HCP LAN
Health Care Payment Learning & Action Network

ADDENDUM

Addendum to the Alternative Payment Model (APM) Framework White Paper

APM Framework and Progress Tracking (FPT) Work Group

Health Care Payment Learning & Action Network

CMS Alliance to Modernize Healthcare

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This Addendum presents the case studies submitted to the APM FPT Work Group in response to the draft APM Framework White Paper released October 2015.

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Please note that the examples cataloged in this Addendum are intended to illustrate the likely ways in which real world APMs will be categorized in the APM Framework. These case studies have been voluntarily submitted by the LAN community. The Work Group will continue to collect and redistribute additional case studies after the release of the Final White Paper, with the goal of identifying examples for each of the subcategories. Categorizations of particular case studies may subsequently change based on additional information.

Category 2: Fee for Service Linked to Quality and Value

Anthem – Quality Cancer Care

Overview

The Cancer Care Quality Program identifies certain cancer treatment pathways based on current medical evidence, peer reviewed published literature, consensus guidelines, and Anthem's clinical policies, to support oncologists in identifying cancer treatment therapies that are proven effective and provide greater value. The program allows in network oncologists to receive treatment planning fees for choosing cancer treatment regimens most likely to produce better outcomes, fewer side effects and cost effective care.

Underlying payment approach

2(C) – FFS with rewards for quality.

Approaches to cost assessment

N/A

Approaches to quality assessment

Pay for performance with quality gates.

Method and magnitude of payment adjustment

Participating practices receive a $350 one-time fee at the onset of treatment planning and care coordination for each member. The practice will also receive $350 per month per member (PMPM) while the member is active in therapy and on pathway.

Providers will continue to be reimbursed for visits and cancer drugs according to the terms of the member's health plan regardless of whether a treatment is on pathway, however, only pathway regimens are eligible for greater reimbursement for health plan in network providers.

Additional infrastructure and operational investments

N/A

Results

Data for Anthem states (GA, IN, KY, MO, OH, & WI) from 7/1/2014 to 12/31/2014 showed:

- 616 practices participating in the Program
- 5538 patients were registered in the Program
- Pathway adherence* for the top three cancers
    - Breast = 63%
    - Colon = 72%
    - Non small cell lung cancer = 63%

* pathway adherence goal for year 1 of Program is 55%.

Anthem – Quality In Sights Hospital Incentive Program

Overview

Anthem's Quality In Sights Hospital Incentive Program (Q HIP) ties increases in hospital reimbursement to performance on a scorecard consisting of nationally recognized measures of quality, outcomes and patient experience. The mission of Q HIP is to improve patient outcomes in the hospital setting and promote health care value by financially rewarding hospitals for practicing evidence based medicine and implementing best practices.

Underlying payment approach

2(C) – FFS with rewards for quality

Approaches to cost assessment

N/A

Approaches to quality assessment

Pay for performance with quality gates, such that higher performance yields higher rewards

Method and magnitude of payment adjustment

Q HIP has shifted annual hospital rate increases to an at-risk model where increases are only earned based on demonstrated performance on key value metrics. Hospitals "earn" their increases in payment rates based standards such as post discharge planning, adherence to a safety checklist and patient satisfaction.

Q HIP utilizes one of two payment methodologies dependent on market needs and hospital specific scenarios. The first Q HIP payment model establishes a static tiered payment scale where hospital performance determines the amount of annual rate increase earned (ex: score of 80 earns a 0.5% increase, a score of 85 earns a 1.0% increase, a score of 90 earns a 1.5% increase and a score of 95 earns a 2% increase). Payment scales are customizable at the market level and specific amounts at risk are specific to individual hospital contracts. Alternatively, a dynamic performance model is available which measures hospital performance against peer facilities within a given state or region. This model utilizes percentile and quartile measurements within the peer group to determine a given facility's earned increase based on their performance against those percentile/quartile thresholds.

Additional infrastructure and operational investments

Q HIP offers numerous tools aimed at assisting facilities in meeting the scorecard goals, including best practice sharing webinars and compliance examples from SME hospitals for specific areas of care and/or metrics. Anthem staff are also available year round to discuss quality improvement activities and opportunities related to Q HIP metrics and connect facilities in need of assistance with "mentor" hospitals within the Q HIP community

Results

Q HIP has driven impressive improvements across a spectrum of patient safety and quality metrics since inception, including:

- A 49% reduction in Early Elective Deliveries between years 2013 and 2014, resulting in fewer avoidable elective deliveries of infants prior to 39 weeks gestation. Ensuring these elective deliveries are prevented reduces both harm and mortality to the mother and child.
- A 13% decrease in likely inappropriate PCIs for patients without acute coronary syndrome between years 2013 and 2014, resulting in avoided angioplasty procedures for patients who didn't need them according to American College of Cardiology Appropriate Use Criteria (AUC).
- A 14% increase in WHO Surgical Safety Checklist adoption by Q HIP hospitals between years 2012 and 2014, resulting in a safer surgery processes that have been shown to lead to lower complications and mortality for patients.

AmeriHealth Caritas– PerformPlus© Program

Overview

PerformPlus© represents ACFC's suite of value based incentive programs available to participating physicians (primary care and specialists), hospitals, and integrated delivery systems. PerformPlus© is designed to reward providers for timely, appropriate care and positive patient outcomes. The programs advance delivery and payment reform and are aligned with efforts in the Medicare and Commercial markets. The quality measures that provide the foundation for each program are designed to incentivize necessary and preventive care and discourage preventable resource utilization. In certain markets, AmeriHealth Caritas' PerformPlus© program includes category 3(A) shared savings arrangements with integrated delivery systems. Approximately 40% of AmeriHealth Caritas' membership is touched in some way by a value-based PerformPlus© program.

Underlying payment approach

2(C) –FFS with rewards for quality and cost efficiency.

3(A) – APM built on FFS architecture

Approaches to cost assessment

Baselined to historical benchmarks and risk adjusted peer targets.

Approaches to quality assessment

Pay for performance with quality gates.

Method and magnitude of payment adjustment

PCP models include semi-annual capitation adjustments, upside only, based upon peer based percentile performance guardrails built upon quality and total cost of care results. IDS shared savings models include trend and peer based measurement based upon quality scorecard and efficiency measures such as preventable admissions, readmissions and emergency room usage. Annual settlement parameters with interim payment stream.

Additional infrastructure and operational investments

Partners participating in the PerformPlus© model can access a secure, web based dashboard to track their progress for each metric, and produce self-service reports with drill down data mining capabilities. The dashboard also allows the identification of frequent emergency department utilizers, readmissions, HEDIS results, care gaps, clinical risk, and other member centric data to foster collaboration and meaningful member outreach. Data reports are updated monthly. Dashboards have been deployed to approximately 300 PCP groups, including FQHC and large IDS partnerships.

Results

The majority of PerformPlus© partnerships have demonstrated positive quality and efficiency results. Quality improvement has been noted in prenatal care, post-partum care, chlamydia screening, beta blocker therapy, cholesterol testing and antiplatelet therapy HEDIS metric performance. Cost efficiency improvements include preventable readmissions, preventable admissions, reduced low acuity emergency room visits and improved NICU LOS management.

