How Alternative Payment Models Can Help Rural Providers

Improve Care and Sustainability

A Value Based Payment Primer and Excel Tool

and

HEALTH MANAGEMENT ASSOCIATES

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General Guidelines to Using this Primer

This Primer is designed as a self-guided tool to support your organization's journey toward value-based payment (VBP). Use the questions as a guide as you make your way through the Primer. They will help your organization consider national trends and experiences of VBP, your current state and readiness level, benefits and barriers, if VBP is right for you and at what level.

The Primer does not need to be read in page order or in its entirety – each organization should tailor its use for its specific needs. We recommend that you review the Table of Contents and determine which sections are most relevant for your organization to explore further. You also can refer to the cross-referenced sources and toolkits to supplement the questions and considerations presented in the Primer.

In addition to the Primer, there is an accompanying **Excel VBP Worksheet** tool that mirrors many of the questions in the Primer and provides a place to document important information you gather as you answer questions. There also is a recorded webinar, ***Value-Based Payment: Is it Disrupting Health Care for the Better? Role of Alternative Payment Models From a Clinician's Perspective*****.** This can be viewed for more background and explanation about VBP and its value to rural health care providers.

Finally, this Primer is mean to help you get started on your VBP journey, and to give your organization the confidence and understanding to take the next steps. It includes additional resources that are available to guide you on some of those next steps.

What is Value Based Payment?

Value-based health care is a delivery model in which providers, including hospitals, health care clinics and practices, are paid based on health outcomes.

The future of health care will be determined by payers and patients looking for the best value and rewarding providers who can deliver better outcomes.[1]

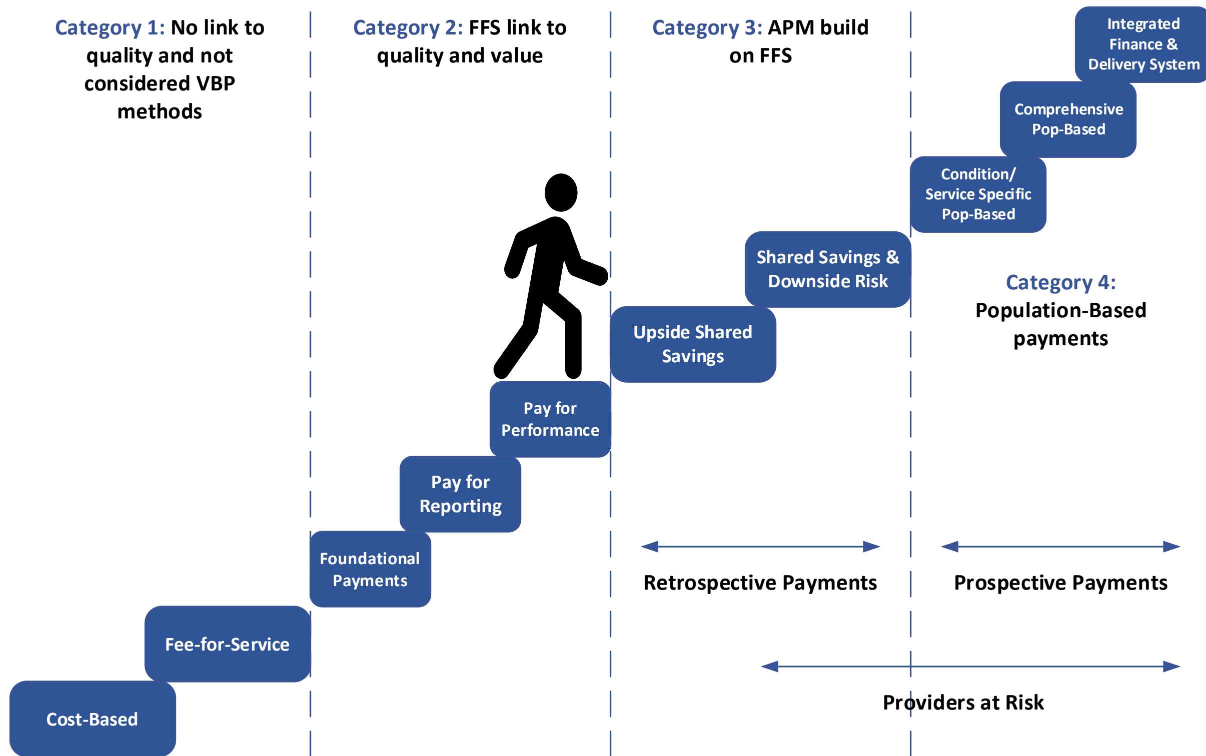
Value-based payment (VBP) is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. These different kinds of reimbursement are referred to as alternative payment models (APMs). VBPs are intended to support the delivery of evidence-based, person-centered, efficient care that contributes to improved quality and positive health outcomes at an appropriate cost.

