315 CYE 16 AND CYE 17 – ACUTE PROGRAM VALUE-BASED PURCHASING INITIATIVE

EFFECTIVE DATE: 10/01/15

REVISION DATES: 04/02/15, 06/11/15, 07/06/17

I. PURPOSE

The AHCCCS Value-Based Purchasing (VBP) Initiative applies to Acute Care 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, and those related to child and adolescent health, by aligning the incentives of the Contractor and provider through VBP strategies.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor applied in the calculation of the quality distribution that ensures that the total quality contribution amount by QMPM equals the total quality distribution amount by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
ENCOUNTER	For the purposes of this policy, all encounters must be in an adjudicated and approved status.
MEASUREMENT YEAR	The period for which the VBP Initiative Policy applies which shall be 10/1 through 9/30.
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 VBP 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.
PERFORMANCE MEASURE SCORE	One of the two scores used in calculating the quality distribution. This score is based on the Contractor's performance relative to the minimum performance standards established by CQM.
PERFORMANCE RANK SCORE	One of the two scores used in calculating the quality distribution. This score is based on a pure ranking of the Contractor's performance.

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.
PROSPECTIVE GROSS CAPITATION	Prospective capitation payments, prior to adjustments for Health Insurer Fee payment, made to Contractors on a monthly basis which includes medical expense, reinsurance offset, administration, risk/contingency and premium tax, and any subsequent amendments thereof. For purposes of this policy, Prospective Gross Capitation is exclusive of Delivery Supplemental, KidsCare and State Only Transplant payments.
QUALITY CONTRIBUTION	A specified percentage of Contractors' Prospective Gross Capitation payments that will be assessed through a reconciliation process to fund the VBP Initiative.
QUALITY MANAGEMENT PERFORMANCE MEASURES (QMPM)	Health care quality measures utilized by CQM. Subsets of these measures were selected for use in the VBP Initiative.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by CQM annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by CQM for each QMPM and used in calculating the performance measure score.
QUALITY DISTRIBUTION	Amounts returned to Contractors, by QMPM, based on the results of the performance measure score and the performance rank score.
RANK FACTOR	A factor applied in the calculation of Contractor's quality distribution amount based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's quality distribution amount for the performance measurement score.

VALUE-BASED PURCHASING (VBP) STRATEGIES

A model which aligns payment more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for this initiative may include any combination of Primary Care Incentives (PC), Performance-Based Contracts (PB), Bundled/Episode Payments (BE), Shared Savings (SS), Shared Risk (SR) and Capitation + Performance-Based Contracts (CP) purchasing strategies as defined below, in order from least to greatest provider financial risk. See Attachment A to view the continuum of VBP strategies.

FEE-FOR-SERVICE

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.

This strategy shall not be counted towards the minimum qualifying criteria outlined under C.1.b. in order to be eligible for quality distribution under this policy.

PRIMARY CARE INCENTIVES

Purchasing strategy in which providers/physicians are rewarded with bonus payments for meeting certain performance measures for quality and/or cost. It can also include disincentives, such as eliminating payments for negative consequences of care (i.e. medical errors) or for increased costs and is typically paid in addition to fee-for-service payments. Also known as Pay for Performance or P4P.

PERFORMANCE-BASED CONTRACTS

Purchasing strategy in which a portion of the provider's total potential payment is tied to a provider's performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.

BUNDLED/EPISODE PAYMENTS

Purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.

SHARED SAVINGS Purchasing strategy which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be based on a fee-for-service purchasing system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and vary based on provider performance.

SHARED RISK Purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of data collection, shared risk programs that include shared savings should only be included in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service purchasing system.

CAPITATION + PERFORMANCE-BASED CONTRACTS Purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers or groups of providers are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

III. POLICY

A. GENERAL

1. All Acute Care Contractors

   All Acute Care Contractors shall be eligible to qualify for a quality distribution by meeting the VBP strategies qualifying criteria in C.1.b. and certify as described in C.1.c. Failure to meet or certify to meeting the criteria in a particular measurement year will disqualify the Contractor from any quality distributions for that year. However, the

Contractor's quality contribution used in the reconciliation described below will still be assessed and included to fund quality distributions to all other Contractors.