Cigna Collaborative Care Hospitals

Overview

Cigna's hospital collaborative initiative includes arrangements with over 330 hospitals and is a pay for performance model, which links the hospital's reimbursement to achievement of quality standards. Hospitals are measured on various quality based metrics including patient safety, patient experience, outcomes and efficiency. The program has two options for reimbursement: one where the at risk portion is paid as an increase in rate schedule based on a hospital's quality results and one where there is a bonus amount paid immediately after the measurement period.

Underlying payment approach

2(D) – Rate escalator methodology: Portion of hospital's annual rate escalator is at risk based on its performance on quality metrics. The amount earned increases some of the FFS payments in future periods.

2(D) – Bonus methodology: Portion of hospital's annual rate escalator is removed and translated into an annual bonus amount which is at risk based on performance on quality metrics. The amount earned is paid after the measurement period.

Approaches to cost assessment

For most measures, achievement is defined as a significant improvement compared to the hospital's baseline, or the hospital being in the top quartile of all hospitals reporting nationally.

Approaches to quality assessment

Hospital performance is based on 14 quality metrics focusing on outcomes, efficiency, patient experience, and process of care measures. Most metrics are CMS/Hospital Compare or all payer measures. Limited Cigna based metrics are also used.

Method and magnitude of payment adjustment

Each measure has a certain weighting attached; failure on any measure lowers the incentive payment by that weighted amount. To earn 100% of the incentive, a hospital must achieve top performance on each metric. The typical weighting is:

- CMS process of care measures 10%
- Outcome measures 45%
- Patient experience measures 20%
- Efficiency measures 25%

Additional infrastructure and operational investments

N/A

Results

Measures should correlate to lowered total medical costs and higher quality outcomes.

Category 3: APMs Built on Fee for Service Architecture

Cigna Collaborative Care – large physician groups

Overview

Cigna has 142 collaborative care initiatives with large physician groups. Similar to CMS MSSP, Cigna provides financial incentives to improve the total medical cost and quality of care for an aligned population of patients. These groups provide care to over 1.6 million Cigna customers and comprise more than 65,000 physicians, over 32,000 of which are primary care physicians. More than two thirds of groups with at least two years of experience are meeting Cigna's total medical cost goals, over two thirds are meeting its quality goals and more than half are meeting both goals.

Underlying payment approach

3(A) –APM built on FFS architecture.

Approaches to cost assessment

Baselined to regional benchmarks.

Total medical cost is evaluated based on the physician group trend compared to market trend. The maximum potential reward is 50% of the difference.

Approaches to quality assessment

Pay for performance with quality gates.

Rewards are based on performance on 17 quality metrics relevant to a commercial population and available through claims data. Quality must be maintained or improved to be eligible for any financial incentive.

Method and magnitude of payment adjustment

The incentive is paid in the following year as a care coordination payment on a PPPM basis. The care coordination payment amount is adjusted annually after reviewing the cost and quality performance of the physician group. When evaluating a group's performance Cigna first determines if the group's total medical costs are lowered compared to market trend to establish the maximum incentive award. The final step is to review the group's quality performance to determine the proportion of the maximum incentive award that the group receives.

- If quality deteriorates, there is no financial incentive.
- If quality is maintained but does not improve, the group gets 50% of the maximum possible incentive.
- If quality improves by four percent or reaches market or national benchmarks, the group can earn up to the entire maximum possible incentive.

Additional infrastructure and operational investments

Cigna provides groups with a comprehensive set of total medical cost and quality performance reports. Information is provided that allows the groups to identify the opportunities for improvement for their patient population and track progress. These reports are also designed to allow the group to engage individual physicians to help drive improvement.

Cigna requires the groups to establish an "embedded care coordinator," typically a nurse employed by the group, who proactively engages with patients in need of greater care coordination, such as patients being discharged from the hospital, patients with multiple care providers, or patients with multiple gaps in care. Cigna provides predictive models to identify patients most in need of care coordination and trains the embedded care coordinators in their use. The embedded care coordinators are linked with Cigna medical case managers, behavioral case managers, pharmacists and chronic disease coaches who can provide additional services to at risk patients.

Finally, Cigna hosts quarterly national learning collaborative meetings designed to be a forum for sharing of best practices among the participating physician groups.

Results

More than two thirds of groups with at least two years of experience are meeting Cigna's total medical cost goals, over two thirds are meeting its quality goals, and more than half are meeting both goals. The average impact on trend was a reduction of more than one percent.

CMS Comprehensive Primary Care (CPC) Initiatives

Overview

The Comprehensive Primary Care (CPC) initiative is a four year multipayer CMS model test designed to strengthen primary care. Since CPC's launch in October 2012, CMS has collaborated with commercial and State health insurance plans in seven U.S. regions to offer population based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions for Medicare FFS beneficiaries. These five 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; (5) Coordination of Care across the Medical Neighborhood. The initiative is testing whether provision of these functions at each practice site (supported by multi payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology) can achieve improved care, better health for populations, and lower costs, and can inform future Medicare and Medicaid policy.

Underlying payment approach

3(A) – APM built on FFS architecture with upside risk only.

Approaches to cost assessment

Baselined to regional benchmarks.

Approaches to quality assessment

Pay for performance based on quality scores derived from EHR clinical quality measures, claims, and patient surveys.

Method and magnitude of payment adjustment

Participating practices receive a monthly care management fee for each Medicare fee for service (FFS) beneficiary and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary. The monthly payment from Medicare averages $20 per beneficiary per month during the years one and two of the initiative (years 2013 14), and decreases to an average of $15 per beneficiary per month during the third and fourth years (2015 16). 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.

Additionally, CMS is offering each CPC practice the opportunity to share net savings generated from improved care to Medicare beneficiaries attributable to the practice. Annually in years 2014 16, savings to the Medicare program will be calculated at a regional level and distributed to practices according to their performance on quality metrics. Practices have similar shared savings opportunities with other CPC payers in their region.

Additional infrastructure and operational investments

CPC provides learning support and other resources to help practices work with patients in the five comprehensive primary care functions: (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.

Results

In year 2014, CPC practices showed positive quality results, with hospital readmissions lower than national benchmarks and high performance on patient experience measures, particularly on provider communication with patients and timely access to care. CPC practices that demonstrated high quality care and reduced spending above a threshold shared in savings generated for Medicare.

During this first shared savings performance year, the initiative decreased Medicare Part A and Part B spending compared to spending targets while achieving high quality outcomes. The CPC initiative generated a total of $24 million in gross savings overall (excluding the CPC care management fees). These results reflect the work of 483 practices that served approximately 377,000 people with Medicare and more than 2.7 million patients overall. Four of the CPC initiative's seven regions (Arkansas, Colorado, Cincinnati Dayton region of Ohio, and Oregon) generated gross savings. The Greater Tulsa region decreased costs in excess of the CPC care management fees, generating net savings of $10.8 million and earning more than $500,000 in shared savings payments.

Anthem – Enhanced Personal Healthcare Model

Overview

Enhanced Personal Health Care (EPHC) is Anthem's value based payment initiative that rewards high quality care, improved health outcomes and cost efficiency, rather than volume of care delivered.

Underlying payment approach

3(A) – APMs built on FFS architecture with upside risk only.

Approaches to cost assessment

Primary care providers held accountable for the total cost of care for their attributed members, including professional, facility and post-acute care.

Approaches to quality assessment

Performance on a scorecard of 27 nationally recognized quality and efficiency measures determines whether providers receive shared savings, and calibrates the amount of shared savings for which providers are eligible.

