug Events (ADE), Central Line-Associated Bloodstream Infections (CLABSI), and Readmissions.

To make care safer and improve care transitions, through Partnership for Patients, CMS is collaborating with more than 8,000 individuals and organizations in a shared effort to save thousands of lives, prevent millions of injuries, and take critical steps toward a more dependable and affordable health care system. These organizations include the following:

⁴ Preliminary estimates for 2013, released in December 2014 (<http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html>), show a further 9 percent decline in the rate of hospital-acquired conditions from 2012 to 2013. From 2010 to 2013, there was a 17 percent decline from 145 to 121 hospital-acquired conditions per 1,000 discharges. A cumulative total of 1.3 million fewer hospital-acquired conditions were experienced by hospital patients over the 3 years (2011, 2012, and 2013) relative to the number of hospital-acquired conditions that would have occurred if rates had remained steady at the 2010 level.

- hospitals and national organizations representing physicians, nurses, and other frontline health care and community-based social services providers committed to improving care processes and systems, and enhancing coordination to prevent inpatient harm;
- patient and consumer organizations committed to raising public awareness and developing information, tools, and resources to help patients and families effectively engage with their providers and avoid preventable complications; and
- employers and states committed to providing the incentives and support that will enable clinicians and hospitals to deliver high-quality health care to their patients.

The 26 Hospital Engagement Networks (HENs) created through the Partnership for Patients represent approximately 3,700 hospitals, or 70 percent of the nation's total general acute-care medical centers and over 80 percent of the total admissions in the United States. HENs are made up of a diverse group: wholly-owned systems, state-based hospital organizations, and other regional or national entities. HENs help identify solutions already working and disseminate them to other hospitals and providers. They work to:

- develop learning collaboratives for hospitals,
- provide a wide array of initiatives and activities to improve patient safety,
- conduct intensive training programs to help hospitals make patient care safer,
- provide technical assistance to help hospitals achieve quality measurement goals,
- establish and implement a system to track and monitor hospital progress in meeting quality improvement goals, and
- identify high performing hospitals and their leaders to coach and serve as national faculty to other hospitals committed to achieving the Partnership goals

The HEN efforts are dedicated to 10 core patient safety areas of focus that include nine hospital-acquired conditions: adverse drug events, catheter-associated urinary tract infections, central line associated blood stream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia as well as the area of readmissions. The Partnership will not limit its work to these areas, but the 10 areas of focus are important places to begin.

Six of the HENs are pursuing Leading Edge Advanced Practice Topics (LEAPT). This project, launched in September 2013, is designed to rapidly test and develop practices to reduce harm from 11 advanced practice topics of concern, including sepsis, clostridium difficile (C-diff), and other clinical conditions where there is less consensus about the measures and practices necessary to eliminate harm. HENs participating in the LEAPT project are committed to the aims of the Partnership for Patients and are working to identify best practices and lessons learned that can be spread quickly at national scale.

Beginning in late 2013, the Center for Clinical Standards and Quality assumed management of the HEN work from the CMS Innovation Center. Partnership for Patients, furthermore, is partnering with other federal entities and quality improvement

programs to align efforts across federal programs in support of progress towards its goals of preventing inpatient harm and reducing readmissions. Federal collaborators include agencies working across the spectrum of care delivery, quality reporting, quality improvement, and provider engagement. Partnership for Patients coordinates a weekly federal partners meeting to improve collaboration across the government.

The relationship between health care providers and their patients (and patients' families) is critical in preventing inpatient harm and reducing complications through improved care transitions. The National Quality Strategy (NQS, <http://www.ahrq.gov/workingforquality/about.htm#aims>), published in 2011, is an effort led by AHRQ to drive improvement on three aims: better care, healthier people, and affordable cost. From the NQS priority area of Person- and Family-Centered Care, Partnership for Patients has defined as one of its program goals better patient and family engagement. To meet this goal, Partnership for Patients is strengthening partnerships among patients, families, and health care providers by engaging patients and families in organizational design and governance, driving adoption of patient-preferred practices at the system level, and anchoring health care in patient and family preferences. In addition, Partnership for Patients is working with a network of many patient advocacy groups as well as a network of patients, families, and 200 patient advocates who are systematically defining best practices for patient and family engagement across the country.

Million Hearts[®]

The Million Hearts[®] initiative brings together communities, health care professionals, health systems, nonprofit organizations, federal agencies, and private-sector organizations around a common goal: preventing 1 million heart attacks and strokes by 2017. Million Hearts[®] calls attention to a small set of changes that can be made in communities and health care systems that support long-term reductions in heart attacks and strokes. Million Hearts[®] also emphasizes the importance of coordination between public health organizations and clinical systems.

CMS does not fund Million Hearts[®] but supports the Million Hearts[®] objectives in several other ways. CMS has adopted the Million Hearts[®] measure set and embedded it across quality reporting programs and models such as Accountable Care Organizations, the Physician Quality Reporting System, and the Comprehensive Primary Care Initiative. CMS also supports Million Hearts[®] goals by encouraging clinicians who lead CMS Innovation Center models to deploy their electronic health record systems to assess and improve their performance, adopt evidence-based tools like hypertension treatment protocols and patient registries, and reach out to patients to address gaps in care. All of these actions are focused on improving health—especially cardiovascular health—for all Americans. The report “Turning Point for Impact” (http://millionhearts.hhs.gov/Docs/MH_Mid-Course_Review.pdf) summarizes Million Hearts[®] progress to date.

Initiatives to Accelerate the Development & Testing of New Payment & Service Delivery Models

Health Care Innovation Awards

Innovation in service delivery and payment reform is occurring throughout the country. The Health Care Innovation Awards (Innovation Awards) were created to accelerate the development and testing of innovations originating in the field. The Innovation Awards fund organizations proposing new payment and service delivery models that hold promise of delivering better care, lower costs, and improved health for people enrolled in Medicare, Medicaid and CHIP, particularly those with the greatest health care needs.

The CMS Innovation Center has issued two solicitations for the Innovation Awards, each receiving a robust response. Collectively, the Innovation Awards fund interventions in urban and rural areas in all 50 states, the District of Columbia, and Puerto Rico. Awardees encompass a diverse set of organizations, including clinicians, hospitals and health systems, academic medical centers, information technology entrepreneurs, community and faith-based organizations, state and local governmental entities, non-profit organizations, and advocacy groups.

Round One, announced in November 2011, was a broad solicitation that encouraged applicants to focus on high-risk populations and to include new models of workforce development. There were 107 Round One awards announced in two groups, in May 2012 and June 2012.⁵ The period of performance is 3 years. Round One models are enhancing primary care, coordinating care across multiple settings, deploying new types of health care workers, helping patients and providers make better decisions, and testing new service delivery technologies. Approximately 575,000 Medicare, Medicaid, and CHIP beneficiaries are being served directly through Round One models.

Round One awards were made in seven general areas. Model tests have been grouped together accordingly, so that evaluation can be more model-specific and data can be aggregated:

1. **Complex/High Risk Patient Targeting group:** comprised of 23 awards with a shared focus on patients with medically complex conditions at high risk for hospitalization or readmission. Awardees employ diverse approaches to improve the care of these populations including care coordination, redesign of clinical care workflow, patient education and support, financial incentives, and workforce development.

The evaluation plan for the Complex/High Risk Patient Targeting group will include individual awardee evaluations as well as evaluation of measures that apply across this entire group of model tests. The goal of the evaluation is to assess impact on a range of quality, utilization, and cost outcomes, including beneficiary experience, for each award individually and for this group of awards as a whole. Results will be

⁵ One of the awards encompasses two separate initiatives that will be evaluated separately. Accordingly, there are 107 awards and 108 evaluations.

measured for the eligible populations as a whole and for subpopulations of interest. The final evaluation report will include analyses based on awardee-provided self-monitoring data and linked Medicare and Medicaid data files and use beneficiary-level information to assess impact on quality, utilization, and spending.

2. Disease Specific group: includes 18 awards targeting patient populations with specific diseases or diagnostic profiles. These patients are medically fragile, living in the community, and suffering from specific chronic conditions. Their treatment may involve multidisciplinary care teams across various care settings for long durations.

The goal of the evaluation of the Disease Specific group is to assess the impact of awardee interventions on participants with specific health conditions, including cancer, heart disease, dementia, end stage renal disease, diabetes, chronic pain, and pediatric asthma. The evaluation will include intensive case studies of all awards and, for awards with available data and sufficient enrollment, quantitative analysis of claims using matched control groups. Outcomes of interest include hospitalizations and readmissions, emergency department visits, and costs. The evaluation will consider demographic characteristics and other contextual factors for sites and participants.

3. Behavioral Health and Substance Abuse group: includes 10 awards focusing primarily on mental health and substance abuse services using an array of interventions. Although their initiatives have similar themes (such as workforce development and care coordination), these model tests target different priority populations, such as individuals with schizophrenia or individuals with both a serious mental illness and a chronic physical condition.

Evaluation of Behavioral Health and Substance Abuse model tests will identify and assess strategies and outcomes that are common across the awardees' projects and compare findings. The final evaluation will include quantitative analyses of the impact on total Medicare and Medicaid utilization and spending based on Medicare, and Medicaid data files. This report will also include qualitative analyses to provide information on care quality, organizational characteristics, and workforce transformation. The synthesis of findings across awardees will increase the validity and generalizability of results, and their usefulness for policymakers and program administrators.

4. Hospital Setting group: encompasses 10 awardees providing acute care interventions in the hospital/inpatient setting. These awardees use improved screening, bundled services, workforce training, and technology to deliver better care. Some awardees work with specific subgroups, such as geriatric and intensive care unit patients and patients with delirium, sepsis, and mobility issues. The goal of these interventions is to reduce hospital admissions, readmissions, inpatient length of stay, and cost while improving patient care, experience, and outcomes.

The evaluation will assess whether and how the programs are redesigning acute care while improving health care utilization and patient outcomes in the hospital and

inpatient setting. Measures will include hospital admissions, readmissions, inpatient length of stay, and cost. The evaluation plan will utilize a mixed-methods approach which includes qualitative and quantitative data collection and analyses to examine implementation and program effectiveness, workforce issues, and the impact on priority populations. Quantitative analysis will be used to estimate the impact of the initiative on quality, utilization, and costs. Data sources will include Medicare and Medicaid claims and administrative data, as well as patient and clinician surveys.

Qualitative analyses will be used to address questions pertaining to the nature of program participants and identifying the care redesign strategies planned and implemented by providers. Qualitative data sources will include focus groups, interviews, and review of documents from the awardees and contractors. Each of the 10 awardees will be evaluated individually, with some potential for comparing those that are similar in terms of goals, populations (for example, awardees focusing on specific subgroups such as patients with delirium, sepsis, and mobility issues, as well as geriatric and ICU patients), and care delivery models.

5. Community Resource Planning, Prevention, and Monitoring group: includes 24 awardees. The goal of this group is to enhance care coordination and improve access to health care through the use of health information technology, care management, patient navigation, and the delivery of preventive and health promotion services.

Evaluation of the awardees in the Community Resource Planning, Prevention, and Monitoring group will include qualitative and quantitative components. The qualitative component will consist of analysis of narratives from quarterly reports, project officer observations, awardee site visits, and interviews and/or focus groups. The quantitative component will include an individual assessment of each awardee, including their development of a credible comparison group for total cost of care, their all-cause inpatient admission rate, their all-cause readmission rates, their hospital emergency department visit rates, and awardee-specific clinical and patient reported outcomes. Awardees with similar participant populations may be grouped for analysis. A cross-cutting analysis of all awardees in the Community Resource Planning, Prevention, and Monitoring group will identify underlying themes.

6. Medication Management and Shared Decision-Making group: comprised of nine awardees. Medication management initiatives are designed to optimize therapeutic outcomes and reduce adverse events through improved medication use. The Shared Decision-Making programs engage patients in discussion with care teams and case managers to actively participate in choosing the most appropriate health treatments or care management options for their individual needs, taking into account the best scientific evidence available, as well as the patient's values and preferences.