The Health Care Payment Learning Action Network (HCP LAN) has defined categories of payment and service delivery with increasing degrees of provider risk and reward.[2] Figure 1 here demonstrates how this VBP continuum works like stairsteps. Each step moves you farther along the continuum from the bottom, which represents payments for specific services with no connection to quality or patient outcomes, to the top, which represents payments that are fully integrated with the delivery and outcomes of services.

[1] Source: NEJM Catalyst-Innovations in Health Care Delivery Jan 2017 "What is Value-Based Healthcare?" available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558

[2] Go to the HCP LAN website to get information on the APM framework https://hcp-lan.org/apm-measurement-2020/

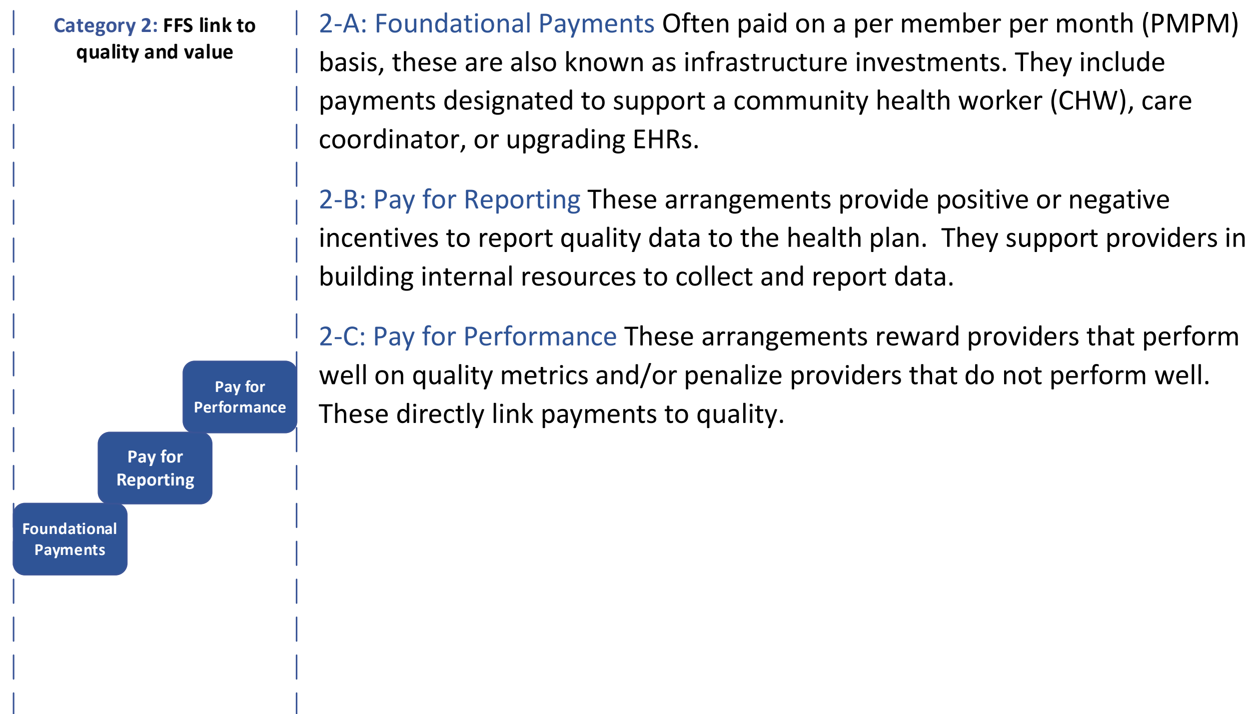
Figure 1. The "Stairsteps" to VBP



Figures 2 – 4 demonstrate each of the levels of APMs in the three categories considered APMs.