Method and magnitude of payment adjustment

Each year, our actuaries set a Medical Cost Target (MCT) for each participating provider group, based on the expected cost of health care services for attributed members. Risk adjusted costs incurred during the year are compared with the medical cost target. If the actual costs are less than the medical cost target and the provider meets a quality threshold, then the provider becomes eligible to receive a portion of the savings. If a provider does not meet the quality threshold, the provider is NOT entitled to any bonus payment, regardless of the savings generated. The amount of the shared savings bonus is calibrated based on the Provider's quality scores, subject to a maximum payment amount. On average, providers are eligible for up to 35% of the shared savings they generate; providers who assume downside risk as well as upside are eligible for up to 50% of shared savings.

Additional infrastructure and operational investments

The EPHC model supports participating providers through investment in expanded access, population health management and care coordination.

- PMPM Clinical coordination payments are targeted to support important clinical interventions that occur outside of a patient visit. This can include investments in population health management (like creating a disease registry or disease management outreach program), investments in population management infrastructure (such as acquiring electronic health records), or hiring care additional clinical staff to help coordinate patient care.
- EPHC fortifies value based payment with a robust suite of tools, support, and resources that providers need to thrive in a value based payment environment.
- Provider Care Management Solutions (PCMS) is a web based population health management application, designed to provide a full picture of patient health history, and identify interventions to manage chronic conditions and exercise preventative care. Through alerts, dashboards, and reports, PCMS gives practices the tools to risk stratify their membership to identify the most vulnerable patients in need of intervention.

Anthem's Care Delivery Transformation team provides transformation support to helps providers assume accountability for the health of patient populations.

Results

Data from Anthem's first year of program experience point to Cost of Care savings of $9.51 per attributed member per month. EPHC generated cost savings through reductions in acute patient stays, emergency room visits, and reduced outpatient surgery costs. EPHC providers outperformed peers on several clinical quality measures, and patients rated many aspects of their care experience better than comparison patients.

FUHN – Safety Net Medicaid ACO

Overview

The Federally Qualified Health Center Urban Healthcare Network (FUHN) is one of sixteen Medical Assistance Integrated Health Partnerships (IHPs) authorized by Minnesota's Department of Human Services (DHS). IHPs were created by the 2010 Minnesota Legislature that authorized DHS to establish a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations (ACO) that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement." (Minnesota Statutes, 256B.0755, 2010, 1st Special Session, Chapter 1, Article 16, Section 19)

In response to this initiative, FUHN formed a "virtual" ACO as it consists solely of FQHCs and is not affiliated with any hospitals or health systems. FUHN consists of 10 FQHCs with 40 delivery sites, all located within the Twin Cities of Minneapolis and Saint Paul. Almost 28,000 Medical Assistance (MA) patients are attributed to FUHN. FUHN is currently the third-largest IHP in Minnesota and is one of the first six IHPs launched in year 2012. FUHN demonstration's approach relies heavily on the primary care relationship, enhanced care coordination efforts supported by robust data analytic capabilities, and patient activation strategies.

Nationally, FUHN is the first FQHC-only Medical Assistance accountable care organization.

Underlying payment approach

3(A) – APM built on FFS architecture

Approaches to cost assessment

DHS sets a "benchmark" cost for FUHN's attributable Medicaid population each year. FUHN is then accountable for the total cost of care for a defined set of Medicaid services. However, some services are excluded from the cost assessment such as ambulatory dental, transportation, long term care, and residential mental health services.

Approaches to quality assessment

IHPs must meet the reporting requirements outlined under the state's Statewide Quality Reporting and Measurement System (SQRMS). FUHN and DHS' IHP contract requires relative improvement in FUHN's SQRMS measures compared to the previous year. Relative improvement and comparison to FUHN only previously reported SQRMS quality outcomes was necessary as SQRMS does not currently consider the social determinants of health (SDH) such as homelessness, poverty, race/ethnicity, language and country of origin to risk-adjust provider quality measures. The lack of such risk-adjustment is especially important given SQRMS reporting reflects an aggregate reported population at the provider organizational. This aggregation fails to control not only for SDH differences that disproportionately affects safety net populations, like FUHN FQHCs, but also fails to control for differences in payer mix among disparate provider organizations.

Method and magnitude of payment adjustment

Achieved total cost of care (TCOC) savings are shared equally (50/50) between FUHN and DHS only when a threshold of 2% of savings is achieved. In addition, FUHN's ability to realize its 50% of achieved TCOC savings is subject to meeting the SQRMS measures as discussed above, with up to 50% of FUHN's TCOC savings currently at risk if quality expectations are not met. As a "virtual" IHP model, there is no "down-side risk."

Of note, FUHN's participant 10 FQHCs individually maintain their right to the federally-mandated Medical Assistance payment methodology known as the Prospective Payment System (PPS). FQHCs payments received under PPS are included in determining FUHN's attributable population's TCOC. Authorized in federal law in 1999, the PPS provides FQHCs with a per encounter reimbursement that recognizes not only the unique patient base of FQHCs – 80% uninsured or enrolled in public programs such as Medical Assistance – and the "enabling" services provided at FQHCs to serve a diverse (70% non-white, 30% served in a language other than English) population.

It is also important to note that the state of Minnesota did not provide any "start-up" or operational funding to the IHPs including FUHN. Instead, FUHN, through a competitive process, secured an administrative services partner to support the needed technical, personnel, and data analytic infrastructure required to stand up FUHN's IHP. These services aided FUHN and its participant FQHC's in identifying opportunities for enhanced primary care-patient engagement and informed the strategic initiatives that FUHN has undertaken as an ACO.

Additional infrastructure and operational investments

N/A

Results

To date, FUHN:

- Reduced the total cost of care in Year 1 (2013) by 3.1%.
- Achieved a projected 4.5% reduction in the total cost of care for Year 2 (2014) with $4.8 million in anticipated
- Achieved a total savings of $9.4 million - $3.6 million in 2013 and $4.8 million in 2014.
- Reduced emergency room use by 18%.

Integrated Healthcare Association (IHA) – Value Based Pay for Performance Program (VBP4P)

Overview

The Integrated Healthcare Association's (IHA's) California Value Based Pay for Performance program, a shared savings model, holds physician organizations accountable for cost, cost trend, and resources used for all care provided to their commercial health maintenance organization (HMO)/point of service (POS) members, as well as the quality of this care. Physician organizations must meet minimum quality and cost trend standards to be eligible for shared savings payments. Along with the incentive design, the program features use of a common set of measures (with benchmarks), public reporting, and physician organization performance recognition awards. Launched in 2001, participation in this statewide program now includes 10 health plans and 200 physician organizations caring for 9 million Californians.

Underlying payment approach

3(A) –APM with FFS Architecture.

Approaches to cost assessment

Cost performance is assessed using a Total Cost of Care measure with adjustments to account for differences in risk and geographic input costs. The percent change in Total Cost of Care between years is compared against a gate of CPI + three percent to determine physician organization eligibility for shared savings incentive payments.

Estimated cost savings are derived from improvements in resource use measures using physician organization specific unit costs applied to resource units saved.

Approaches to quality assessment

A composite definition of quality is used in two ways: (1) minimum standard for eligibility for incentives and (2) adjustment to the share of savings earned. The quality composite combines three domains: clinical care measures (e.g., administratively derived HEDIS and PQA measures) weighted at 50%, patient experience (using CG CAHPS) weighted at 20%, and meaningful use of health IT (based on the CMS meaningful use standards) weighted at 30%. Physician organization performance is assessed on both attainment and improvement (similar to CMS Hospital Value Based Purchasing model).