The evaluation of Medication Management and Shared Decision-Making model tests will use a mixed-methods approach to assess whether and how these programs reduce cost while improving or maintaining the standard of care, patient health and quality of life, and workforce satisfaction. To the extent that a particular approach is promising, this evaluation will describe the contextual factors needed to make success likely, and

the contextual factors that may present barriers. The evaluation will report program-specific measures, such as all-cause and preference-sensitive surgery rates and costs and the proportion of days covered, as well as mortality, inpatient admissions, readmissions, emergency department visits, and costs.

7. Primary Care Redesign group: includes 14 awardees that represent a wide range of intervention models, target populations, and organizational settings.

The evaluation will assess whether and how the initiatives are redesigning primary care practices and improving the coordination, efficiency, and quality of patient care. Site visits and key informant interviews will provide insight into what the intervention entails and how it is implemented. Outcome measures, based on analysis of administrative claims data, will include expenditures per beneficiary, hospitalization rates, emergency department visit rates, and readmission rates.

Round One incorporates a Learning System framework to capture, share, package, and disseminate strategies and resources to help Innovation Award recipients successfully implement their projects and make sustainable improvements in health care system design and delivery. Over 900 individuals have participated in aspects of the learning system in the past year. This multifaceted learning system includes all-awardee webinars and virtual meetings; small group interactions; written collaboration products; and a highly interactive CMS Innovation Center collaboration site. Activities and products have specifically tailored themes based on common issues, challenges, and awardee feedback. Topics have included development of driver diagrams to focus improvement, strategies for participant recruitment, measurement of cost savings, data management and reporting, and workforce development. Small group projects connect awardees with common areas of emphasis/populations and allow for ongoing collaboration and sharing of strategies and lessons learned.

Awards are for a 3-year cooperative agreement period, with continuation contingent upon meeting operational plan milestones. These may include the achievement of patient recruitment goals, the execution of contracts, the dissemination of information, and the application of new technology. The performance period for Round One began in July 2012 and extends through June 2015. Round One awardees completed the second year of the 3-year performance period in mid-2014. Project Officers monitor each award biweekly and review quarterly reports prepared by an independent evaluation contractor. In addition, technical assistance is provided to awardees as needed. A design for evaluation of the 107 awards was completed in early 2013. At the conclusion of the Round One Innovation Award models, the evaluation will assess the impact of interventions on care, cost, and patient outcomes for each award and across awardees.

It is too early to draw any conclusions about quality improvement or cost savings from the Innovation Awards Round One model tests.

Round Two, announced in May 2013, was a more targeted solicitation focused on defined categories and priority areas. Round Two awardees were announced in two groups in May 2014 and June 2014. The period of performance is 3 years. These models

include interventions that will improve care for children, the frail elderly, and those living with HIV/AIDS; enhance emergency care and the management of cardiovascular diseases; better coordinate care in rural areas; and provide support for aging in the community. As in Round One, awards are for a 3-year cooperative agreement period, with continuation contingent upon meeting operational plan milestones.

The second round of Health Care Innovation Awards funded applicants who proposed new payment and service delivery models with the greatest likelihood of driving health care system transformation and delivering better outcomes for Medicare, Medicaid, and CHIP beneficiaries. In Round Two, the CMS Innovation Center sought new payment and service delivery models in four broad categories described below. These categories were identified as gaps in the current CMS Innovation Center portfolio and as areas that could result in potentially usable models for changes in Medicare, Medicaid, and CHIP payment methods.

The four broad categories are as follows:

1. Models designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings.
2. Models that improve care for populations with specialized needs.
3. Models that test the means through which specific types of providers might transform their financial and clinical models.
4. Models that improve the health of populations through activities focused on prevention, wellness, and comprehensive care that extend beyond the clinical service delivery setting.

Round Two required each applicant to propose both an innovative care delivery model and a payment model that would support sustainability. Applicants were encouraged to focus on alternative payment models that did not simply expand FFS payments.

In Category One, three awards were made. Of these, one awardee will test a model to redirect patients with chronic illness and “super-utilizers” with non-emergent conditions from the emergency room to primary care medical homes. Another will test a combination of several proven tools designed to improve care and reduce hospital admissions for patients at 11 nursing facilities.

In Category Two, 11 awards were made. Examples include one awardee that will test a model using technology-enabled care management, virtual visits, and a peer support network to promote better care for people living with HIV/AIDS. Another awardee will test a model using a coach and support team to coordinate health and social services for young adults transitioning out of foster care.

In Category Three, there were 13 awards, including one awardee that will test a model for high-need families providing integrated medical, behavioral health, and community-based services, coordinated by a multidisciplinary team. Another awardee will test a model using a medical neighborhood of primary care and specialty providers designed to promote evidence-based practices and to avoid unnecessary services and imaging for patients with low back pain.

In Category Four, 12 awards were given. One of these awardees will create a statewide hospital telehealth system to provide optimal stroke care and avoid unnecessary transfer to tertiary care centers. Another will test a model to identify patients with Hepatitis C and provide comprehensive medical and behavioral care. Another will test a combination of LEAN process improvements, chronic disease management, and clinical-community integration across 25 critical access hospitals and 73 associated primary care clinics.

The performance period for Round Two began in September 2014 and extends through June 2017. Round Two awardees are testing new models in all categories and priorities. Lessons learned from Round One have been leveraged in the implementation and management of Round Two awards. These lessons include incorporating operational plans into the application process, soliciting payment models, and requesting financial and actuarial review.

State Innovation Models

In February 2013, the CMS Innovation Center announced funding to 25 states to participate in the State Innovation Models (SIM) initiative, an initiative intended to accelerate state-level health care transformation. Six states (Arkansas, Massachusetts, Maine, Minnesota, Oregon, and Vermont) received funding as Model Test states. These states are currently implementing transformation plans. Nineteen states (California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Maryland, Michigan, New Hampshire, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, and Washington) received Model Design awards to develop State Health Care Innovation Plans. The periods of performance were 9 months for Design states and 36-45 months for Test states.

In May 2014, a second round of SIM funding was announced. The CMS Innovation Center will fund up to 15 Model Design awards and up to 12 Model Test awards in Round Two. States, territories, and the District of Columbia are eligible to apply. Round Two awards will be announced by the end of 2014.⁶ The periods of performance will be 1 year for Model Design awards and 3 years for Model Test awards.

States play a critical role in determining the effectiveness of the health care system and the health of their state's population. Not only are states health care payers for the Medicaid, CHIP, and state employee populations, they also impact care delivery through their licensing and public health activities. Moreover, successful health care

⁶ SIM Round Two awards were announced in December 2014 (<http://innovation.cms.gov/initiatives/State-Innovations-Round-Two/index.html>).

transformation design and implementation processes require partnering with the private and public sector at both a state and a national level. States are, therefore, uniquely positioned to partner with the CMS Innovation Center in health care reform.

Under this initiative, the CMS Innovation Center provides financial and technical support to states to help them design and test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP while maintaining or improving quality of care. States cannot use SIM funding to supplant funding levels for activities that are already provided by states or other payers, but they can use SIM funding to supplement existing efforts to enhance the broader transformation of the delivery system.

SIM supports two broad areas of activity:

- Model Design Awards: In Round One, the 19 states that received Model Design awards were charged with developing or enhancing a State Health Care Innovation Plan. These plans were intended to guide innovation and to be used to apply for an expected second round of Model Test awards. The 19 states submitted their State Health Care Innovation Plans to CMS in December 2013.
- Model Testing Awards: The six Round One Model Test states received awards to implement their State Health Care Innovation Plan. These states are expected to: 1) bring a wide range of stakeholders into the implementation process; 2) implement multi-payer payment and service delivery models that include Medicare, Medicaid, CHIP, and other payers; 3) utilize their authority to facilitate and support new health care delivery models that improve care and health while lowering cost; and 4) ensure that models complement and coordinate with other initiatives sponsored by CMS and HHS. The Model Testing award provides funds for the state to carry out and evaluate their transformative payment and service delivery model.

The six Round One Model Test states continue to strengthen, implement, and evaluate their State Health Care Innovation Plan based on finalized Operational Plans. They are receiving extensive guidance and support from the CMS Innovation Center regarding their accountability targets, milestones, self-evaluation plans, and progress reporting. These states are implementing innovative payment and delivery models including ACOs, patient-centered medical homes, and bundled payments. At this time, all test states have implemented innovative approaches to Medicaid and are expanding these approaches to include commercial payers.

The Funding Opportunity Announcement and subsequent terms and conditions of the SIM cooperative agreements required the Design state awardees to consider policy levers and strategies that could be applied to influence the structure and performance of the state's entire health care system and accelerate transformation. In developing their State Health Care Innovation Plan, the state awardees engaged a broad group of stakeholders in

the design process to review, identify, and collaboratively determine how to create multi-payer strategies to move away from payment based on volume and toward payment based on outcomes.

Over the course of the project period, the CMS Innovation Center played a significant role in supporting the states' design of their State Health Care Innovation Plans. All states were assigned a dedicated Project Officer to coordinate resources and monitor awardee progress. The Project Officers interacted regularly with the states, shared actions and activities, and worked collaboratively with other CMS and HHS staff and contractors to ensure the states received targeted support.

The CMS Innovation Center worked with contractors to provide technical assistance to the Design and Test state awardees. Specific topic areas included payment reform, financial analysis, actuarial modeling, behavioral health, substance abuse, dental and long-term services, and quality reporting and analysis. Design states also received assistance developing evaluation plans.

The CMS Innovation Center and the Centers for Disease Control and Prevention (CDC) facilitated a meeting of the SIM states in January 2014 to address the integration of population health strategies in service delivery system and payment reform efforts. During 2014, organizations such as the National Governor's Association, the National Association of State Health Policy, the Commonwealth Fund, the Milbank Memorial Fund, and the Catalyst for Payment Reform hosted or participated in virtual and in-person forums dedicated to supporting SIM states.

An internal review of all available Model Design State Health Care Innovation Plans reveals significant progress and effort in wide-ranging stakeholder engagement. Approximately 100 commercial payers (excluding Medicare and state Medicaid and CHIP agencies) were engaged across the Design and Pre-Test states. At last count, 5,283 stakeholders were engaged throughout the cumulative design deliberation process, encompassing the types of organizations and entities listed above. In addition, the states reported that more than 1,200 meetings were conducted throughout the design and engagement process. Three Design States engaged tribal communities and all states engaged with significant numbers of providers, consumers, and payers. Methods of engagement varied across states.

The six Round One Model Test states have made progress toward the State Health Care Innovation Plan goals. States worked with providers, payers, and CMS to support policy decisions and legislative plans needed to implement their Plans. State SIM teams also worked with physician practices, health systems, health plans, and hospitals to transition to value-based clinical models and to adopt a state's chosen strategy.

All six Round One Test states are using SIM funds to either build new or expand existing health information technology systems that will enable their State Health Care Innovation Plans to be implemented. These states continued to engage stakeholders through work groups or task forces that meet regularly to discuss particular, often technical, issues.

More than 50 stakeholder meetings took place in the last quarter of 2013 with more than 1,000 stakeholders engaged, including the full continuum of health care providers, Medicaid plans, commercial payers, public health agencies, and the general public.

Round Two SIM requirements were modified based on experiences in the initial round. Since states participating in Round One awards requested additional time to design plans, the performance period for second round SIM states will be extended to afford states more time to design and implement strategies. Larger states with diverse populations reported to CMS the need to develop region-specific efforts that require additional resources. In consideration of state variations as a factor in transformation, CMS increased funding for Round Two Model Test states based on the size and scope of the innovation plan. Finally, in recognition of the value of senior leadership engagement in Round One, the CMS Innovation Center required Round Two Model Test applicants to include Senior State Health Officials in the application process.

The CMS Innovation Center views partnerships with states through SIM as a critical channel to accelerate health care transformation. In the upcoming years, state-led innovations will provide valuable lessons that have the potential to identify scalable innovative delivery and payment models in health care across the nation.

Medicaid Innovation Accelerator Program (IAP)

In July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP), a collaborative initiative with states to promote transformation in state Medicaid delivery systems and payment innovations. Investments will be made over 4 years to provide technical assistance to help states accelerate the development and testing of new state-led payment and service delivery innovations to achieve better care, better health, and lower costs for individuals enrolled in Medicaid.

