I. PURPOSE

This Alternative Payment Model (APM) Initiative - Strategies and Performance-Based Payments Incentive Policy applies to Acute Care, Arizona Long Term Care System Elderly and Physical Disability (ALTCS/EPD), Children’s Rehabilitative Services (CRS), Regional Behavioral Health Authority (RBHA), ALTCS Division of Economic Security/Developmental Disabilities (DDD) Contractors and DDD Sub-Contractors. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM strategies.

II. DEFINITIONS

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

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

The APM strategies discussed in this initiative originate from the Learning Action Network APM Framework (LAN-APM) which include the following categories and strategies:

- Fee-For-Service – No Link To Quality & Value,
- Fee-For-Service – Link To Quality & Value (Foundational Payments for Infrastructure & Operations, Pay for Reporting, Pay for Performance),
- APMs Built on Fee-For-Service Architecture (APMs with Shared Savings, APMs with Shared Savings and Downside Risk),
- Population Based Payment (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, Integrated Finance & Delivery Systems).

See Attachment A to view the LAN-APM strategies.
### Fee-For-Service – No Link To Quality & Value (LAN-APM Category 1)

<table>
<thead>
<tr>
<th>Block Purchase Payment Arrangement Methodology</th>
<th>A current payment arrangement methodology where a contracted amount for a block of services is divided by 12 and paid in monthly installments to the provider. AHCCCS considers this to be LAN-APM Category 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This strategy, when not linked to quality and value as described in LAN-APM Categories 2, 3, and 4, shall not be counted towards the minimum qualifying criteria outlined under B.1.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Fee-For-Service (No Link To Quality and Value) | Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. (LAN-APM Category 1) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This strategy, when not linked to quality and value as described in LAN-APM Categories 2, 3, and 4, shall not be counted towards the minimum qualifying criteria outlined under B.1.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Fee-For-Service – Link To Quality & Value (LAN-APM Category 2)

<table>
<thead>
<tr>
<th>Foundational Payments for Infrastructure &amp; Operations</th>
<th>Purchasing strategy in which payments are made 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. Examples include care coordination fees and payments for health information technology investments. (LAN-APM Category 2A)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This strategy shall not be counted towards the minimum qualifying criteria outlined under B.1.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pay For Reporting</th>
<th>Purchasing strategy in which providers/physicians are rewarded with bonus payments for reporting quality data or penalties for not reporting quality data. (LAN-APM Category 2B)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This strategy can be counted towards the minimum qualifying criteria outlined under B.1 only upon pre-approval by AHCCCS for expansion to services/service providers/provider types not traditionally utilized for APM arrangements.</strong></td>
<td></td>
</tr>
</tbody>
</table>
Purchasing strategy in which providers are rewarded for performing well on quality metrics. It can also include penalties for providers who do not perform well on quality metrics. In this strategy specific providers are responsible for the cost and quality associated with a particular set of procedures or services. Payments are not subject to rewards or penalties for provider performance against aggregate cost targets, but may account for performance on a more limited set of utilization measures. (LAN-APM Category 2C)

**APMs Built on Fee-For-Service Architecture (LAN-APM Category 3)**

**APMs with Shared Savings**

Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. In this strategy multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. (LAN-APM Category 3A)

**APMs with Shared Savings and Downside Risk**

Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. This strategy includes episode-based payments for procedures and comprehensive payments with upside and downside risk. (LAN-APM Category 3B)

**Population Based Payment (LAN-APM Category 4)**

**Condition-Specific Population-Based Payment**

Purchasing strategy of prospective, population-based payments, for all care delivered by particular types of clinicians structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice. This strategy includes per member per month payments, payments for specialty services, such as oncology or mental health, and bundled payments for the comprehensive treatment of specific conditions. (LAN-APM Category 4A)
### COMPREHENSIVE POPULATION-BASED PAYMENT

Purchasing strategy of prospective, population-based payments, covering all of an individual’s health care needs, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a comprehensive collection of care. This strategy includes global budgets or full/percent of premium payments which encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct. (LAN-APM Category 4B)

### INTEGRATED FINANCE & DELIVERY SYSTEMS

Purchasing strategy of prospective, population-based payments structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. This strategy includes global budgets or full/percent of premium payments in integrated systems. (LAN-APM Category 4C)

### ENCOUNTER

For the purposes of this policy, all encounters shall be in an adjudicated and approved status.