Method and magnitude of payment adjustment

The Value Based P4P incentive design is based on shared savings; adjusted for quality results. Shared savings are calculated based on performance on resource use measures, including: inpatient utilization

and readmissions, emergency department visits, outpatient procedures utilization, and generic prescribing. Cost savings are estimated for each of the five resource use measures. The number of units of utilization below the target (which is generally the physician organization's previous year performance) is multiplied by the unit cost; 50% of the resulting amount is the physician organization's base incentive amount for that resource use measure. Base incentive amounts may be positive or negative depending on whether performance improved or worsened, and are then summed across resource use measures to generate net shared savings. The net shared savings amount is then adjusted based on the physician organization's quality performance.

Additional infrastructure and operational investments

From a physician organization perspective, participants voluntarily participate in the collection of patient experience results (clinician and group CAHPS survey) and may invest in systems to support improved data collection, patient monitoring, and self-reporting of audited performance results.

From a program administration perspective, IHA provides a Web reporting portal with downloadable data, benchmarks, and visualizations of performance compared to peers. For resource use measures, patient level files that support measurement results are available. IHA is currently developing interim reports with benchmarks and patient level detail to support performance improvement efforts. We also annually convene a stakeholders' conference highlighting overall program performance and focusing on learnings and best practices in various areas.

Results

The first participating health plan made payments using the design in year 2014, two additional health plans implemented in year 2015, and two more have adopted the design. Together these five health plans – Aetna, Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare. For the first year, 39% of physician organizations (52) earned a shared savings payment by meeting the minimum standards for quality and cost trend and generating net adjusted shared savings across five resource use measures. The total shared savings payments for the one health plan were $8.05M and averaged $1.90 PMPM.

Summary information on health plans' year 2015 payments are still being collected. However, based on the program measure results, it appears that almost half of POs are on track to meet the minimum quality and cost trend standards and generate adjusted shared savings.

UnitedHealthcare – Episode Payment Program for Cancer Therapy

Overview

UnitedHealthcare's pilot program included five medical oncology groups from Atlanta, Fort Worth, Miami, Dayton, and Memphis.

Underlying payment approach

3(A) –APM with FFS Architecture.

The program was designed as a risk sharing arrangement without downside risk. The medical oncologists chose their specific chemotherapy regimen for 19 different clinical scenarios in breast, colon and lung cancer. The medical group was paid the calculated drug profits from those regimens on the first day of

treatment (episode payment). All other services were paid fee for service. Chemotherapy drugs were paid at cost.

The medical groups were free to change the chemotherapy regimens at any time, but the episode payment was frozen until the pilot was completed. The episode could only be increased if the groups demonstrated a reduction of total cost of care or an improved survival compared to patients treated in standard fee for service.

Approaches to cost assessment

The pilot group was compared using total cost of care to a matched cohort of cancer patients treated in a contemporary fee for service design. No costs were excluded from the analysis.

Approaches to quality assessment

There were 64 measures of quality. Representative measures include mortality, hospitalization, and emergency room usage, median days from last chemotherapy to death and use of erythropoietin in adjuvant therapy.

Method and magnitude of payment adjustment

The pilot sample of 810 patients was measured using a difference of differences between the fee for service control group using a pre test and post test measurement. Regression models for the type of cancer, stage and previous performance were examined.

Additional infrastructure and operational investments

Most of the medical groups added additional clinic hours including weekend coverage. The business office required a dedicated individual to adjust the claims and receipts with this model.

Results

The pilot group delivered their cancer care for $33,361,272 less than the comparable fee for service patients. This represented a 34% reduction in the cost of care. Survivals were the same for both groups. The pilot group had far fewer hospitalizations for complications of the cancer and the therapy.

Arkansas Healthcare Payment Improvement Initiative (AHCPII)

Overview

The Arkansas Healthcare Payment Improvement Initiative (AHCPII) is a collaborative effort across public and private payers focused on designing and supporting implementation of a new payment system in Arkansas tailored to the unique needs of patients and providers. The model employs two primary components: 1) Patient centered medical homes (PCMH) and 2) Retrospective episodes for medical care.

Underlying payment approach

PCMH 3(A) –APM with FFS Architecture.

Episodes of care model – 3(B) – APM with FFS Architecture.

Approaches to cost assessment

For PCMH, providers risk adjusted average cost are assessed and compared to historical Arkansas based benchmark trend. Providers may receive shared savings for achieving cost growth that is lower than their own historical benchmark trend or a statewide benchmark trend.

For the episodes of care model, providers average episode cost are assessed based on episode specific algorithms, and compared on an annual basis to statewide historical benchmarks. Acceptable costs are characterized as approximately the middle 50 percentile range, commendable costs are approximately the lower 25 percentile range, and unacceptable cost are approximately the upper 25th percentile range.

Approaches to quality assessment

For both the PCMH and episodes model, providers must meet predetermined quality targets in order to be eligible for any gain share payments (for episodes) or shared savings payments (PCMH). Detailed descriptions for episodic and PCMH quality targets can be found at the Health Care Payment Improvement Initiative website.

Method and magnitude of payment adjustment

For the PCMH model, providers are eligible for up to 50 percent of the savings generated as a result of achieving cost growth below either the historical statewide or provider specific benchmark trend.

For episodes providers may receive fifty percent of average costs below the commendable threshold, or conversely may be subject to 50 percent of average costs that fall above the unacceptable threshold.

Additional infrastructure and operational investments

PCMH participants receive per member per month care coordination payments if they successfully achieve practice transformation milestones and quality metrics. Providers receive quarterly reports that are accessed on an online provider portal. These reports offer providers detailed information about key quality and utilization metrics for their performance.

Results

PCMH

In year 2014, Medicaid realized $34.3 million in direct cost avoidance through trend reduction. Of the $34.3 million in savings, $12.1 million went to care coordination payments to providers. The remaining 22.2 million in net cost avoidance was shared between the state and those providers who met both quality and cost requirements.

In year 2014, enrolled practices received a cost decrease of 1.2 percent, beating both the 2.6% benchmark trend increase and the 0.6% cost growth of non-enrolled practices

In year 2014, the vast majority of practices met transformation milestones, and approximately 78% of quality measures either improved or maintained prior year levels.

Episodes of care

Medicaid has achieved quality improvements and cost avoidance

- Perinatal: C section rated reduced from 36% 34%, with an estimated 2 4% savings to date
- URI: 17% reduction in antibiotic prescriptions; episode costs remained flat despite a 10% increase in drug prices
- ADHD: average episode cost fell by 22%, with 400 providers contacted regarding stimulant prescribing
- Total Joint Replacement: number of episodes down from 141 to 101; 30 day all cause readmission rate reduced from 3.9% to zero; estimated 5% 10% direct savings to date

For 2014, Arkansas BCBS reported reductions in cost across several implemented episodes, either beating projected trend or demonstrating actual cost reductions

- Heart Failure: lowered actual costs 10.3%
- Perinatal: lowered actual cost 1.3%
- Colonoscopy: lowered actual cost 1.5%
- Total Hip Knee Replacement: 2.9% below projected costs, costs increased 0.8%

CMS – Medicare Shared Savings Program (MSSP)

Overview

The Medicare Shared Savings Program (Shared Savings Program) was established by Section 3022 of the Affordable Care Act to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee For Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). These ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

Under the program regulations, the ACO providers and suppliers continue to be paid for services rendered to Fee for Service Medicare beneficiaries in the same manner as they would otherwise. In addition, the ACO that meets the program's quality performance standards may receive a share of the savings if its assigned beneficiary expenditures are below its own specific updated expenditure benchmark. The regulations would also hold certain ACOs accountable for sharing losses by requiring ACOs to repay Medicare for a portion of losses (expenditures above its updated benchmark). To provide an entry point for organizations with varied levels of experience with and willingness to share losses, the regulations allow an ACO to choose one of two program tracks.