CMS has been actively engaged with states and stakeholders on health care reform efforts. The Medicaid IAP will build on these discussions by focusing on targeted areas that will accelerate states' efforts to undertake Medicaid delivery system and payment reform.

While payment and service delivery innovation is already underway in states, opportunities for improvement remain. The Medicaid IAP will help strengthen state Medicaid program capabilities in technical areas such as data analytics, service delivery, financial modeling, quality measurement, and rapid cycle evaluation to improve payment and service delivery.

The IAP and its focus areas – data analytics, quality measurement, model development, disseminating best practices, and evaluation – were developed with input from states, including the National Governor's Health Care Sustainability Task Force, and surveys of states participating in the State Innovation Models initiative. Ongoing consultation and collaboration with states as well as consumer groups, health plans, and health care providers will be built into the IAP as it moves forward.

Maryland All-Payer Model

Maryland operates the nation's only all-payer hospital rate regulation system that applies in lieu of the Inpatient Prospective Payment System and Outpatient Prospective Payment System. Maryland sets rates for hospital services, and all third party payers pay the same rate. Maryland's all-payer system operated from 1977 until December 2013 under section 1814(b)(3) of the Social Security Act.

Effective January 2014, Maryland entered into a new agreement with CMS to implement the Maryland All-Payer Model, a 5-year hospital payment model. Under the terms of the agreement with CMS, Maryland will meet a number of quality targets and limit annual cost growth for all payers, including Medicare. The purpose of this model is to test the impact of transformation in the context of an all-payer rate setting system. Specifically, the model will test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health, and reduced costs.

The agreement between Maryland and CMS provides for the following:

- Maryland elects that specified Maryland hospitals will no longer be reimbursed by Medicare in accordance with its previous statutory waiver in section 1814(b)(3), which is based on Medicare payment per inpatient admission, in exchange for the new CMS model based on Medicare per capita total hospital cost growth;
- Maryland agrees to take measures intended to generate \$330 million in Medicare savings over a 5-year performance period, measured by comparing Maryland's Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth;
- Maryland will limit its annual all-payer per capita total hospital cost growth to 3.58 percent, the 10-year compound annual growth rate in per capita gross state product;
- Maryland will shift virtually 100 percent of its hospital revenue over the 5-year performance period into global payment models;
- Maryland will take measures to achieve a number of quality targets that will improve the care for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries, such as the following:
 - Readmissions: Maryland will reduce its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate to the national rate over 5 years.
 - Hospital Acquired Conditions: Maryland will achieve an annual aggregate reduction of 6.89 percent in 65 Potentially Preventable Conditions over 5 years for a cumulative reduction of 30 percent.
 - Population Health: Maryland will submit an annual report demonstrating its performance along various population health measures.

- Maryland will transition Maryland hospitals over 2 years to the national Medicare payment systems, if for any reason the 5-year performance period of the model is terminated before its intended end date; and
- Maryland will develop a proposal for a new model based on a Medicare total per capita cost of care test before the start of the fourth year of the model, to begin no later than after the end of the 5-year performance period.

The CMS Innovation Center expects that this model will engage all Maryland acute-care hospitals, as well as other care providers, in innovation and payment reform. The model will work synergistically with other important delivery reform innovations in the state.

Medicare Care Choices Model

The Medicare Care Choices Model provides a new option for beneficiaries with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and HIV/AIDS to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. This initiative represents a fundamental change in the delivery of care for persons with advanced illness.

Currently, Medicare beneficiaries are required to forgo curative care in order to receive access to palliative care services offered by hospices. The Medicare Care Choices Model will test whether Medicare beneficiaries who qualify for coverage under the Medicare hospice benefit will elect to receive the palliative and supportive care services typically provided by a hospice if they can continue to seek services from their curative care providers. The CMS Innovation Center will study whether access to such services will result in improved quality of care and patient and family satisfaction, and whether there are any effects on use of curative services and the Medicare hospice benefit.

The Request for Application for the Medicare Care Choices Model was announced in March 2014. The deadline for applications was June 2014. The CMS Innovation Center received a robust response from Medicare certified and enrolled hospice organizations that spanned most of the United States and Puerto Rico. The CMS Innovation Center will select at least 30 rural and urban Medicare certified and enrolled hospices that have demonstrated experience with an established network of providers who have been referring patients to hospice. Preference will be given to hospices that demonstrate experience in developing, reporting, and analyzing quality assurance and performance improvement data. The CMS Innovation Center expects to announce selected participants by the end of 2014.

Through selected hospices, CMS expects to enroll 30,000 beneficiaries throughout the 3-year period of performance. Participants will begin delivering services under the model no later than 180 days after announcement.

Prior Authorization Models

In May 2014, the CMS Innovation Center, in collaboration with CMS' Office of Financial Management, announced that it will begin testing two prior authorization models for repetitive scheduled non-emergent ambulance transport and non-emergent

hyperbaric oxygen therapy. The models, authorized under Section 1115A, build on an earlier prior authorization demonstration for power mobility devices. Repetitive, scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy are the focus of these models due to the high incidences of improper payments for these services as reported by the Department of Health and Human Services Office of Inspector General, as well as concerns about beneficiaries receiving services that are not medically necessary.

The objective of the models is to test whether prior authorization helps reduce improper payments and thereby lowers Medicare costs, while maintaining or improving quality of care. The models will not create additional documentation requirements; rather, they will require reporting the same information that is currently necessary to support Medicare payment, only earlier in the process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

The prior authorization model for repetitive scheduled non-emergent ambulance transport will be implemented in South Carolina, New Jersey, and Pennsylvania, and the non-emergent hyperbaric oxygen therapy model will be implemented in Illinois, Michigan, and New Jersey. These states were chosen because of their high Medicare expenditures for repetitive scheduled non-emergent ambulance transports and non-emergent hyperbaric oxygen therapy. The CMS Innovation Center expects to announce performance period dates by the end of 2014.

Both models will follow a similar prior authorization process. The provider or beneficiary will be encouraged to submit to their Medicare Administrative Contractor (MAC) a request for prior authorization along with all relevant documentation to support Medicare coverage of the service. The MAC will review the request and provide a provisional affirmative or non-affirmative decision within a specified timeframe. A claim submitted with an affirmative prior authorization will be paid as long as all other requirements are met, and a claim submitted with a non-affirmative decision will be denied (with appeal rights available). Unlimited resubmissions are allowed under the models. If a provider or supplier chooses to forego prior authorization and submits a claim without a prior authorization decision, the claim will undergo pre-payment review. The models will include an expedited review process to address circumstances where the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. However, we expect requests for expedited reviews to be extremely rare since both models apply only to non-emergent services.

In the repetitive scheduled non-emergent ambulance transport model, a provisional affirmative prior authorization decision will affirm a specified number of trips (up to 40 round trips), within a 60-day period. In the non-emergent hyperbaric oxygen therapy model, a provisional affirmative prior authorization decision may affirm up to 36 courses of treatment in a year.

Outreach and education to participating providers, suppliers, and beneficiaries will begin prior to the start of both models and will continue throughout the performance periods.

Outreach and education will include Open Door Forums, frequently asked questions, operational guides, and updates through the model websites. In addition, the MACs will conduct in-person educational events and will post a letter to physicians explaining their role in the models.

Prior authorization supports ongoing efforts to safeguard beneficiaries' access to medically necessary items and services, while reducing improper Medicare billing and payments. The initiative will improve access to services by giving Medicare beneficiaries greater confidence that their services are covered before they are rendered.

4. Beneficiaries Participating in CMS Innovation Center Initiatives

Table 2: Estimated number of beneficiaries participating, or projected to participate in models authorized under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). A comprehensive listing of all initiatives currently administered by the CMS Innovation Center is contained in the Appendix.

BENEFICIARIES PARTICIPATING IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2014)	
INITIATIVE	DIRECT BENEFICIARIES*
Primary Care Transformation	
Comprehensive Primary Care Initiative	396,000
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	207,000
Accountable Care	
Pioneer Accountable Care Organization Model	625,000
Advance Payment Accountable Care Organization Model	301,000 [†]

BENEFICIARIES PARTICIPATING IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2014)	
INITIATIVE	DIRECT BENEFICIARIES*
Comprehensive End-Stage Renal Disease Care Model (CEC)	Data Not Yet Available [†]
Bundled Payments for Care Improvement	
Model 1	78,000 [§]
Model 2	33,000 [§]
Model 3	15,000 [§]
Model 4	4,000 [§]
Initiatives Focused on the Medicaid Population	
Strong Start for Mothers and Newborns (Strategy 1)	16,000
Strong Start for Mothers and Newborns (Strategy 2)	11,000
Initiatives Focused on Medicare-Medicaid Enrollees	
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Included in Financial Alignment Initiative
Financial Alignment Initiative	200,000
Initiative to Reduce Preventable Hospitalizations Among Nursing Facility Residents	24,000

BENEFICIARIES PARTICIPATING IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2014)	
INITIATIVE	DIRECT BENEFICIARIES*
Initiatives to Speed the Adoption of Best Practices	
Partnership for Patients	Not Applicable**
Million Hearts®	Not Applicable**
Initiatives to Accelerate New Service Delivery and Payment Model Testing	
Health Care Innovation Awards (Round One)	575,000
Health Care Innovation Awards (Round Two)	Data Not Yet Available‡
State Innovation Models (Round One)	80% of test states' beneficiaries
State Innovation Models (Round Two)	Data Not Yet Available‡
Maryland All-Payer Model	830,000††
Medicare Care Choices Model	Data Not Yet Available‡
Medicaid Innovation Accelerator Program	Not Applicable††
Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy	Data Not Yet Available‡
Medicare Prior Authorization Models: Repetitive Scheduled Non- Emergent Ambulance Transport	Data Not Yet Available‡

* Beneficiaries may be participating in more than one model.

† Source: Medicare Shared Savings Program

‡ Model is pre-operational

§ Projected

** This is a national quality improvement initiative without direct beneficiary participants.

†† This number only includes Medicare Fee-for-Service beneficiaries.

‡‡ This initiative will provide federal tools and resources to support states in advancing Medicaid-specific delivery system reform and by sharing lessons and best practices, but it will not directly engage beneficiaries.

5. Payments Made on Behalf of Beneficiaries Participating in Models

Table 3 below outlines the estimated payments made on behalf of beneficiaries participating in models authorized under section 1115A of the Social Security Act, as well as payments under Titles XVIII and XIX of the Social Security Act and CMS Innovation Center obligations to date to support each initiative. A comprehensive listing of all demonstrations and other initiatives administered by the CMS Innovation Center is included in the Appendix. In general, payments made under the applicable titles for services on behalf of beneficiaries assigned to CMS Innovation Center models continue to be made in accordance with existing payment provisions. This table does not include Medicare, Medicaid, and CHIP payment amounts that providers, suppliers, or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.

As required by the statute, each of these models was selected to address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures, with a focus on models expected to reduce program expenditures while preserving or enhancing the quality of care received by beneficiaries. During the review of each model, the CMS Innovation Center will evaluate the models' evidence base by reviewing the potential cost and quality impact of the initiative. The CMS Innovation Center will also prepare estimates, typically with the participation of the CMS Office of the Actuary, of the financial impact of the proposed initiatives as well as an analysis of their potential impact on the quality of health care among beneficiaries. The strength of this evidence will be used to support decisions to advance a particular initiative.

The data included in this table are defined as follows:

- The column titled “CMS Innovation Center *payments made to model participants*” reflects payments to participants in the testing of models, such as providers of services, suppliers, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through CMS Innovation Center funds as provided under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). These payments were made by September 30, 2014.

- The column titled “*Payments under Title XVIII or XIX made for services on behalf of beneficiaries*” reflects payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. For example, certain models (such as the Pioneer ACO Model) include opportunities to share in the savings that providers generate for Medicare through payment under Title XVIII. This column does not include Medicare, Medicaid, and CHIP payment amounts that providers, suppliers, or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.
- The column titled “*Other CMS Innovation Center funds obligated to support model development and testing*” reflects the total CMS Innovation Center funds obligated as of the end of Fiscal Year 2014, September 30, 2014, such as contract awards for administrative and evaluation obligations, but excluding payments listed in other columns.