Figures 2 – 4. HCP LAN Categories of APMs

Category 2 APMs include fee-for-service (FFS) payments with links to quality and value.

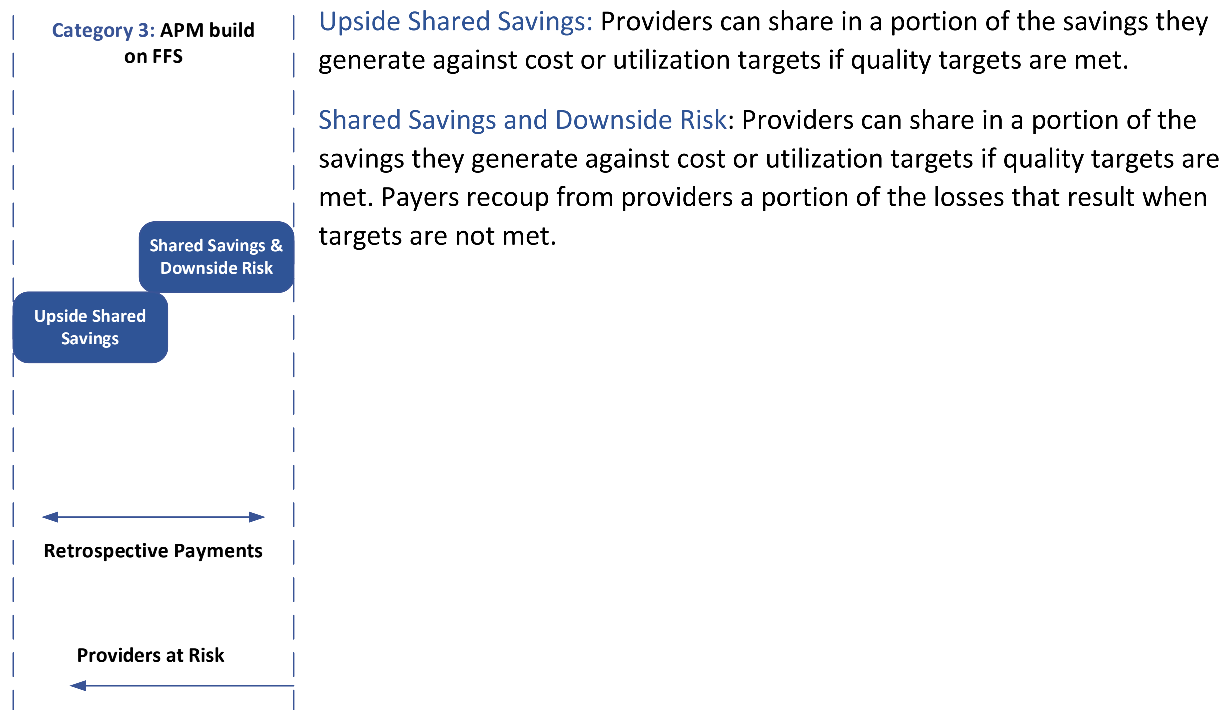


2-A: Foundational Payments Often paid on a per member per month (PMPM) basis, these are also known as infrastructure investments. They include payments designated to support a community health worker (CHW), care coordinator, or upgrading EHRs.

2-B: Pay for Reporting These arrangements provide positive or negative incentives to report quality data to the health plan. They support providers in building internal resources to collect and report data.

2-C: Pay for Performance These arrangements reward providers that perform well on quality metrics and/or penalize providers that do not perform well. These directly link payments to quality.

Category 3 payments are based on cost (and occasionally utilization) performance against a pre-defined target.