### PERFORMANCE BASED PAYMENT

A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the APM strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

### PREMIUM TAX

The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

## III. POLICY

### A. GENERAL

The Contractor shall meet the APM strategies qualifying criteria in B.1 and B.3, and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in:

- Disqualification of Acute Care and ALTCS/EPD Contractors from any Earned Withhold or Quality Measure Performance Incentive Payments discussed in
ACOM Policy 306 - Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive

- Assessment of sanctions for CRS, RBHA and DDD Contractors and DDD sub-contractors up to a maximum of the amounts listed in the table below

<table>
<thead>
<tr>
<th>CONTRACTOR</th>
<th>MAXIMUM SANCTION AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRS</td>
<td>$250,000</td>
</tr>
<tr>
<td>Maricopa County RBHA</td>
<td>$600,000</td>
</tr>
<tr>
<td>South RBHA</td>
<td>$400,000</td>
</tr>
<tr>
<td>North RBHA</td>
<td>$200,000</td>
</tr>
<tr>
<td>Affiliated Acute Contractor and RBHA</td>
<td>$250,000</td>
</tr>
<tr>
<td>DDD Sub-Contractors</td>
<td>$50,000</td>
</tr>
</tbody>
</table>

B. CONTRACTOR RESPONSIBILITIES

1. A minimum percentage of total Title XIX payments (both APM and non-APM, whether contracted or non-contracted), shall be governed by APM strategies for the contract year, according to the table below

<table>
<thead>
<tr>
<th>CYE 18</th>
<th>Acute 1</th>
<th>ALTCS/EPD</th>
<th>CRS 1</th>
<th>RBHA</th>
<th>DDD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
<td>35%/35%</td>
<td>50%</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5%</td>
</tr>
</tbody>
</table>

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

2 Relative to the MA-DSNP contract for ALTCS/EPD Duals, should a Contractor’s MA-DSNP contract serve AHCCCS populations other than ALTCS/EPD Dual members, the Contractor shall split out their MA-DSNP populations served to prove that they have met the minimum percentage requirements for the ALTCS/EPD MA-DSNP population. Contractors may count both aligned and non-aligned members in their ALTCS/EPD MA-DSNP population.

AHCCCS intends that the minimum value threshold will grow each year according to the schedule below.
<table>
<thead>
<tr>
<th></th>
<th>AHCCCS COMPLETE CARE</th>
<th>ALTCS/EPD (EPD/MA-DSNP)</th>
<th>RBHA</th>
<th>Non-INTEGRATED</th>
<th>SUB-CORPORATORS</th>
<th>DDD</th>
<th>LTSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYE 19 Anticipated</td>
<td>50%</td>
<td>50%/50%</td>
<td>35%</td>
<td>20%</td>
<td>35%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>CYE 20 Anticipated</td>
<td>60%</td>
<td>60%/60%</td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>CYE 21 Anticipated</td>
<td>70%</td>
<td>70%/70%</td>
<td>60%</td>
<td>25%</td>
<td>60%</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

Strategies for this initiative may not include:
- Block Purchase Payment Arrangement Methodology with no link to quality and value
- Fee-For-Service Strategy with no link to quality and value (LAN-APM Category 1)
- Foundational Payments for Infrastructure & Operations strategy (LAN-Category 2A)

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

Strategies utilized shall meet the definitions provided under Section II. Strategies shall be designed to achieve cost savings and quantifiable improved outcomes.

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

AHCCCS will have a requirement beginning in CYE19 for specific usage of strategies in LAN-APM Categories 3 and 4, this information will be determined based upon a review of Contractor deliverables and will be released in a Public Notice published in or after January 2018. AHCCCS intends that the required percentage of strategies in LAN-APM Category 3 and Category 4 grow each year.

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

The same dollars shall not be counted under multiple contracts.

Additionally, one contract shall not be counted under multiple strategies.

The Contractor may use quality measures other than the measures identified in ACOM Policy 306 - Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive as part of the Contractor’s APM strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts. For those contracts executed prior to February 1 of each contract year, AHCCCS shall count the strategies for the time period in the contract year for which the contract is in effect. For those contracts executed after February 1 of each contract year, AHCCCS shall count the strategies for the time period from the execution date forward for which the contract is in effect.