Table 3: As of September 30, 2014, estimates of payments made to model participants (including providers, suppliers, states, conveners and others); shared savings or other payments under Title XVIII or XIX made on behalf of beneficiaries; and other CMS Innovation Center funds obligated to support model development and testing.

ESTIMATED PAYMENTS			
INITIATIVE	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Primary Care Transformation			
Comprehensive Primary Care Initiative	\$172,740,615	Payments Not Yet Made (expected in FY 2015)	\$57,609,096
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	\$45,967,680	Not Applicable	\$22,868,754

ESTIMATED PAYMENTS			
INITIATIVE	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Accountable Care Organizations			
Pioneer Accountable Care Organization Model	Not Applicable	\$80,719,585	\$87,048,657
Advance Payment Accountable Care Organization Model	\$67,801,572 ^{\$\$}	\$5,705,754 ^{***}	\$5,371,781
Comprehensive End-Stage Renal Disease Care Model	Not Applicable	Payments Not Yet Made	\$16,476,376 ^{†††}
Bundled Payments for Care Improvement			
Bundled Payments for Care Improvement (Models 1-4)	Not Applicable	Data Not Yet Available	\$40,399,579
Initiatives Focused on the Medicaid Population			
Strong Start for Mothers and Newborns (Strategies 1 & 2)	\$23,594,395	Not Applicable	\$47,649,930
Initiatives Focused on Medicare-Medicaid Enrollees			
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	\$70,509,361	Not Applicable	\$18,928,906

ESTIMATED PAYMENTS			
INITIATIVE	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Financial Alignment Initiative	\$5,207,996	Data Not Yet Available	\$79,839,514 ^{***}
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	\$78,900,786	Not Applicable	\$11,245,590
Initiatives to Speed the Adoption of Best Practices			
Partnership for Patients	Not Applicable	Not Applicable	\$451,352,024
Million Hearts [®]	Not Applicable	Not Applicable	Not Applicable
Initiatives to Accelerate New Service Delivery and Payment Model Testing			
Health Care Innovation Awards Round 1	\$879,640,554 ^{\$\$\$}	Not Applicable	\$60,477,074
Health Care Innovation Awards Round 2	\$120,033,340	Not Applicable	\$7,272,376
State Innovation Models (Round One)	\$181,418,835	Not Applicable	\$32,335,764
State Innovation Models (Round Two)	Payments Not Yet Made	Not Applicable	\$1,985,982 ^{****}
Medicaid Innovation Accelerator Program	Not Applicable	Not Applicable	Obligations Not Yet Made
Maryland All-Payer Model	Not Applicable	Not Applicable	\$5,608,084

ESTIMATED PAYMENTS			
INITIATIVE	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Medicare Care Choices Model	Payments Not Yet Made	Not Applicable	\$1,857,149
Prior Authorization Model: Non-Emergent Hyperbaric Oxygen Therapy	Not Applicable	Not Applicable	Obligations Not Yet Made
Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport	Not Applicable	Not Applicable	\$4,338,941
SUBTOTALS:	\$1,645,815,124	\$86,425,339	\$952,665,577

^{§§} Payments made to model participants in the Advance Payment ACO Model represent the advance payments given to ACOs as part of the model, which were distributed under the authority of section 1115A of the Social Security Act.

^{***} Payments to participants in the Advance Payment ACO Model under Title XVIII or XIX were distributed as shared savings payments under the authority of the Medicare Shared Savings Program.

^{†††} Of this amount, \$1,321,039 was obligated as application support through the FY2013 pre-implementation budget.

^{†††} Of this amount, \$1,495,660 was obligated for the Financial Alignment Initiative under the FY2011 budget for the State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees.

^{§§§} This total reflects the full amount of grant funding provided to HCIA awardees for the 3-year period of performance. Funds are used by awardees to implement models, including payments to providers of services, and to suppliers.

^{****} This funding was used for the Medicaid Innovation Accelerator Program (IAP) Learning Collaborative in FY2014. The IAP program is budgeted separately in FY2015 and thereafter.

To date, total payments made to model participants (excluding payments under Title XVIII and XIX) and other obligations for CMS Innovation Center models, as detailed above, are estimated at \$2.600 billion (exclusive of administrative costs). Actual costs may vary based on the numbers of providers and beneficiaries participating, as well as changes in expected operational and evaluation costs.

6. Results and Recommendations

Results from evaluations

The payment and service delivery models announced by the CMS Innovation Center under the authority of section 1115A of the Social Security Act, as well as the initiatives to speed the adoption of best practices, have not completed their respective periods of performance and many are in the early stages of implementation. Caution is urged in the interpretation of preliminary findings based on limited data from the early stages of model implementation. The findings from summative evaluations needed to assess the impact of new payment and service delivery models are not available. Interim results from two of the first models to be implemented, Partnership for Patients and Pioneer ACOs, have been included with their respective model descriptions in this report. The CMS Innovation Center will conduct summative evaluations of each model after the conclusion of its respective period of performance. As they become available, evaluation results will be included in future Reports to Congress, and will inform recommendations regarding model expansions or legislative action.

Models chosen for expansion

As of September 30, 2014, none of the models tested under section 1115A of the Social Security Act have been in the testing phase long enough to generate sufficient data to assess the impact of the model or to allow for a recommendation about its expansion.

Recommendations for legislative action

This report conforms to the requirements of section 1115A and describes the models launched under this authority. Any legislative recommendations related to CMS programs, including the CMS Innovation Center, would typically be included in the President's budget request.

7. Conclusion

Over the past 4 years, the CMS Innovation Center has, in accord with its legislative charge, actively tested new payment and service delivery models that show promise for reducing program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries.

The CMS Innovation Center's portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serves Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. We estimate that over 2.5 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by the more than 60,000 providers participating in CMS Innovation Center initiatives. Because a number of these initiatives involve multiple payers or focus on broad areas of quality improvement, millions of other Americans are benefiting from the CMS Innovation Center's model testing activities.

The CMS Innovation Center has solicited input from stakeholders across the country and federal partners in the selection and design of new payment and delivery models to be tested. To implement these models, the CMS Innovation Center has collaborated with CMS components, including the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Financial Alignment Initiative), the Office of Financial Management (for the Prior Authorization Models), and the Center for Clinical Standards and Quality (for Partnership for Patients) for the joint development and administration of these models. Other CMS components, and other federal agencies such as the Centers for Disease Control and Prevention, Health Resources and Services Administration, Agency for Healthcare Research and Quality, Office of the National Coordinator of Health Information Technology, Administration for Community Living, Department of Housing and Urban Development, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration, have assisted in design and testing activities for multiple models.

Under section 1115A authority, the CMS Innovation Center is testing 22 initiatives intended to achieve better care, better health, and lower costs for Medicare, Medicaid, and CHIP beneficiaries. Models have been designed to align financial incentives with improved quality and efficiency and to promote multi-payer participation in payment and delivery system reform. New payment mechanisms are enabling providers to better coordinate treatment across the continuum of care, to manage the health of populations, and to redesign care to be more patient-centered, more effective, and ultimately less costly.

These CMS Innovation Center initiatives are being conducted in partnership with a broad array of providers, health and community organizations, and researchers. Model tests are routinely monitored on performance and quality measures. Continuous quality improvement in the model tests is supported through technical assistance, learning and diffusion resources, facilitated collaboration between participants, and rapid cycle feedback on monitoring and reporting. The CMS Innovation Center is further accelerating improvement and health care transformation by disseminating successful strategies and lessons learned from model testing among program participants and throughout the health care community. The evaluation of model tests is driven by the CMS Innovation Center's Research and Rapid Cycle Evaluation Group, which reviews the program design, research methodology, and the evaluability of all proposed models and oversees both intermediate and final evaluation of model tests, aimed respectively at improving model performance during the period of performance and at providing rigorous and valid summative assessments of a model's impact on the quality and cost of care.

The efforts of the CMS Innovation Center represent important steps forward in the transformation of the health care system. Models underway and in development will help providers, payers, states, and other stakeholders achieve a system in which beneficiaries, and eventually all Americans, receive comprehensive, integrated care driven by evidence, performance, and improving outcomes. The CMS Innovation Center looks forward to building on its existing work and continuing to advance improvements in health care delivery and the reduction of expenditures.

8. Appendix: The CMS Innovation Center Program Portfolio

(All Projects With Activity During the Period November 2012-September 2014)

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Advance Payment ACO Model	Prepayment of expected shared savings to certain eligible ACOs to advance development of ACO infrastructure and care coordination	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Bundled Payment for Care Improvement	Evaluate 4 different episode payment models around inpatient hospitalization to incentivize care redesign Model 1: Retrospective Acute Care Model 2: Retrospective Acute Care Episode & Post-Acute Care Model 3: Retrospective Post-Acute Care Model 4: Prospective Acute Care	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Comprehensive End Stage Renal Disease (ESRD) Care (CEC)	An initiative to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Comprehensive Primary Care Initiative	A public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice-Demonstration	Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Financial Alignment Initiative	Opportunity for states to partner with CMS to implement new integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Health Care Innovation Awards Round One	A broad appeal for innovations with a focus on developing the workforce for new care models	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Health Care Innovation Awards Round Two	A second appeal for innovations with a focus on payment and system delivery reform in 4 categories for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP), particularly those with the highest health care needs	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents	Initiative to improve the quality of care and reduce avoidable hospitalizations among long-stay nursing facility residents through cooperative agreements with independent organizations partnering with nursing facilities to test enhanced on-site services and supports	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Maryland All-Payer Hospital Model	To test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health and reduced costs	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Medicaid Innovation Accelerator Program	Initiative providing states with technical assistance in such areas as data analytics, service delivery and financial modeling, quality measurement, and rapid cycle evaluation to accelerate the development and testing of state-led payment and service delivery innovations	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Medicare Care Choices Model	To test whether Medicare beneficiaries who meet Medicare hospice eligibility requirements will achieve patient-centered goals if they receive hospice services with continuation of curative services	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy	A prior authorization model for non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport	A prior authorization model for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina to test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Million Hearts®	National initiative to prevent 1 million heart attacks and strokes over 5 years; brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke; this initiative is not a payment and service delivery model for purposes of section 1115A, but rather is an initiative that is part of the infrastructure of the CMS Innovation Center	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) ^{††††}
Partnership for Patients	Efficacy of hospital engagement networks (and other interventions) in reducing hospital acquired conditions by 20 percent, and readmissions by 40 percent (Community-Based Care Transitions Program is covered in another row)	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Pioneer ACO Model	Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Support states in designing integrated care programs for Medicare-Medicaid enrollees	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
State Innovation Models Round One	Provides financial, technical, and other support to states that are either prepared to test, or are committed to designing and testing new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
State Innovation Models Round Two	Provides financial, technical, and other support to up to an additional 32 states to develop or implement state health care innovation plans	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Strong Start for Mothers and Newborns	<p>Strategy I: Testing the effectiveness of shared learning and diffusion activities to reduce the rate of early elective deliveries among pregnant women</p> <p>Strategy II: Testing and evaluating a new model of enhanced prenatal care to reduce preterm births (less than 37 weeks) in women covered by Medicaid and CHIP</p>	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Mandated Demonstrations and Other Initiatives Authorized Under Various Statutes		
Acute Care Episode (ACE) Demonstration	Test the effect of bundling Part A and B payments for episodes of care to improve the coordination, quality, and efficiency of care	Section 1866C of the Social Security Act
Community-Based Care Transitions Program (a part of the Partnership for Patients)	Reduce readmissions by improving transitions of high-risk Medicare beneficiaries from the inpatient hospital setting to home or other care settings	Section 3026 of the Affordable Care Act