Track 1: Allows an ACO to operate on a shared savings only arrangement for the duration of their first agreement.

Track 2: Allows ACOs to share in savings and losses for the duration of the agreement, in return for a higher share of any savings it generates.

Underlying payment approach

Track 1: 3(A) – APMs built on FFS architecture with upside risk only.

Track 2: 3(B) – APMs built on FFS architecture with upside and downside risk.

Approaches to cost assessment

Baselined to provider's past performance

Section 1899(d)(1)(B)(ii) of the Act requires the Secretary to establish the "benchmark for each agreement period for each ACO using the most recent available 3 years of per beneficiary expenditures for Parts A and B services for Medicare Fee For Service beneficiaries assigned to the ACO." This section also requires the benchmark to "be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare Fee For Service Program, as estimated by the Secretary." A new benchmark is to be established, consistent with these requirements, at the beginning of each agreement period.

Approaches to quality assessment

Pay for performance based on quality performance standards

Thirty three individual measures of quality performance are used to determine if an ACO qualifies for shared savings. These 33 measures span four quality domains: Patient Experience of Care, Care Coordination/Patient Safety, Preventive Health, and At Risk Population. The ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs.

Pay for performance will be phased in over the ACO's first agreement period as follows:

- Year 1: Pay for reporting applies to all 33 measures.
- Year 2: Pay for performance applies to 25 measures. Pay for reporting applies to eight measures.
- Year 3: Pay for performance applies to 32 measures. Pay for reporting applies to one measure that is a survey measure of functional status. CMS will keep the measure in pay for reporting status for the entire agreement period. This will allow ACOs to gain experience with the measure and will provide important information to them on improving the outcomes of their patient populations.

Method and magnitude of payment adjustment

Track 1 – The ACO may earn a sharing rate of up to 50 percent based on quality performance. Under the one sided model, the performance payment limit is 10 percent of the applicable year's Part A and Part B updated benchmark.

Track 2 – The ACO may earn a sharing rate of up to 60 percent based on quality performance. Under the two sided model, the performance payment limit is 15 percent of the applicable year's Part A and Part B updated benchmark.

Additional infrastructure and operational investments

N/A

Results

Ninety-two Shared Savings Program ACOs held spending $806 million below their targets and earned performance payments of more than $341 million as their share of program savings. No Track 2 ACOs owed CMS losses. Total net savings to the Medicare Trust Funds was $465 million. These numbers represent an increase from year 2013, when 58 ACOs held spending $705 million below their targets and earned performance payments of more than $315 million. Total net savings to the Medicare Trust Funds was $383 million.

- An additional 89 ACOs reduced health care costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.
- ACOs with more experience in the program were more likely to generate shared savings. Among ACOs that entered the program in year 2012, 37 % generated shared savings, compared to 27 % of those that entered in year 2013, and 19 % of those that entered in year 2014.
- Shared Savings Program ACOs that reported in both year 2013 and year 2014 improved on 27 of 33 quality measures. Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, screening for tobacco use and cessation, screening for high blood pressure, and electronic health record use.
- Shared Savings Program ACOs achieved higher average performance rates on 18 of the 22 Group Practice Reporting Option Web Interface measures reported by other Medicare FFS providers reporting through this system.
- Eligible professionals participating in ACOs also qualify for their Physician Quality Reporting System (PQRS) incentive payments for reporting their quality of care through the ACO. These providers will also avoid the PQRS payment adjustment in year 2016 because their ACO satisfactorily reported quality measures on their behalf for the 2014 reporting year.
- The Shared Savings Program continues to receive strong interest from both new applicants seeking to join the program as well as from existing ACOs seeking to continue in the program for a second agreement period starting in year 2016. New and renewing ACOs will be announced around the end of year 2015.

Minnesota Integrated Health Partnership

Overview

Minnesota's Integrated Health Partnership (IHP) program allows Medicaid providers to form ACO like entities that meet state criteria including offering a full scope of primary care; coordinating, locating and monitoring of health care services across the care system; partnering with community based organizations and public health agencies; having data systems that are able to receive data electronically from the state, stratify beneficiaries by need; and that participate in required quality measurement and improvement activities for Medicaid beneficiaries.

There are two types of IHP delivery models: "virtual" model entities, which include FQHCs and entities with smaller numbers of attributed beneficiaries and "integrated" model entities, which include larger numbers of attributed beneficiaries and providers such as hospital systems. IHP entities that meet pre-established quality targets and which lower the total cost of care of their beneficiaries relative to projected costs are eligible to receive "shared savings" payments from the state. IHP entities which are not able to lower beneficiary costs below established thresholds are at risk of financial penalties. In addition, quality targets must be met to receive the total, potential shared savings payment amount.

Underlying payment approach

Years 1 & 2: 3(A) – APMs built on FFS architecture with upside risk only

Year 3: 3(B) – APMs built on FFS architecture with upside and downside risk

The Medicaid state plan authorizes shared savings payments through 1905(t) authority to IHPs that demonstrate quality care and reduce the TCOC of their attributed beneficiaries. IHPs that are classified as "integrated" providers are subject to downside risk (financial penalties) if TCOC measured in the "participation year" exceeds the target TCOC. IHPs with fewer than 2,000 attributed beneficiaries and IHPs that include FQHCs are classified as "virtual" providers and are not subject to downside risk, i.e., these providers are not required to pay back costs that exceed target costs.

Approaches to cost assessment

Cost is measured per IHP based on Medicaid beneficiaries attributed during the performance period. Beneficiary attribution is determined retrospectively by the state Medicaid agency. The total cost of care per beneficiary includes fee for service (FFS) cost and managed care cost in the total cost pool, but providers are only rewarded in the state plan for FFS TCOC reductions. The TCOC includes services mandated by the state Medicaid agency and any additional services agreed upon by an IHP and the state Medicaid agency. Cost projections are adjusted for risk based on attributed beneficiaries' diagnoses and trended based on state calculated Medicaid cost trends. Individual claims in excess of $50,000 are excluded from the TCOC and certain populations are excluded from attribution.

Approaches to quality assessment

Pay for performance with quality gates.

The amount of shared savings payments is subject to meeting quality performance targets established by Minnesota Community Measurement and are updated yearly*. Quality measures impact the payments differentially per contract year. In year one, 25% of the shared savings payment is at risk if providers do not report quality measure results. In year two, 25% of the shared savings payment is at risk if providers do not achieve the quality measure targets, and in year three the percent at risk increases to 50%.

The IHP quality & patient experience measures, using year 2014 data, are found online.