2. The Contractor will certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format and through the Structured Payment File described in Section D:
   a. An initial APM strategies Certification as provided in Attachment B to the DHCM Finance Manager within 60 days of the start of the contract year, and
   b. A final APM strategies Certification as provided in Attachment B to the DHCM Finance Manager, and the Structured Payment File, due 270 days after the end of the contract year.

For ALTCS/EPD and RBHA Contractors: Attachment B contains two tabs to be submitted as an executed copy and an electronic copy as listed below in accordance with B.2.a. and B.2.b.

<table>
<thead>
<tr>
<th>CONTRACTOR</th>
<th>POPULATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALTCS - EPD</td>
<td>EPD</td>
</tr>
<tr>
<td>RBHA</td>
<td>SMI- Integrated</td>
</tr>
</tbody>
</table>

DDD will submit the APM strategies certifications on behalf of the DDD Sub-Contractors.

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

Failure to certify to the APM strategies qualifying criteria in a particular contract year will result in disqualification from the provisions of ACOM Policy 306 or the application of sanctions listed in Section A.
AHCCCS reserves the right to request an audit of the Certifications included in Attachment B. The Contractor, upon the request of AHCCCS, will provide documentation of APM contracts and payments to providers for performance based payments.

3. Acute Care Contractors Affiliated with a RBHA Contract, and RBHA Contractors:
   a. In addition to those requirements outlined above in Section B.1, an Acute Care Contractor Affiliated with an entity that holds a RBHA Contract, and the RBHA Contractor, shall also enter into at least two APM contracts with integrated providers who offer physical and behavioral health clinical integration, for aligned members who are not already integrated under the Acute or RBHA contract, but who receive their acute care or behavioral health services from affiliated entities, e.g. children, non-dual adults with GMH/SA needs, non-integrated adults with SMI. Contracts executed under this requirement may be used to fulfill the APM strategies qualifying criteria under B.1.
   b. The Contractor shall certify to AHCCCS that this requirement will be met by completing and submitting the comporting section in Attachment B. The Contractor shall submit Attachment B as outlined in Section B.2 above.

Failure to attest to the APM strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

AHCCCS reserves the right to request an audit of the Certifications included in Attachment B. The Contractor, upon request of AHCCCS, will provide documentation of APM contracts and payments to providers for performance based payments.

C. AHCCCS Responsibilities

1. The performance-based payments made by the Contractor to providers will be paid by AHCCCS through a lump sum payment through a future monthly capitation payment. For DDD this payment is limited to Long Term Care services for HCBS providers. No performance-based payment incentives will be made for DDD Sub-Contractors. Upon receipt and review of the final APM Strategies Certification discussed in B.2.b, AHCCCS will perform testing of the performance-based payment amounts reported by the Contractor prior to payment of the incentive, including review of Contractor documentation of APM contracting and payments to providers for performance-based payments. The performance-based payment incentive will be adjusted for premium tax.

The Contractor shall report the performance-based payments on an accrual basis. AHCCCS reserves the right to perform a look-back and true-up of the previous year’s accrual in a subsequent year’s payment.

2. For any APM contract that is effective for a period other than the measurement year, AHCCCS will allow performance-based payments to be included in the year to which the lump sum performance-based payments incentive is attributable. For example, a
contract effective from April 1, 201X to March 31, 201Y will have six months (April 1, 201X – September 30, 201X) in the 201X lump sum payment and six months (October 1, 201X – March 31, 201Y) in the 201Y lump sum payment.

The Contractor is not required to meet the APM strategies qualifying criteria in B.1 and B.3 in order for the performance-based payments incentive to be paid to the Contractor.

AHCCCS shall test the total amount of performance-based payments incentive due to the Contractor to ensure that the Federal limit of 5% of annual prospective gross capitation is met. Any amount in excess of the limit shall be reduced to bring the final due payment within the Federal requirement. Federal regulation requires that all incentive payments combined shall not exceed this 5% limit, thus the test of the 5% limit will include both the performance-based payment incentives included in this Policy, and the Quality Measure Performance Incentive payments described in ACOM Policy 306.

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


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

If the Contractor knows upfront that the encounter is tied to a member/provider under APM contract, the Contractor should include the APM Indicator in the original encounter submission.

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

All applicable encounters should have the APM Indicator included 270 days following the contract year end.