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Environmental Health Hazards (Libby)	Pilot program provides certain environmental exposure affected individuals deemed eligible for Medicare, comprehensive, coordinated, and cost effective care (including coverage of certain benefits and services not normally authorized or covered under Medicare)	Section 1881A of the Social Security Act (section 10323 of the Affordable Care Act)
Frontier Community Health Integration Program (F-CHIP)	Develop and test new models of integrated, coordinated health care in the most sparsely-populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures	Medicare Improvements for Patients and Providers Act Section 123 and Affordable Care Act Section 3126
Frontier Extended Stay Clinic Demonstration	Allows remote clinics to treat patients for more extended periods of time than are usually provided in routine physician visits, including overnight stays	Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Graduate Nurse Education Demonstration	Designed to increase the nation’s primary care workforce by supporting facilities that train Advanced Practice Registered Nurses (APRNs) through payments to eligible hospitals, helping them offset the costs of clinical training for APRN students	Section 5509 of the Affordable Care Act
Independence at Home Demonstration	Home-based care for Medicare beneficiaries with multiple chronic conditions	Section 1866E of the Social Security Act, as added by section 3024 of the Affordable Care Act
Intravenous Immune Globulin (IVIG) Demonstration	Evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of primary immune deficiency disease (PIDD)	P.L. 112-242 Title I - Medicare IVIG Access Sec. 101

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Medicaid Emergency Psychiatric Demonstration	Provides federal matching funds to States for emergency Medicaid admissions to private psychiatric hospitals for beneficiaries aged 21 to 64	Section 2707(e) of the Affordable Care Act
Medicaid Incentives for Prevention of Chronic Diseases Demonstration	Initiatives to provide incentives to Medicaid beneficiaries who successfully participate in a comprehensive, evidence-based, widely available, and easily accessible program, which has demonstrated success in helping individuals achieve ceasing use of tobacco, controlling or reducing their weight, lowering cholesterol, lowering blood pressure, and avoiding onset of diabetes, or in the case of a diabetic, improving the management of the condition	Section 4108 of the Affordable Care Act
Medicare Coordinated Care Demonstration (Health Quality Partners)	This project tests whether providing coordinated care services to Medicare beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs	Section 4016 of the Balanced Budget Act of 1997
Medicare Health Care Quality Demonstration	Test major changes to improve quality of care while increasing efficiency across an entire health care system	Section 1866C of the Social Security Act
Medicare Imaging Demonstration	Collect data regarding physician use of advanced diagnostic imaging services in relation to appropriateness criteria which, for purposes of the demonstration, are medical specialty guidelines meeting specific conditions	Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Medicare Low Vision Rehabilitation Demonstration	Examine the impact of coverage for vision rehabilitation services provided to Medicare beneficiaries with moderate to severe visual impairments that cannot be corrected through surgery or glasses	Appropriations Conference Report 2004 (H.R. 2673) and Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)
Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)	State-led, multi-payer collaborations to help primary care practices transform into advanced primary care practices	Section 402 of the Social Security Amendments of 1967 as amended (42 U.S.C. 1395b-1)
Physician Group Practice (PGP) Transition Demonstration	A precursor to the Medicare Shared Savings Program; rewards physician groups for efficient care and high quality	Section 1899(k) of the Social Security Act
Physician Hospital Collaboration Demonstration	Examines the effects of gainsharing aimed at improving the quality of care in a health delivery system	Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended by Section 3027 of the Affordable Care Act
Private, For-Profit Demonstration Project for the Programs of All-Inclusive Care for the Elderly (PACE)	Study of the quality and cost of private, for-profit entities providing PACE program services under the Medicare and Medicaid programs	Section 4804 of the Balanced Budget Act of 1997

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Rural Community Hospital Demonstration	Test the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals	Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as amended by sections 3123 and 10313 of the Affordable Care Act
Treatment of Certain Complex Diagnostic Laboratory Tests	Make separate payments for certain complex diagnostic laboratory tests, such as gene protein expression, typographic genotyping, or cancer chemotherapy sensitivity assay	Section 3113 of the Affordable Care Act

⁺⁺⁺ The Million Hearts[®] initiative does not receive any funding from the CMS Innovation Center.

9. Glossary of Acronyms

ACO	Accountable Care Organization
ADRC	Aging and Disability Resource Center
ADE	Adverse Drug Events
AHRQ	Agency for Healthcare Research and Quality
BPCI	Bundled Payments for Care Improvement
CDC	Centers for Disease Control and Prevention
CEC	Comprehensive ESRD Care
CHIP	Children’s Health Insurance Program
CLABSI	Central Line-Associated Bloodstream Infections
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
CPC	Comprehensive Primary Care
ECCP	Enhanced Care and Coordination Provider
EED	Early Elective Deliveries
ESCO	ESRD Seamless Care Organization
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FQHC ADCP	Federally Qualified Health Center Advance Primary Care Practice Demonstration
HEN	Hospital Engagement Network

HHA	Home Health Agency
HHA VBP	Home Health Agency Value-Based Purchasing
HIV/AIDs	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HHS	Department of Health and Human Services
HVBP	Hospital Value-Based Purchasing
IAP	Medicaid Innovation Accelerator Program
LEAPT	Leading Edge Advanced Practice Topics
LDO	Large Dialysis Organization
MAC	Medicare Administrative Contractor
MFFS	Managed Fee-for-Service
MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
MS-DRG	Medicare Severity Diagnosis Related Group
NCQA	National Committee of Quality Assurance
NQS	National Quality Strategy
ONC	Office of the National Coordinator of Health Information Technology
PCMH	Patient-Centered Medical Home
RFI	Request for Information
SDO	Small Dialysis Organization
SHIP	State Health Insurance Counseling and Assistance Program

SIM	State Innovation Models
VAP	Ventilator Associated Pneumonia

ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Final White Paper

Written by:

Alternative Payment Model Framework
and Progress Tracking (APM FPT) Work Group

For Public Release
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Executive Summary

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene this large national initiative.

To advance this goal, the Alternative Payment Models Framework and Progress Tracking Work Group (“the Work Group”) was charged with creating an alternative payment model (APM) Framework (“the APM Framework”) that could be used to track progress towards payment reform. Composed of diverse health care stakeholders, the Work Group has deliberated and reached consensus on many critical issues related to the classification of APMs, resulting in a rationale and a pathway for payment reform that is capable of supporting the delivery of person centered care.

Although the Work Group was not charged with developing a working definition of person centered care, it thought that it was important to do so because it views payment reform as one means for accomplishing the larger goal of person centered care. The Work Group believes that person centered care rests on three pillars: quality, cost effectiveness, and patient engagement. For the purposes of the White Paper, the term is nominally defined as follows: *high quality care that is both evidence based and delivered in an efficient manner, and where patients’ and caregivers’ individual preferences, needs, and values are paramount*. In addition, it should be noted that the opinions expressed within the White Paper are those of the Work Group Members and not of the organizations of which they are affiliated.

The Work Group is committed to the notion that transitioning the U.S. health care system away from fee for service (FFS) and towards shared risk and population based payment is necessary, though not sufficient in its own right, to a value based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is not conducive to the delivery of person centered care because it does not reward high quality, cost effective care. By contrast, population based payments (including bundled payments for clinical episodes of care) offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, enable providers to treat patients holistically, and encourage care coordination. Because these and other attributes are very well suited to support the delivery of high valued health care, the Work Group and the LAN as a whole believe that the health care system should transition towards shared risk and population based payments. The Work Group hopes the Framework will be useful in this context to establish a common nomenclature upon which progress can be discussed and measured.

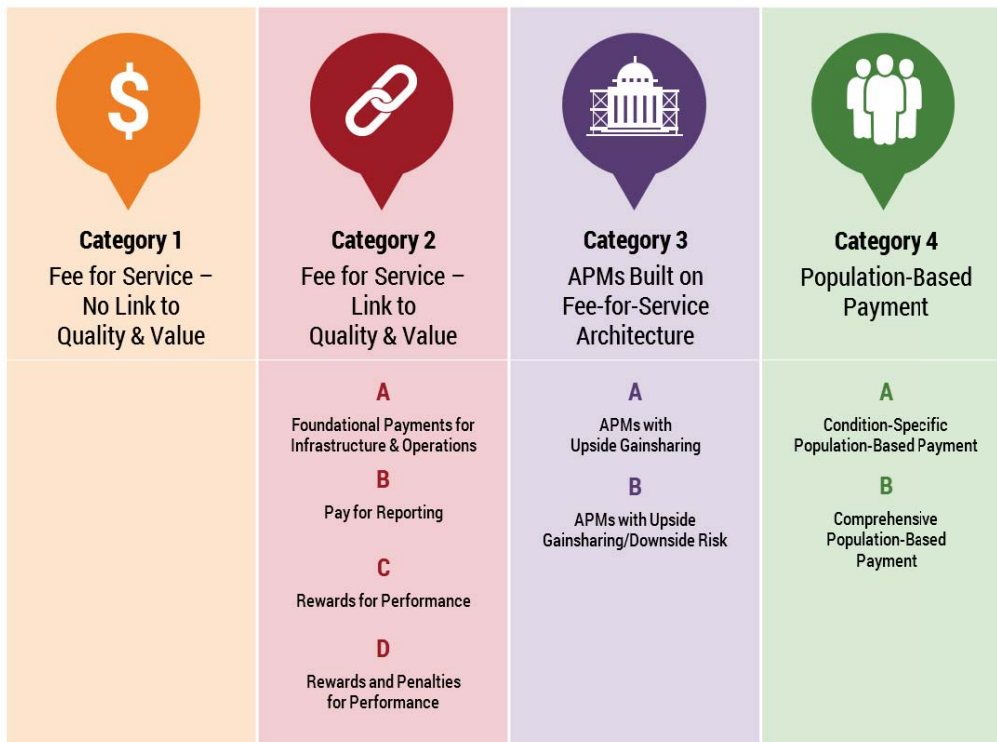
The APM Framework rests on seven principles, which can be summarized as follows:

1. Changing providers’ financial incentives is not sufficient to achieve person centered care, so it will be essential to empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

With these principles in place, the Work Group began with the payment model classification scheme originally put forward by the Centers for Medicare & Medicaid Services (CMS), and subsequently reached a consensus on a variety of modifications and refinements. The resulting Framework is subdivided into four Categories and eight subcategories, as illustrated below:

Figure 1. APM Framework (At-A-Glance)



Overview

A LAN Guiding Committee was established in May 2015 as the collaborative body charged with advancing the alignment of payment approaches across and within the public and private sectors. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher quality and more affordable care. In alignment with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population based payments by year 2016, and 50% by year 2018.

The Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group (the “Work Group”) and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the “APM Framework”). The Work Group brought together public and private stakeholders to assess APMs in use across the nation and to define terms and concepts essential for understanding, categorizing, and measuring APMs. (A roster of Work Group members, representing the diverse constituencies convened by the LAN, is provided in [Appendix A](#). Please note that opinions expressed within the White Paper are those of the Work Group Members not of the organizations of which they are affiliated.) The aim of the Work Group is to create a clear and understandable APM Framework, to provide a deeper understanding of payment models and how those models can enhance health and health care, and to provide examples of how public and private payment models are organized within the APM Framework.

The Work Group is aware that CMS is in the process of soliciting recommendations on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Work Group is hopeful that this White Paper will help CMS consider some of the issues involved in implementing MACRA, but stresses that providing formal recommendations on how to do so is explicitly not part of the Work Group’s charge. Although the Work Group is no longer soliciting comments on the White Paper, formal recommendations for implementing MACRA and/or other CMS programs and policies should continue to be made directly to CMS.

Health Care Payment Learning & Action Network (LAN)

To achieve the goal of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. To enable these reforms, the Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community. By making a commitment to changing payment models, by establishing a common framework and aligning approaches to payment innovation, and by sharing information about successful models and encouraging use of best practices, the LAN can help to reduce barriers and accelerate the adoption of alternative payment models (APMs).