Method and magnitude of payment adjustment

The IHP program is based on 3 year contract periods per provider. Shared savings payments are made to Integrated and Virtual IHPs from the first dollar saved (no minimum savings rate). The magnitude of the amount of savings shared between the state and the IHP provider is negotiated between the state and the provider, but in year 3, the amount of gain sharing (for Integrated IHPs) must be the same amount as the risk sharing. For example, if the gain sharing amount is 70% IHP provider / 30% state Medicaid agency in year three, losses must be shared at 70% IHP provider / 30% state Medicaid agency as well.

Additional infrastructure and operational investments

N/A

Results

Nine providers and 165,000 Minnesota medical assistance enrollees participated in the program in year 2014. As of June 2015, the IHP demonstration expanded to include 16 providers, covering over 200,000 enrollees, which equates to about one in five people served by Minnesota's public health care programs.

Minnesota has reported that the program saved $14.8 million in the first year of operations and $61.5 million in the second year, while decreasing hospitalizations and emergency room visits.

(Minnesota press release)

MD-Value In Prevention (VIP) - Personalized Preventive Primary Care

Overview

MDVIP, consists of a network of affiliated primary care physicians, uses a model based on an augmented physician-patient relationship and focused on preventive medicine. A five-year, prospective study, completed in 2010, was conducted to investigate the impact of this model on hospital admissions in primary care practices in five states: New York, Florida, Virginia, Arizona, and Nevada. The study population included 2360 Medicare Advantage and commercial participants with case-matched controls.

Underlying payment approach

3(B) – APMs with Upside Gainsharing/Downside Risk.

Primary care capitation (population-based), at 10-14% of the global cost of healthcare. Uncontrolled FFS payment for all other services (hospital, other specialties)

Approaches to cost assessment

Baselined to regional benchmarks, case-control comparisons. Utilization metrics included annual rates of emergency department visits, inpatient expenditures, and readmissions, as well as length (in days) of hospital stay and average inpatient expenditures comparing participants with matched non-participants. Intellimed database and Medicare database used to compare admissions and cost.

Approaches to quality assessment

Direct feedback to practices, admission rates for ambulatory care sensitive conditions, readmission rates for acute MI, Pneumonia, and CHF.

Method and magnitude of payment adjustment

Providers were paid only primary care capitation.

Additional infrastructure and operational investments

Providers were advised of recommended screening and access requirements.

Results

Study resulted in:

- Reduction in annual hospital admissions of 42%, 47%, 54%, 58% and 62% for all participants.

- Reduction in annual hospital admission rates for Medicare participants of 70%, increasing to 79% over the study.
- Reduction in elective, non-elective, emergent, urgent, avoidable and unavoidable admissions.
- Reduction in avoidable admissions of 23%, 31%, 38%, 47%, and 49% annually.
- Reduction in supposedly unavoidable admissions of 45%, 49%, 56%, 59%, and 63% annually.
- Reduction in hospital readmissions for Medicare participants, including a 97% reduction for acute MI, 95% reduction for CHF, and a 91% reduction for pneumonia when compared to the control population.
- Savings of $2551per Medicare participant per year ($212.58 pmpm).

Reference: Personalized Preventive Care Reduces Healthcare Expenditures among Medicare Advantage Beneficiaries, Page 3.

CMS Bundled Payments for Care Improvement

Overview

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. CMS defines an episode of care as the set of services provided to treat a clinical condition or procedure, such as a heart bypass surgery or a hip replacement. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care.

Three BPCI models of care (Models 2, 3, and 4) provide upside risk. Models 2 and Model 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care.

In Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long term care hospital or home health agency.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit “no pay” claims to Medicare and are paid by the hospital out of the bundled payment. The first cohorts of Awardees in Models 2, 3, and 4 began in October 2013.

Underlying payment approach

3(B) APMs built on FFS architecture with upside and downside risk.

Approaches to cost assessment

At risk if costs for the bundle are higher than a historical benchmark.

Approaches to quality assessment

CMS is committed to ensuring that beneficiaries receiving care from providers participating in BPCI receive high quality care. To that end, CMS is analyzing information available from Awardees' claims and quality reporting, as well as surveys and patient assessment tools to assess care experience and health outcomes. CMS' monitoring effort aims to identify quality improvements, including process improvements, changes in outcomes, and reductions in expenditures, and to detect inappropriate practices such as care stinting, patient selection to maximize financial gain, and cost shifting. Participants are required to comply with and participate in evaluation and monitoring activities and data collection efforts. Participants must also continue to meet current quality standards required by the Medicare program.

Method and magnitude of payment adjustment

Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under these payment models, Medicare continues to make fee for service (FFS) payments to providers and suppliers furnishing services to beneficiaries. At the time of reconciliation, the total expenditures for all related services during a beneficiary's episode are compared against a bundled payment amount (the target price) determined by the Centers for Medicare & Medicaid Services (CMS). If the total expenditures are below the bundled payment amount, then CMS shares those savings with the Awardee; if the total expenditures are above the bundled payment amount, then the Awardee pays a recoupment amount to CMS.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which includes the entire inpatient stay and any related readmissions. In general, physicians and other practitioners are paid by the hospital out of the prospective bundled payment amount.

Additional infrastructure and operational investments

Implementation of Models 2, 3 and 4 was divided into two phases. During Phase 1, also referred to as "the preparation period," CMS shared data and engaged in education and shared learning activities with participants as they prepared for assumption of financial risk under Phase 2, the performance, or "risk bearing implementation," period.

Results

It is still too early to report results. See the context below:

Implementation of Models 2, 3 and 4 was divided into two phases. During Phase 1, also referred to as "the preparation period," CMS shared data and engaged in education and shared learning activities with participants as they prepared for assumption of financial risk under Phase 2, the performance, or "risk bearing implementation," period. CMS announced the first set of BPCI Phase 1 participants on January 31, 2013. By October 1, 2013, some BPCI participants entered into Awardee Agreements with CMS, at which point they became Awardees and began bearing financial risk with CMS for some or all of their episodes. CMS required all participants to transition at least one episode into Phase 2 by July 1, 2015 in order to continue participation in the initiative.

As of July 1, 2015, BPCI has 2115 participants in Phase 2. The 2115 participants are composed of 360 Awardees and 1755 Episode Initiators actively involved in care redesign. The breakdown of participants by provider type is as follows:

- Acute Care Hospitals (423)
- Physician Group Practices (441)
- Home Health Agencies (101)
- Inpatient Rehabilitation Facilities (9)
- Long Term Care Hospitals (1)
- Skilled Nursing Facilities (1071)

Capital District Physicians' Health Plan (CDPHP®) -Enhanced Primary Care (EPC) Program

Overview

The CDPHP Enhanced Primary Care (EPC) program moves primary care doctors from a historic fee for service (FFS) payment model, to a risk adjusted global payment with the addition of a quality bonus. These two payment structures combine to give physicians the opportunity to increase their earning potential by an average of 40%. Now in its seventh year, EPC includes 193 network practices, 836 network clinicians, and more than 250,000 CDPHP members (more than 50% of total enrollment.)

Underlying payment approach

3(B) – APMs with Upside Gainsharing/Downside Risk. The replacement of the FFS model with a risk adjusted global payment for primary care services currently pays an average of 40% more than FFS equivalent claims, with the opportunity for an average 20% bonus based on success in the goals of the Triple Aim.

Approaches to cost assessment

Cost or efficiency is assessed using a risk adjusted relative utilization of health care resources in six categories: inpatient hospital, emergency room, medical imaging, pharmacy, laboratory, and specialists. CDPHP uses a risk adjusted total cost of care assessment (Optum Impact Intelligence) that creates an index of the practice's performance compared to the network. The practice is then assigned a percentile rank of efficiency performance, which creates an efficiency score.