Quality distributions will be made to Contractors based on relative Contractor performance for the measurement year, as determined by CQM, on selected Quality Management Performance Measures (QMPMs - see highlighted rows in Attachment B). Each QMPM is allocated a percentage of the total quality contribution funds available for distribution, see Attachment C for the percent of contribution by QMPM. Each measure will be considered independently of other measures, such that a Contractor can earn distributions on any or all of the QMPMs.

The quality distribution formula is based on two factors: Contractors' performance relative to minimum performance standards established by CQM (i.e. performance measure score), and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment C. The quality distribution formula first determines payments based on the performance measure score. The balance of quality contribution funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total quality distributions equal the total quality contributions. Due to Federal requirements, the maximum distribution across all QMPMs made to any Contractor will be limited to five percent of annual prospective gross capitation attributable to the Acute VBP Initiative.

Modifications to the quality distribution formula, and additional methods for determining quality distributions, including quality distributions based on improvement in measures from year-to-year, may be considered in future measurement years.

AHCCCS reserves the right to eliminate a particular measure from the VBP Initiative. In such a case, AHCCCS will remove each Contractor's quality contribution amount for that measure.

AHCCCS reserves the right to exclude a particular Contractor from one or more measures of the VBP Initiative based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will remove the Contractor's quality contribution amount for that measure, provided that the Contractor has met and certified to meeting the qualifying criteria under VBP strategies stipulated in C.1.b. and C.1.c. of this Policy.

Quality distributions to Contractors will be funded by assessing one percent of Prospective Gross Capitation (quality contribution).

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. Risk adjustment methods for the QMPMs will be considered and utilized, if deemed to be appropriate.

2. Acute Care Contractors Affiliated with a Regional Behavioral Health Authority (RBHA) Contract

In addition to those requirements outlined above in Section A.1, an Acute Care Contractor affiliated with an entity that holds a RBHA contract must also meet the VBP strategies qualifying criteria in C.2.a. and certify as described in C.2.b. Failure to meet or certify to meeting the criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

Quality contributions and quality distributions do not apply to this section.

B. AHCCCS RESPONSIBILITIES

1. All Acute Care Contractors
   a. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a contract year basis,
   b. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS shall tabulate results of the VBP Initiative and reconcile the contribution from and distribution to Contractors,

      The quality contribution may be adjusted, if necessary, for the elimination of a particular measure from the VBP Initiative or the elimination of a Contractor from a particular measure as indicated above.

      The full amount of the quality contribution will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The quality distribution by QMPM will be calculated as follows (see Attachment C for an example):

      Q= Quality Contribution
      S = Scaling Factor
      CMeasure = Contractor's QMPM Result
      MinStd = Quality Management Minimum Performance Standard
      A = Adjustment Factor
      R = Rank Factor

      Performance Measure Score:
      If equal to or above MinStd, then Q * S * ([CMeasure – MinStd]/MinStd)
      If below minimum standard, then zero

      Performance Rank Score: A * Q * R
      Quality Distribution: Performance Measure Score + Performance Rank Score
   c. Through the reconciliation, the total quality distribution will be subtracted from the net quality contribution to establish the amount due to or due from the Contractor,
   d. The difference computed in B.1.c. shall be adjusted by adding the total of all performance-based payments certified by the Contractor attributed to dates of service from October 1, 2015 through September 30, 2016 for the CYE16 reconciliation and October 1, 2016 through September 30, 2017 for the CYE17 reconciliation, and submitted to AHCCCS in the final Attachment E as prescribed in C.1.c. 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 reconciliation.

For any VBP contract that is effective for a period other than the measurement year, AHCCCS will allow performance-based payments to be included in the appropriate years' reconciliations to which the payments are 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 reconciliation and six months (October 1, 201X – March 31, 201Y) in the 201Y reconciliation.

AHCCCS shall test the total amount due to/from 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 to/from within the Federal requirement.