U.S. Health Care Payments in APMs



The Case for Reforming the Health Care Payment System

The LAN and the Work Group are unanimous in their desire to drive payment approaches that improve the quality and safety of care and the overall performance and sustainability of the U.S. health system. The Work Group, along with many other stakeholders, envisions a health care system that provides person centered care. Recognizing that the Work Group was not charged with developing a comprehensive definition of the term or its constituent components, and that these terms may encompass additional characteristics that are not captured below, the Work Group understands person centered care to mean *high quality care that is both evidence based and delivered in an efficient manner, and where patients' and caregivers' individual preferences, needs, and values are paramount*. The Work Group believes that person centered care, so defined, rests upon three pillars:

- **Quality:** This term indicates that patients receive appropriate and timely care that not only is consistent with evidence based guidelines and patient goals, but also results in optimal patient outcomes and patient experience. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process, outcome, patient reported outcome, and patient experience measures that both provide an accurate and comprehensive assessment of clinical and behavioral health, and that report results that can be meaningfully accessed, understood, and used by patients and consumers.
- **Cost Effectiveness:** This term indicates a level of severity adjusted total costs (and, when relevant, unit prices) that reflect benchmarked best achievable results, and that are consistent with robust and competitive health insurance marketplaces as characterized by the deployment of multiple affordable, attractive products across employer group, individual commercial, and government programs sectors. Care that is less expensive than expected, but that results in poor clinical outcomes, is not considered cost effective. Conversely, care that is costly but that results in dramatic improvements in patient outcomes could be considered cost effective. Affordable health care services are vital to ensuring that the nation can support investments in education, housing, and other social determinants that can independently improve population health.
- **Patient Engagement:** This term encompasses the important aspects of care that improve patient experience, enhance shared decision making, and ensure that patients and consumers achieve their health goals. Patient engagement should occur at all levels of care delivery, with patients and caregivers serving as partners when setting treatment plans and goals at the point of care; when designing and redesigning delivery and payment models; on governance boards and decision making bodies; and when identifying and establishing connections to social support services. Engaged patients and consumers are informed of their health status and share in their own care; they are easily able to access appointments and clinical opinions; they seek care at the appropriate site; they possess the information they need to identify high value providers and to tailor treatment plans to individual health goals; they provide ongoing feedback that providers can use to improve patient experience; they are able to obtain transparent price information about services and their value for patients and consumers; and they can move seamlessly among providers that are engaged in different aspects of their care. Routine communication with family caregivers and other support members is also a critical part of comprehensive, person centered care.

As evidenced by the creation of the LAN, there is an emerging consensus among providers, payers, patients and consumers, purchasers, and other stakeholders in the health care system that efforts to deliver person centered care have been stymied, in large part, by a payment system that is oriented largely towards volume, as opposed to value for patients and caregivers. These stakeholders and the

Work Group believe that by reconfiguring payments to incentivize value, and by ensuring that valuable activities (e.g., care coordination) are compensated appropriately, providers will be able to invest in care delivery systems that are optimized for the provision of care that is more focused on patient needs. In other words, changes in payment are necessary (though insufficient on their own) to change provider behavior and drive delivery system transformations, thereby ensuring that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

The Work Group believes that shifting from traditional fee for service (FFS) payments to person focused payments (in which all or much of a person's overall care or care for related conditions is encompassed within a single payment) is a particularly promising approach to creating and sustaining delivery systems that value quality, cost effectiveness, and patient engagement. Such payments should thus include accountability for the quality of care at the population level, rather than for the volume of particular services. Although it is not yet possible to reach a definitive, evidence based conclusion about the impact of population based payments on patient care, there is a belief that these types of payment models are designed in a way that holds substantial promise. This is because person focused, population based payments give providers more flexibility to coordinate and manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and increased incentives to provide services that are currently undervalued in FFS, there is a consensus that this flexibility will expedite fruitful innovations in care delivery, particularly for individuals with chronic, complex, or costly illnesses.

At present, FFS payments are ill suited for initiating investments and sustaining population health management innovations, such as information technology, clinical decision support tools, patient engagement and care coordination functions, and additional opportunities to increase access to care (e.g., payments for telehealth, home visits, and additional office hours). This is because FFS incentivizes providers to optimize volume. As a result, FFS may at times discourage the perspective that patients require individualized and highly coordinated care. Population based payments may enable providers to develop more innovative approaches to person centered health care delivery because they reward providers that successfully manage all or much of an individual's care. Provided that safeguards are put in place to ensure that quality and patient engagement are not sacrificed to reduce costs, and that the care delivered is state of the art and takes advantage of valuable advances in science and technology, these innovative approaches to health care delivery stand to benefit patients and society alike. Patients may come to expect a more coordinated, more accessible, and more effective health care system, and the nation would benefit from reductions in national health care expenditures, and a healthier, more productive workforce.

The Work Group recognizes that new payment models require providers to make fundamental changes in the way they provide care, and that the transition away from FFS may be costly and administratively difficult. The Work Group also recognizes that participation in shared risk and population based payment models involves financial risk for providers, that not all provider organizations possess the capacity to successfully operate in these payment models, and that providers will need assistance to develop additional capabilities. In order to smooth and accelerate this transition, the Work Group believes that a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a population based health system that delivers the best health care possible. If providers were able to participate in APMs that were consistently deployed across multiple payer networks, this would reduce the administrative burden of making the transition and allow investments to be applied to all patient populations, independent of payer. Aligned payments from a critical mass of payers would enable providers to establish an infrastructure that would increase the likelihood of success for innovative delivery systems over the long term. The Work Group

expects that the adoption and diffusion of these innovative delivery systems should ultimately improve the quality, efficiency, safety, and experience of patient care, while becoming sustainable business models for providers that are eager to take a more comprehensive and coordinated approach to medical practice.

The Work Group believes that a shift to person focused, population based payments will, in concert with other reforms, result in an expansion of high value care in the United States. The Work Group recognizes the possibility that shifts in payment can result in unintended and unanticipated consequences, such as cost increases owing to provider consolidation, reduced provider willingness to exchange data, and a potential reduction in costly but effective medical services. The Work Group believes that it is therefore absolutely essential to monitor the impact of population based payment systems on patient outcomes, health care costs, and other indicators of significance to patients and other stakeholders in the health care system. The Work Group envisions the shift to person focused, population based payment as a course correcting feedback loop between innovation, implementation, and evaluation; it also anticipates that its forthcoming effort to measure progress will help accelerate this process. The Work Group is hopeful this, the first in a series of LAN publications, will help align stakeholders in the public and private sectors and support the implementation of payment systems that promote person centered care.

Purpose of the White Paper

In order to accelerate the transformations described above, the Guiding Committee charged the Work Group with creating an APM Framework through which progress towards payment reform can be described and measured. In addition to providing a roadmap to measure progress, the APM Framework helps establish a common nomenclature and a shared set of conventions that can facilitate discussions among stakeholders and expedite the generation of evidence based knowledge about the capabilities and results of APMs.

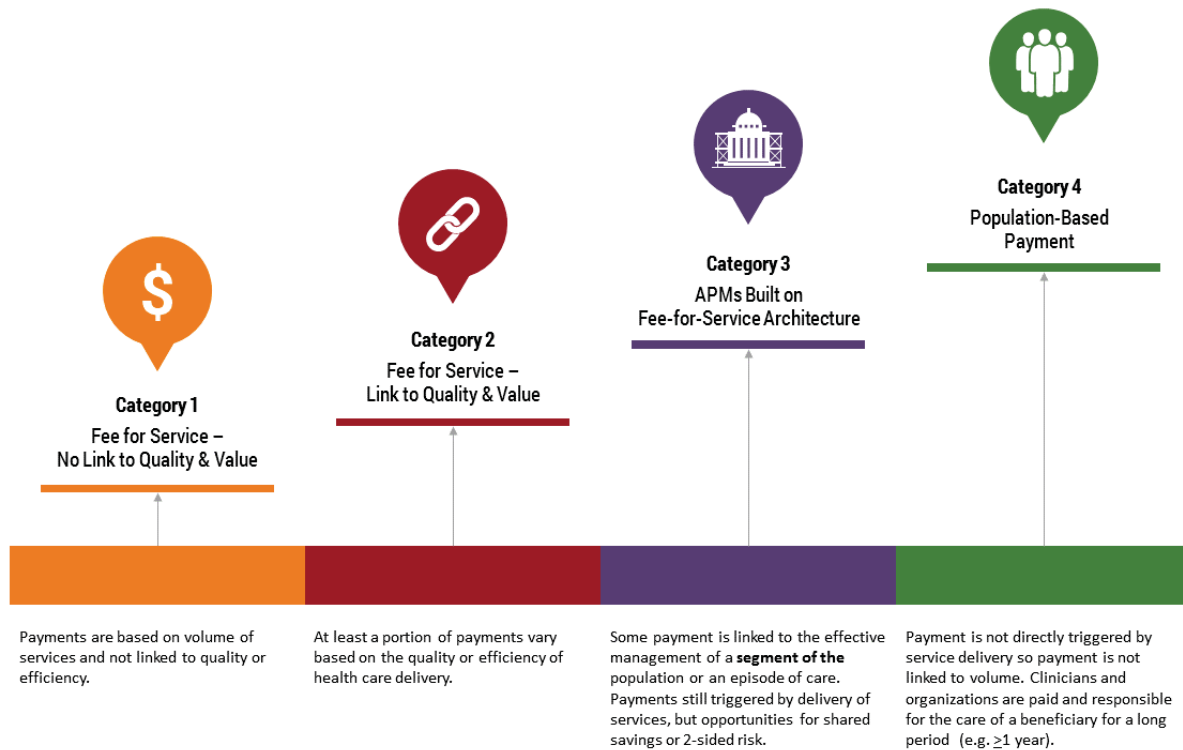
The White Paper begins by describing the approach that the Work Group used to develop the APM Framework, and then describes the principles upon which the APM Framework is based. With these principles in mind, the White Paper differentiates the Categories within the APM Framework by explaining how the Categories are defined and where their boundaries lie. The White Paper concludes with a summary of the Work Group's key findings and recommendations, as well as recommendations for how various stakeholders can use the Framework to accelerate payment reform. To further clarify the classification of individual APMs, the Work Group has separately released a collection of APMs that are currently in use.

Approach

When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS recently advanced,¹ and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 2, the CMS Framework assigns payments from plans to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).

¹ Rajkumar R, Conway PH, Tavenner M. [CMS: Engaging multiple payers in payment reform](#). JAMA. 2014 May 21: 311(19):1967-8.

Figure 2. CMS Payment Framework



The Work Group added to and refined the CMS model by: 1) articulating key principles to explain what the APM Framework does and does not mean to convey; 2) introducing four new Categories to account for payment models that are not considered progress towards payment reform; 3) introducing eight subcategories to account for nuanced but important distinctions between APMs within a single Category; 4) delineating explicit decision rules that can be used to place a specific APM within a specific subcategory; and 5) compiling, with the help of the LAN, examples of APMs that illustrate key characteristics of each of the subcategories.

Key Principles for the APM Framework

The Work Group’s Framework is predicated on several key principles. To provide context for understanding the APM Framework and the Work Group’s recommendations, these principles are delineated and explained below.