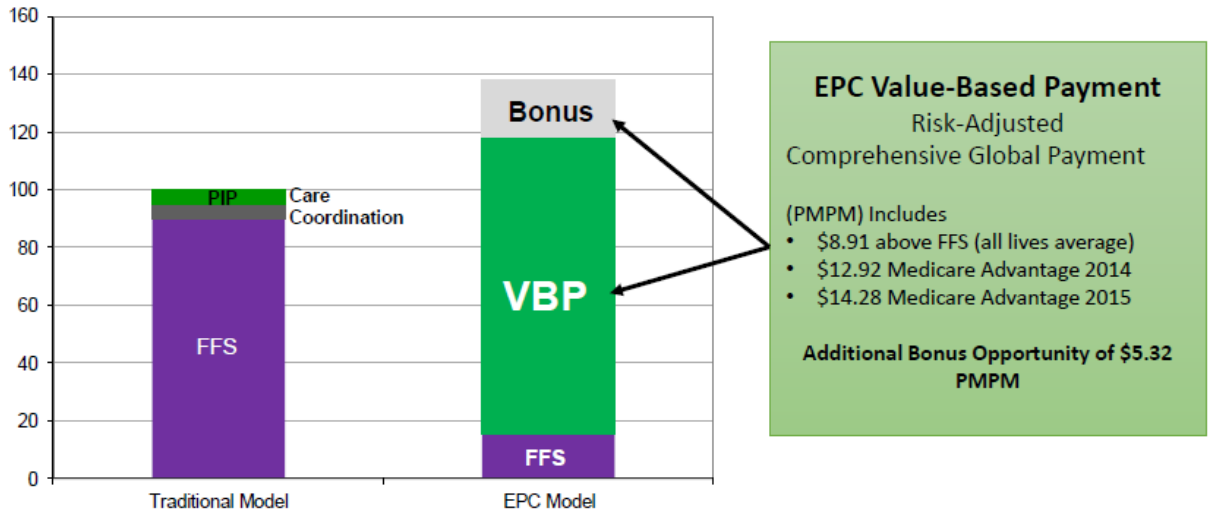
Approaches to quality assessment

Quality is assessed using HEDIS metrics or composites in four categories: population health and prevention, management of chronic conditions, use of antibiotics in adults and children, and behavioral health, as well as experience of care composite of ten CG CAHPS questions. CDPHP creates an aggregate quality score by creating a ratio of the sum of the numerators to the sum of the denominators in these measures. This aggregate quality score is then assigned a percentile rank which creates an effectiveness score.

Method and magnitude of payment adjustment

The risk adjusted global payment for primary care services is more than 80 % of payments that primary care practices receive, and accounts for the vast majority of codes for which CDPHP reimburses. CDPHP uses a unique risk adjustment factor created by Verisk, Inc., which predicts payments to primary care physicians based on member diagnoses received from all sites of care (hospital, specialist, etc.). This risk adjustment factor drives specific risk adjusted global payment rates for commercial HMO, commercial non HMO, Medicaid, and Medicare patients. The payment is made monthly with adjustments for the prior month's patient responsibility for actual visits received. The plan continues to use FFS reimbursement for a small set of services that are outside of the capitation code list, such as immunizations and skin biopsies.

CDPHP also offers primary care practices the opportunity to earn an additional 20% bonus payment based on performance in the goals of the Triple Aim. Each CDPHP practice has a specific potential bonus, which is determined by the number of CDPHP members in the practice and the risk of those members. This potential bonus is then multiplied by the effectiveness and efficiency scores to determine the amount that the practice has earned. For example, if a provider is at the 50th percentile for quality and cost, those two amounts are multiplied, and the provider receives 25% of the potential total bonus. This approach ensures that practices are appropriately incentivized for high quality, efficient care, only.
The chart below compares a traditional FFS model against the current EPC model, demonstrating how PCPs engaged in the program can earn up to 40% more.



Additional infrastructure and operational investments

CDPHP provides primary care practices with a year long transformation program, which begins with leadership and cultural assessments. Four learning collaboratives are used to facilitate the sharing of best practices among provider groups and also provide additional education. Practices undergoing transformation are each given a $20,000 stipend to support their time away from their practice. At the end of the transformation program, the practice becomes eligible for the enhanced payment model described above.
CDPHP also provides significant financial investments to support practices needing to acquire electronic health records, establish connections to the local health information exchange, and achieve meaningful use designation.
As a result, new resources were added, including a performance management department, to support the success of practices in the program. This support includes:

- Engagement and training to achieve cultural shift across organizational boundaries, to create a more collaborative, patient centered approach;
- Coaching and support of primary care practices to achieve NCQA Level 3 PCMH recognition;
- Engagement with practices to provide actionable information, identify and promote opportunities, assist in the clinical integration of care management, and other available services in the community of from the health plan; and
- Assistance to primary care practitioners with the transition toward value based payments (VBP), and away from traditional FFS models.

CDPHP also continues to make significant investments in claims payment systems and analytics to support the automated member attribution methodology, risk adjustment methodology, system generated global payments, solutions to address changing member panels and network providers, as well as requirements to address the challenges of member responsibility in high deductible and other copayment arrangements.

Results

CDPHP has seen a $17.11 PMPM reduction in the total cost of care, resulting in a 2.9% overall cost reduction, and $20.7 million annual total savings for the organization in year 2014.
Under this global model of payment, the actual rate of visits for healthy members decreased as physicians found alternate ways of providing necessary care. At the same time, the rate of visits increased for those with the greatest need – Medicaid, Medicare, and the sickest 10% of the population. These savings were accomplished despite paying the primary care community $10 million in additional reimbursements. Savings came largely from drug utilization management, outpatient services, and the sickest members having a greater level of engagement with primary care.
The table below demonstrates cost savings by line of business and severity of condition.

PMPM	All	Healthiest 50%	Sickest 50% 10%	Sickest 10%
All	**$ 17.11**	$ 3.81	**$ 26.37**	$ 49.34
Commercial	**$ 15.81**	$ 1.92	**$ 33.07**	$ 15.35
Medicaid	**$ 22.30**	$ 4.41	$ 15.79	**$ 104.65**
Medicare	$ 24.03	$ 10.64	$ 28.81	**$ 146.30**

Note: Total estimated as the product of the year 2014 average PMPM difference in TCOC, and the sum of the total member months in each cohort in year 2014. Meaningful estimates have at least 60% of the weight sum corresponding to significant cohort estimates and are highlighted in orange.

Presbyterian Health Plan, Albuquerque, New Mexico

Overview

Presbyterian Health Plan instituted a Medicaid multispecialty sub capitation model for primary care and multispecialty groups that have invested in care management infrastructure and demonstrate the ability to improve performance. The model allows both upside and downside risk and has an actuarially determined capitated medical budget.

Underlying payment approach

Years 1–5: 3(B) – APMs built on FFS architecture with upside/downside risk
Year 5+: 4(B) – Full or percent of premium population based payment linked to quality; global budget based on population served linked to quality.

Approaches to cost assessment

The annual capitated budget is calculated off prior year FFS claims data and then adjusted downward to guarantee savings to the plan. The primary performance measures examine outpatient pharmacy costs, emergency department visits and emergency department costs.