The Contractor is not required to meet the VBP strategies qualifying criteria in C.1.b. or C.2.a. in order for the performance-based payments to be added to the Contractor's reconciliation results computed in B.1.c., and

e. The result computed in B.1.d. will be adjusted for premium tax. See Attachment D for example.

AHCCCS will provide the Contractor with the reconciliation and written notice of the deadline for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and address any issues as warranted.

Any amount due to or due from the Contractor as a result of the reconciliation will be paid or recouped through a future monthly capitation payment.

2. Acute Care Contractors Affiliated with a RBHA Contract

AHCCCS shall affirm that the Contractor met the VBP strategies qualifying criteria in a particular contract year and will assess sanctions up to a maximum of $250,000 for failure to meet the criteria.

C. CONTRACTOR RESPONSIBILITIES

1. All Acute Care Contractors
   a. The Contractor shall adhere to all requirements of the AMPM Policy 970,
   b. A minimum of 20 percent in CYE 16 and 35 percent in CYE 17 of the value of total prospective payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the measurement year. AHCCCS intends that the minimum value threshold will grow each year according to the schedule below.

YEAR	INTENDED MINIMUM VALUE PERCENTAGE
CYE 18	50%
CYE 19	60%
CYE 20	70%
CYE 21	70%

Strategies for this initiative may include any combination of the VBP strategies defined in Section II with the exception of the Fee-For-Service Strategy. Strategies utilized must meet the definitions provided under Section II. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

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

The Contractor shall be responsible for identifying which strategy applies to each VBP 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 Attachment B as part of its VBP strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts. For those contracts executed prior to February 01 of each measurement year, AHCCCS shall count the strategies for the time period in the measurement year for which the contract is in effect. For CYE 16 and CYE 17: For those contracts executed after February 1 of each measurement year, AHCCCS shall count the strategies for the time period from the execution date forward for which the contract is in effect, and

c. The Contractor shall 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:
   i. An initial VBP Strategies Certification as provided in Attachment E to the DHCM Finance Manager within 60 days of the start of the measurement year, and

ii. A final VBP Strategies Certification as provided in Attachment E to the DHCM Finance Manager, and the Structured Payment File, due 270 days after the end of the measurement year.

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

AHCCCS reserves the right to request an audit of the Certifications included in Attachment E.

2. Acute Care Contractors Affiliated with a RBHA Contract
   a. In addition to those requirements outlined above in Section C.1, an Acute Care Contractor affiliated with an entity that holds a RBHA contract shall also enter into at least two VBP 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 contracts, but who receive their acute care and behavioral health services from affiliated entities, e.g. children, non-dual adults with GMH/SA needs, non-integrated adults with serious mental illness. AHCCCS intends to further extend and refine the scope of this requirement in future years. The physical health portion of contracts executed under this requirement may be used to fulfill the VBP strategies qualifying criteria under C.1.b, and
   b. The Contractor shall certify to AHCCCS that this requirement will be met by completing and submitting the comporting section in Attachment E. The Contractor shall submit Attachment E as outlined in Section C.1 above.

      Failure to attest to the VBP 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 E.

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

1. AHCCCS has developed a Structured Payment File to automate the VBP Strategies Certification Excel file. The Contractor shall submit this file annually for CYE 16 and CYE 17. (See C.1.c.ii.) For details on the file layout and FTP submission process, refer to the AHCCCS Structured Payment Transmission User Manual https://azahcccs.gov/Resources/Downloads/OperationsReporting/StructuredPaymentTransmissionCompanionGuide.pdf.

2. In order to link encounters to the Structured Payment File, the Contractor shall add a VBP Indicator to encounters paid under a VBP contract. Refer to the AHCCCS Technical Interface Guidelines (TIG) - Post Adjudicated Structured Payment File for information on the VBP 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 VBP contract, the Contractor should include the VBP Indicator in the original encounter submission.

If the Contractor does not know upfront that the encounter is tied to a member/provider under VBP contract, the Contractor shall add the VBP 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 VBP Indicator to adjudicated encounters, if desired.

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