Principle 1: *Changing the financial reward to providers is only one way to stimulate and sustain innovative approaches to the delivery of person centered care. In the future, it will be important to monitor progress in initiatives that empower patients to have a voice in model design, to seek care from high value providers (via performance metrics, financial incentives, and other means), and to become active participants in shared decision making.*

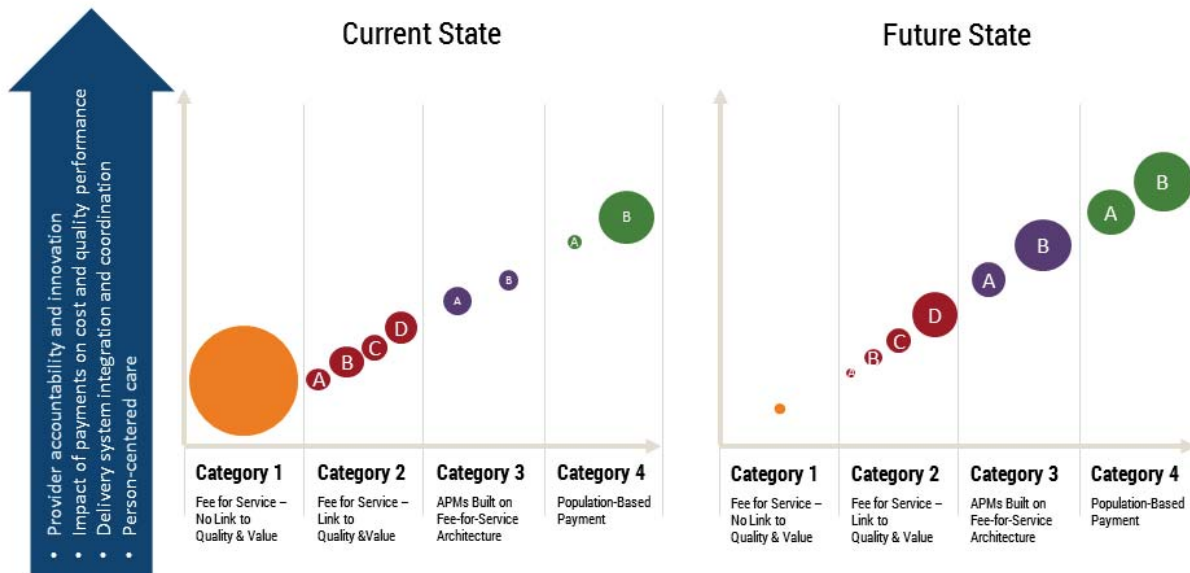
Although it was necessary to focus on financial incentives for providers as a critical first step, the Work Group recognizes that additional efforts to engage patients and consumers will be needed to achieve a high value, coordinated health care system. As more providers begin to participate in payment models that are divorced from traditional FFS, the Work Group expects all stakeholders to collaborate on approaches to empower patients to become active partners as they strive to achieve their health goals. Such approaches may include strategies to clearly and meaningfully communicate, to patients and consumers, information about provider and health plan performance on clinical and patient experience measures; financial rewards for patients and consumers to select high value providers and to successfully manage chronic diseases; and efforts to enlist patients and caregivers as partners in the setting of health goals and the development of treatment plans. In order to avoid unintended consequences associated with APMs, the Work Group also believes it is essential for payment models to include safeguards to prevent selection against individuals with more complex illnesses or a greater need for social support, and that patients and consumers will be informed of providers' financial incentives in APMs. Additional activities and monitoring will also be needed to ensure that the expansion of population based payments does not lead to disparities in health outcomes or to a decline in access to care.

Principle 2: As delivery systems evolve, the goal is to drive a shift towards shared risk and population based payment models that incentivize improvements in the quality and efficiency of person centered care.

The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional FFS payment. Consistent with this objective, the Work Group recommends that over time, the U.S. health care system should move concertedly towards APMs in Categories 3 and 4. Nevertheless, the Work Group strongly believes that providers should clearly understand the requirements for financial and clinical participation in APMs, as well as that participation in APMs should be voluntary and that providers should not take on risk that they are not prepared to accept. The Work Group also recognizes that market forces have led to different levels of delivery system organization and integration, and investment in infrastructure and management will be required to build the capabilities that will ensure greater success of more robust population health payments. Therefore, APMs in Categories 3 and 4 will not be readily achievable in every market, for every clinical domain (e.g., dental care), or for every patient population. Furthermore, the Work Group anticipates that some regional markets may be slower to make the transition to these Categories. In particular, the Work Group expects participation in Category 3 and 4 APMs to be more limited for rural providers and for certain small or solo practices. Additionally, the transition may be more challenging for safety net providers, given the broad array of other services needed by their patient populations that are not integrated into health care, unless such services can be better integrated into payment reform.

A more detailed depiction of the Work Group's goals for the health care system appears in Figure 3.

Figure 3. The Work Group's Goals for Health Care Reform



** Note: The values presented in the above “current state” graphic are based on available data on private plans from Catalyst for Payment Reform and Medicare FFS allocations. This graphic is meant to represent the Work Group’s belief of how the health care system should change, and it takes into account the likely impact of Medicare’s Merit Based Incentive Payment System. The Work Group cautions that values displayed in the graphic are not precise, nor are they intended to lay out specific targets for health care reform.*

In Figure 3, the size of the various circles represents spending across various types of payment models. As Figure 3 illustrates, payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally, the Work Group expects that, over time, APMs within a particular category will increase the extent to which payments are linked to provider accountability, enable more innovation in care, make a greater impact on quality and cost performance, increase coordination in delivery systems, and result in more value based care.

Principle 3: *To the greatest extent possible, value based incentives should reach providers across the care team that directly delivers care.*

Based on the experience of members of the Work Group, payment reforms for quality improvement and cost reduction are most effective when they directly impact payments for providers that are principally responsible for providing care to patients. These incentives are effective because providers delivering patient care are best positioned to develop mechanisms that drive person centered, well-coordinated, and high value care that ultimately lead to better outcomes. For example, an accountable care organization (ACO) that is at risk for cost and quality would ideally design financial incentives for individual physicians and hospitals in a way that aligns with the ACO’s incentives as an organization. The Work Group recognizes that it may not always be possible to measure accurately the degree to which incentive payments reach individual practitioners. Nevertheless, the Work Group considers this a best practice and affirms that all delivery systems participating in Category 3 and 4 APMs should commit to

this principle. The Work Group believes that making population based payments to provider organizations that, in turn, pay individual providers on an FFS basis will not harness the full potential of the incentives in the APM.

Principle 4: Payment models that do not take quality and value into account will be classified within the appropriate category with a designation that distinguishes them as a payment model that is not value based. They will not be considered APMs for the purposes of tracking progress towards payment reform.

As illustrated in Figure 4, the APM Framework represents a continuum of payment approaches across four Categories. Category 1 represents FFS payment not linked to quality incentives. Categories 2 through 4 are organized according to the degree to which they advance beyond traditional FFS payment. The Work Group believes strongly that there is limited merit in moving toward population based payments if the resulting payment models do not include incentives to deliver quality health care based on current clinical knowledge. Although the Work Group was not charged with making specific recommendations about what constitutes meaningful quality measurement, it believes that APMs should use harmonized measure sets that include process, clinical outcome, patient reported outcome, and patient experience of care measures. Quality measures should be appropriately adjusted for patient mix, and whenever possible the measures used should be endorsed by professional organizations, the National Quality Forum, the Core Quality Measures Collaborative, and others involved in developing consensus. Measure sets should also be robust enough to provide a comprehensive portrait of a population's clinical and behavioral health. Payment models that represent some movement away from traditional FFS, but that do not take quality (and therefore value) into account, will be placed under the appropriate payment category and marked with an "N" to indicate "No Quality" considerations (e.g., population based payments not linked to value will fall into Category 4N). Accordingly, such models will not be considered to represent progress toward true payment reform, and the Work Group will not track them as part of measuring the achievement of the LAN's goals.

Principle 5: In order to reach the LAN's goals for health care reform, value based incentives should be intense enough for providers to invest in and implement delivery reforms, and they should increase over time. However, the strength of incentives does not affect the classification of APMs in the APM Framework.

The Work Group believes that APMs can be effective stimuli for delivery system change if providers are given meaningful incentives to develop and sustain innovative approaches to care delivery, and it acknowledges that shifting to person focused, population based payment systems will require substantial investments on the part of providers. Accordingly, it is critical that value based incentives be large enough to motivate providers to invest in and adopt new approaches to care delivery, and—over time—to outweigh profits that could be generated by increasing FFS billing. For example, the Work Group believes that a two sided incentive of plus or minus 10% is likely to promote change to a greater extent than a plus or minus 2% incentive. To accelerate and sustain progress throughout the entire health care system, the Work Group also believes that the size of this incentive should grow over time, as providers obtain greater experience in advancing quality while managing costs. A similar principle

applies to the setting of cost and quality benchmarks, in the sense that higher expectations for quality improvements and cost reductions are more effective at stimulating innovative approaches to care delivery.

At this time the Work Group classifies APMs without considering the intensity of the associated incentive payments because it believes that doing so would unnecessarily complicate the APM Framework. Using the example above, an episode based payment with a 10% financial risk/reward is classified the same as an episode based payment with a 2% financial risk/reward. The Work Group believes that more experience and analysis will be needed to determine what the “right” risk/reward level is to promote progress, while also recognizing that it may be different for hospitals and health systems than for physician organizations and health professionals. Nevertheless, the Work Group believes that a minimal threshold of risk and reward should be 5%, but likely greater.

Principle 6: For tracking purposes, when health plans adopt hybrid payment models that incorporate multiple APMs, the payment dollars will count towards the category of the most dominant APM. This will avoid double counting payments through APMs.

The Work Group recognizes that a particular payment model may utilize several APMs concurrently, especially as the model is evolving. For example, an ACO may utilize a shared savings model in years one and two along with nominal pay for performance incentives, and then transition to a shared risk model in year three. For the purpose of tracking progress in such hybrid cases, the entire payment model will be placed in the category that best captures the “dominant” APM (in this case, shared savings for years one and two, and shared risk in year three). It is also possible that bundled payments may be used within gainsharing, shared risk, and population health models, and that a patient centered medical home may be supported by FFS based care coordination fees, pay for performance, and shared savings. In these and other scenarios, payment dollars will count towards the most dominant APM in use, meaning the APM to which the greatest amount of incentive payments are directed.

Principle 7: Centers of excellence, patient centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable APMs and need the support of APMs, but none of them are synonymous with a specific APM. Accordingly, they appear in multiple categories of the APM Framework, depending on the underlying payment model that supports them.

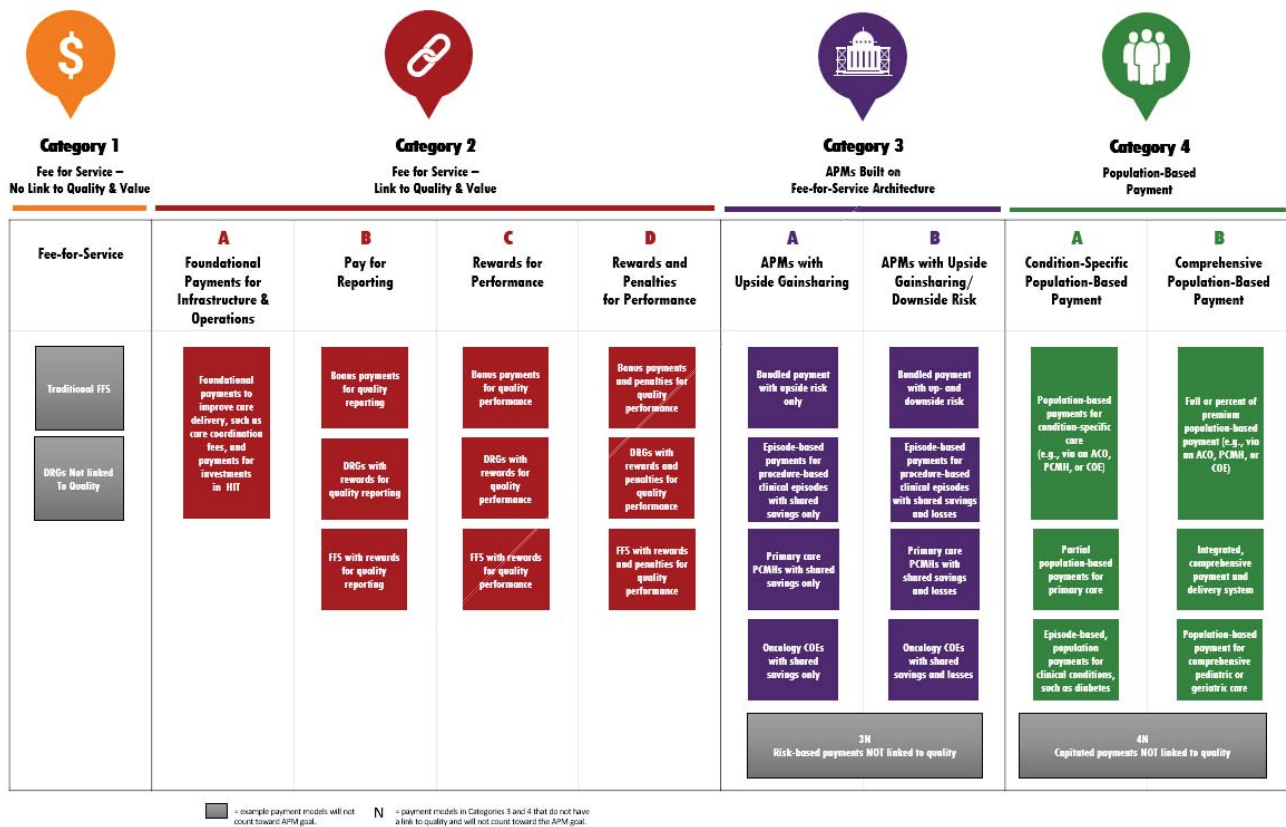
Consistent with the mission of the LAN, the Work Group limited the scope of the APM Framework to payment models, as opposed to delivery models. Because centers of excellence (COEs), patient centered medical homes (PCMHs), and ACOs are delivery models that can accommodate a wide variety of payment arrangements, they will be listed according to their underlying payment arrangement when they appear in the APM Framework. For example, a PCMH that participates in a shared savings/risk model will be classified in Category 3, but a PCMH that receives population based payments linked to value will be classified in Category 4. The Work Group recognizes that PCMHs and ACOs are commonly understood to be associated with risk sharing payment models. Nevertheless, the Work Group strongly

recommends maintaining a clear distinction between concepts that describe payment models and those that describe delivery models. At the same time, the Work Group believes these delivery models have been developed with the goal of driving care coordination and delivery improvements, and will enable more advanced payment models while at the same time requiring more advanced payment models to succeed. In recognition of their dramatic potential to improve the delivery of high quality and efficient health care, the Work Group elected to represent ACOs, PCMHs, and COEs in multiple categories, where corresponding APMs exist today and, likely, in the future.