Approaches to quality assessment

Performance measures ensuring that the payment model does not deteriorate quality and access include: encounter value of services for members, timely submission of encounters, penetration rates, hospitalization rates, complaint and grievance data and emergency department visits by persons with significant behavioral health needs.

Method and magnitude of payment adjustment

Presbyterian Medical Services receives a monthly capitated payment for Medicaid members. Using years 2013 and 2014 Medicaid membership and claims data, Presbyterian Health Plan developed models to measure medical costs for fee for service claims. This information is used to define covered services that will be included in the capitated payment and the projected PMPM costs for those services.
The two main avenues of savings to the plan are pharmacy spend and emergency department diversion. To ensure savings for both the plan and providers, pharmacy costs are designated as a component of medical costs. Presbyterian Health Plan then reduced the capitated payment for outpatient pharmacy costs by 30% and allowed providers to retain the difference between the set pharmacy budget and the actual year end drug costs inclusive of the discounts under the 340B Drug Pricing program.
Emergency department diversion savings are calculated against the prior year's usage and split equally between the plan and providers.
During a provider's first year in the model, the plan institutes risk corridors so that losses or gains are within 2% of what would have been earned under FFS. This allows the practice to adjust to value based care. The level of risk grows over a five year process and culminates in 100% global risk.

Additional infrastructure and operational investments

In some cases, grants from external sources or the plan itself have been used to encourage physician groups to participate in APMs. Grants serve as incentive to participate and also increase requisite core competencies including health information technology, care managers, data analytics support and more.

Results

The structure of the model helps the plan achieve a 30% reduction in pharmacy costs for providers that participate, as well as shared savings from reduced unnecessary emergency department utilization.

Category 4: Population Based Payments

Tufts Health Plan, Watertown, Massachusetts

Overview

Tufts Health Plan's risk model functions as a fee for service (FFS) payment that is reconciled with an annual global budget. The plan has 86% of its Massachusetts Commercial HMO membership engaged with a primary care physician participating in an APM, and 29% of members have a primary care physician in full risk capitation in which providers adopt 100% risk above and below a negotiated PMPM budget amount. This case study pertains to the 29% of providers that receive 100% risk.

Underlying payment approach

4(B) A full or percent of premium population based payment linked to quality; global budget based on population served linked to quality.

Approaches to cost assessment

Tufts Health Plan works with providers to set an annual budget target based on prior claims, which is adjusted for severity and other factors as appropriate. The plan examines the three primary pieces of unit cost, case mix and utilization rates.

Approaches to quality assessment

The measures that Tufts Health Plan uses include, but are not limited to: cost and utilization, referral patterns, practice patterns, quality and total medical expenses.

Method and magnitude of payment adjustment

In the standard risk agreement, Tufts Health Plan works with providers to set an annual budget target based on prior claims experience, which is adjusted for severity and other factors as appropriate. If the total cost is less than the budget target (surplus), the provider will receive a percentage of the surplus. If the total cost is more than the budget target (deficit), the provider will pay Tufts Health Plan a percentage of the deficit.

Tufts Health Plan in the commercial space typically has a direct relationship with a delivery network that includes primary care physicians and specialists. In negotiations with the delivery network, the group includes hospitals, specialists and PCPs in aggregate. It is up to the delivery group to decide how to allocate risk amongst itself, though Tufts Health Plan provides some guidelines.

Additional infrastructure and operational investments

Tufts Health Plan identifies specific measures in which each provider group is struggling and uses resources to help drive improvement on those measures. The plan aims to pay for improvement, not just continued performance. It writes contracts so that more money is put into improving operations rather than simply protecting against regression.

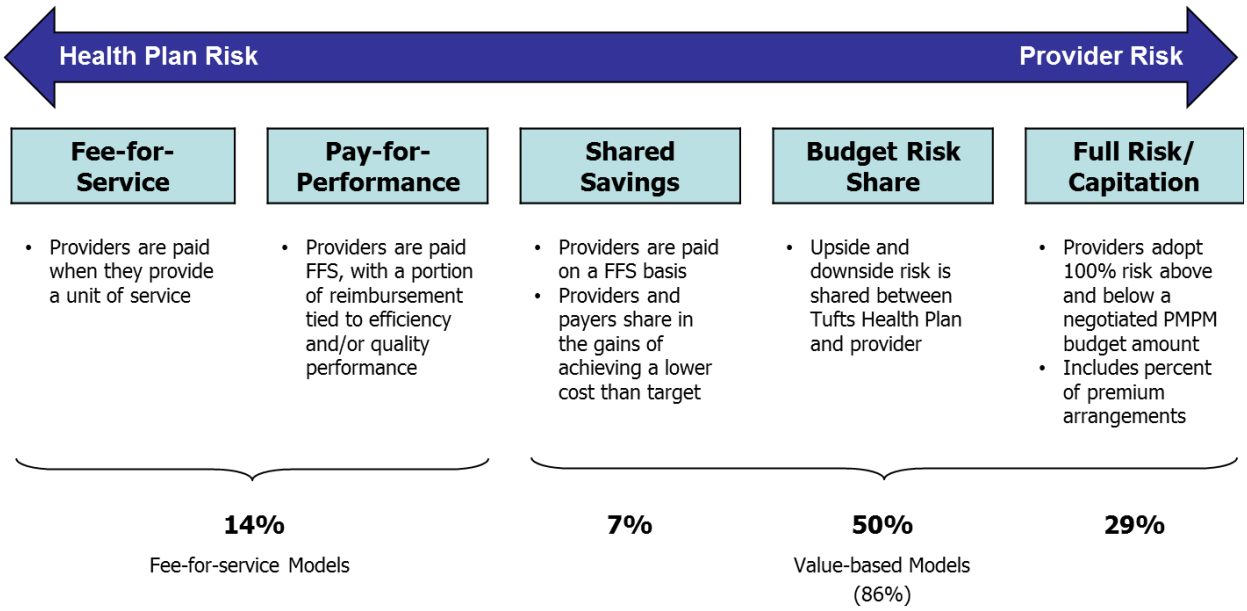
Results

Early results indicate a more favorable total medical expense trend for global payment providers than for fee for service.

Under these contract arrangements, providers are more engaged in reporting and analytics related to managing overall cost and quality of care.

Tufts Health Plan has seen positive change in provider referral patterns for contracts with APMs. Providers under APM contracts have made progress to retain care within systems and have moved care to lower cost settings. Providers have been able to move care that must go to an ambulatory medical center to more efficient care partners.

The graphic below shows how Tufts Health Plan has been able to move provider groups along the risk spectrum from FFS to accepting full risk, and what percentage of contracted practices participate in each type of APM. With respect to the Framework, this corresponds to a movement from Category 1 through Category 3B, with an aim to end up in Category 4. Currently, 29% of practices are in a full risk arrangement.


Health Plan Risk
Provider Risk
Fee-for-Service
Pay-for-Performance
Shared Savings
Budget Risk Share
Full Risk/ Capitation
• Providers are paid when they provide a unit of service
• Providers are paid FFS, with a portion of reimbursement tied to efficiency and/or quality performance
• Providers are paid on a FFS basis
• Providers and payers share in the gains of achieving a lower cost than target
• Upside and downside risk is shared between Tufts Health Plan and provider
• Providers adopt 100% risk above and below a negotiated PMPM budget amount
• Includes percent of premium arrangements
14%
7%
50%
29%
Fee-for-service Models
Value-based Models (86%)