The APM Framework

The Work Group's APM Framework is depicted in Figure 4. The Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations. The following discussion identifies the organizing principles that serve as the foundation for each Category, explains how the Categories are differentiated, and highlights examples of APMs in each Category. Please note that the examples in Figure 4 are not meant to be exhaustive, but are rather intended to give a sense of possible arrangements in each of the subcategories.

Figure 4. APM Framework



① *Fee for Service with No Link to Quality & Value (Category 1):*

Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments are made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor for provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1. This is because the Work Group has determined that DRGs are used to reimburse a group of services delivered within a hospitalization, and while DRGs drive efficiencies in inpatient care, hospitals typically bill DRGs in much the same way that physicians bill services that are paid on a fee schedule. In both instances, the provider's incentive may be to bill for additional services because they are paid more for more volume.

Payments in Category 1 are distinguished from those in Category 2 in that the latter incentivizes infrastructure investments and/or involves some method of reporting or assessing the quality of the care delivered. Unlike payments made in Category 1, payments made in Category 2 are influenced by whether a provider invests in infrastructure, reports quality data, or achieves quality targets.

② *Fee for Service Linked to Quality & Value (Category 2):*

Payment models classified in Category 2 utilize traditional FFS payments (i.e., payments that are made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics.

The Work Group has split Category 2 into subcategories A, B, C, and D as outlined below:

- Payments placed into **Category 2A** involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A. Because investments in these and similar delivery enhancements will likely improve patient experience and quality of care, the Work Group considers these types of FFS or per member per month (PMPM) payments an important—though preliminary—step toward payment reform.
- Payments placed into **Category 2B** provide positive or negative incentives to report quality data to the health plan and—preferably—to the public. Providers may have initial difficulties reporting clinical data accurately. Participation in a pay for reporting program therefore gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan's reporting system. Because pay for reporting does not link payment to quality performance, the Work Group maintains that participation in Category 2B payment models should be time limited and that participation in Category 2B payment models will often evolve into subsequent categories.
- Payments are placed into **Category 2C** if they provide rewards for high performance on clinical quality measures. Much like pay for reporting programs, pay for performance programs that only reward high performance on quality metrics give providers an opportunity to acclimate themselves to the applicable reporting systems and measures before they are subject to penalties for low performance. In some instances, these programs have an extensive set of performance measures

that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in a hospital acquired infections.

- Payments placed into **Category 2D** reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive lower updates to their FFS baseline or may receive a percent reduction on all claims paid if they do not meet quality goals. (Please note that payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets, but may take into account performance on a more limited set of cost measures.)

In addition to their capacity to stimulate and focus quality improvement initiatives, investments in quality performance assessment are also valuable because they can drive the development and expansion of health information technology (HIT). Although the Work Group was not tasked with developing specific recommendations on HIT and data sharing, it believes that providers should invest in interoperable systems; that administrative reporting requirements should be minimized as much as possible; that patients and caregivers should have free and ready access to patient records; and that HIT should be used to maintain patient registries and contribute to the development of clinical measures and guidelines.

As indicated in the discussion above, the Work Group expects that providers receiving Category 2A and 2B payments are investing in the HIT and other infrastructure needed to assess and improve quality performance, and that payments in these categories will be an “on ramp” to participation in subsequent categories. In other words, the Work Group expects that under most circumstances, providers and provider groups will transition quickly into Categories 2C and 2D, though they may do so in different ways. In the private sector, few payment plans support pay for reporting arrangements, and providers often move directly into pay for performance models. By contrast, Medicare pay for reporting programs typically precede and serve as the foundation for pay for performance programs in the same facility setting. Because data from the former determine payment adjustments in the latter, providers paid under that Medicare arrangement are typically eligible to receive both Category 2B and Category 2D payment adjustments. The Work Group stresses that the payment models in Categories 2A through 2C will prepare providers to take on the additional accountability and financial risk associated with APMs in Categories 3 and 4. This concept of Categories 2A and 2B as an “on ramp” for subsequent categories will be assessed as the Work Group measures and tracks progress towards adoption of APMs.

Payments that fall under Category 2 are distinguished from those that fall under Category 3 in two respects. First, Category 2 payments do not involve arrangements in which providers assume either shared savings or shared losses based on established cost targets. Second, FFS based payments in Category 3 reflect, to a greater degree, care that is provided longitudinally, such that multiple providers are responsible for the cost and quality associated with a particular set of procedures or services. By contrast, Category 2 payments are limited to specific providers.

③ *APMs Built on Fee for Service Architecture (Category 3):*

Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account (as in Category 2), Category 3 payments are based on cost performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. For APMs in Category 3, providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.

Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures, such as hip replacement or back surgery.

The Work Group has split Category 3 into subcategories A and B as outlined below:

- **Category 3A** gives providers an opportunity to share in the savings they generate. If a provider participating in a Category 3A APM meets quality targets but does not meet cost targets, then the provider is not held financially responsible for excess spending.
- Payments in **Category 3B** involve both upside gainsharing (i.e., positive payment adjustments) and downside risk (i.e., negative payment adjustments) based on performance on cost measures.

Most ACO arrangements today can be placed into either Category 3A (most often) or Category 3B, depending on whether the underlying risk arrangement includes only upside gainsharing or both upside gainsharing and downside risk for providers. The Work Group believes payments in Category 3 will advance clinical integration and affordability to a greater extent than payments in Category 2 because risk sharing arrangements provide stronger incentives to manage health care costs and reward care coordination across the span of care.

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single payment that encompasses a broad array of services, whereas providers participating in Category 3 models are eligible for only a portion of the losses and/or savings they generate. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the total cost of care for treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population. By contrast, even if they are fully capitated, payments that cover a more limited set of specialty services (including primary care) would be classified in Category 3. For example, a Category 4 model for pediatric care would have to cover a wide range of medical, preventive, and developmental services, whereas a population based payment model for primary care would fall under Category 3 if it did not hold primary care providers accountable for care coordination and the appropriate utilization of specialty services. Similarly, clinical episode payments tied to conditions (e.g., diabetes or cancer) fall under Category 4, whereas clinical episode payments tied to procedures (e.g., hip replacement or back surgery) fall under Category 3, even if they are made on a per member per month basis. As such, Category 4 payments are more person focused, insofar as they include stronger incentives to promote health and wellness throughout the care continuum.

④ *Population Based Payment (Category 4):*

Payment models classified as Category 4 involve population based payments, structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined (4A) or overall (4B) budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments within Category 4 are intended to cover a wide range of preventive health, health maintenance, and health improvement services, and these payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Additionally, and in contrast to capitated arrangements in Category 4N, providers participating in Category 4A and 4B APMs are held accountable for delivering high quality, clinically necessary, and appropriate care.

The Work Group has split Category 4 into subcategories A and B as outlined below:

- **Category 4A** payments are limited to certain sets of condition specific services (e.g., asthma, diabetes, or cancer), but they remain person focused in the sense that they hold providers accountable for the total cost and quality of care related to that condition. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. The Work Group recognizes that in certain instances patient care will predominantly revolve around the management of particular types of conditions, such as cancer or heart disease. In such cases, we recognize that Category 4A may become a suitable and justifiable endpoint, especially for smaller provider organizations which may never be able to deliver certain types of care (such as transplants). Nevertheless, the Work Group maintains that providers should ideally be paid to maintain health and manage illness for an entire population, rather than compartmentalizing payments according to particular conditions. We also believe that condition specific payments should, in time, become part of a comprehensive approach to improving health and reducing costs for an entire population. For highly integrated delivery systems, the Work Group envisions that Category 4A payments will evolve into Category 4B.
- Payments in **Category 4B** are capitated or population based for all of the individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements with varying degrees of integration between plans and provider groups. On one end of the spectrum, plans and providers in Category 4B models may be virtually integrated. On the other end of the spectrum are highly integrated arrangements that are characterized by vertical integration of financing and care delivery, common ownership, and strong linkage across strategy, clinical performance, quality, and resource use. These groups may also have a higher percentage of salaried physicians. After reviewing the literature and discussing these highly integrated arrangements with people who operate within them, the Work Group has reached the conclusion that they can be ideally suited for delivering person centered care because they: 1) force transformational thinking about delivery system reform; 2) optimize coordination of infrastructure investments; 3) most fully remove financial incentives for volume; and 4) expedite community investment and engagement. Although the underlying payment approaches were not sufficiently distinct to warrant the creation of a separate subcategory for highly integrated payment and delivery systems, the Work Group believes that these arrangements yield key benefits and efficiencies, because they have a greater impact on organizational responses to quality and value incentives.

Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care. Nevertheless, the Work Group recognizes that not every market currently is suited to support APMs in Category 4, and that the journey to Category 4 will occur along different trajectories in different markets, based in significant part on the organization of care delivery systems.

Conclusion

As set forth in this document, the Work Group is committed to the concept that transitioning from FFS to population based payments is critical for health care transformation. Keeping in mind the underlying principles, the APM Framework provides a high level mapping of payment approaches, as well as a pathway for payment reform and a foundation for measuring progress. The Work Group envisions that these mappings will be useful for all stakeholders and prove enduring as they navigate the health care ecosystem.

While the Work Group believes that this Framework identifies and encompasses all models of payment reform and will be enduring, Work Group members hope to return to the White Paper at a later date to take into account new developments in the health care sector. Nevertheless, the Work Group intends the APM Framework to be robust enough to accommodate foreseeable changes, and it strongly believes that this should become the overarching framework for discussing and evaluating payments in the U.S. health care system. The LAN intends to continue compiling and periodically releasing case studies of payment models. (See APM Framework White Paper Addendum.) The Work Group believes this is important because it will disseminate lessons learned and provide the nation with models to consider as public and private plans align around common payment approaches.

Stakeholders and the APM Framework

Patient Advocacy Groups can use the APM Framework to understand the context behind plan and benefit design so that they can identify and communicate desirable elements and become empowered to participate in decisions about how to design payment plans and delivery systems.

Providers can use the APM Framework to make sense of the types of payment reforms underway, to achieve a better understanding of where they are situated, to begin to conceive of where they might like to end up, and—most importantly—to plan for the future.

Plans can use the APM Framework to drive payment and contracting models and as an accounting tool to track spending and the distribution of members/beneficiaries and providers. This is crucially important, because adopting a common classification scheme would represent a first step towards the alignment of payment approaches.

Purchasers can use the APM Framework to engage and educate their employees about the health insurance landscape and to share information for population based plans, along with the safeguards and benefits that would tip them towards enrolling in such plans.

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