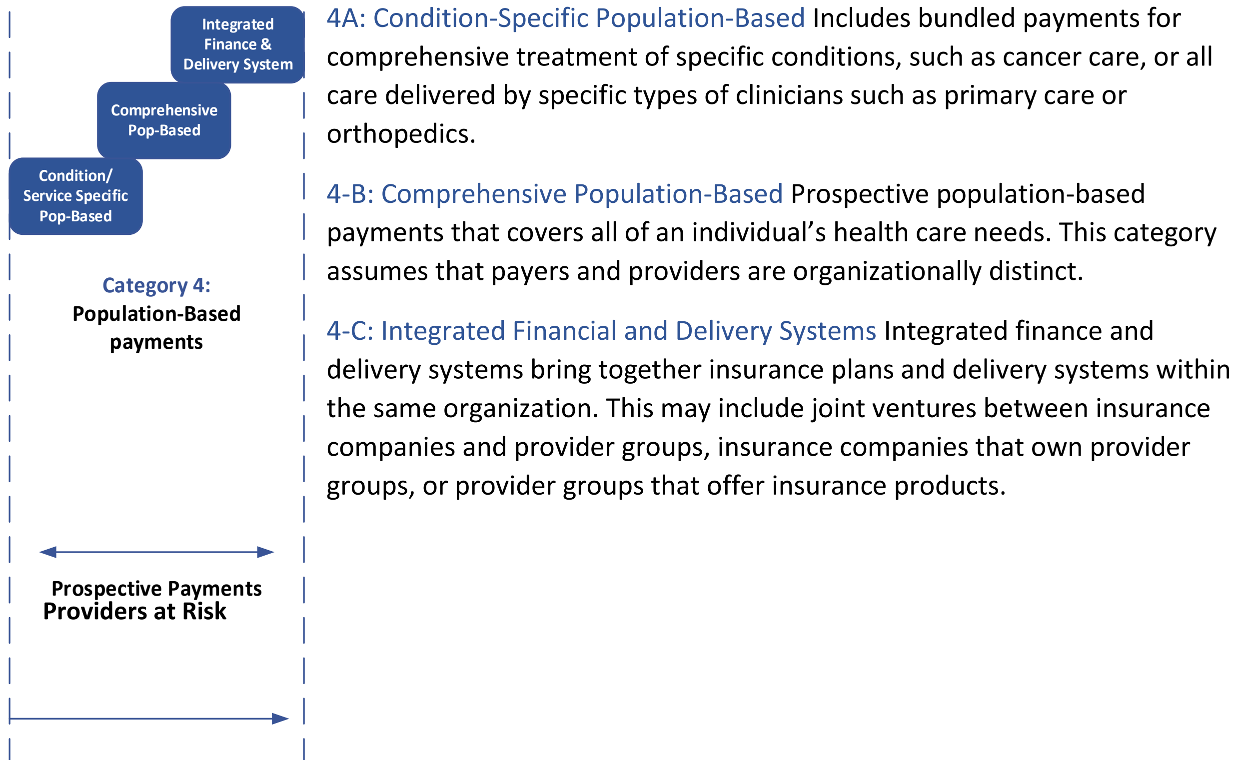


Upside Shared Savings: Providers can share in a portion of the savings they generate against cost or utilization targets if quality targets are met.

Shared Savings and Downside Risk: Providers can share in a portion of the savings they generate against cost or utilization targets if quality targets are met. Payers recoup from providers a portion of the losses that result when targets are not met.

Category 4 APMs:

- Involve prospective, population-based payments that encourage the delivery of coordinated high-quality, and person-centered care
- Require accountability for measures of appropriate care to safeguard against incentives to limit necessary care



4A: Condition-Specific Population-Based Includes bundled payments for comprehensive treatment of specific conditions, such as cancer care, or all care delivered by specific types of clinicians such as primary care or orthopedics.

4-B: Comprehensive Population-Based Prospective population-based payments that covers all of an individual's health care needs. This category assumes that payers and providers are organizationally distinct.

4-C: Integrated Financial and Delivery Systems Integrated finance and delivery systems bring together insurance plans and delivery systems within the same organization. This may include joint ventures between insurance companies and provider groups, insurance companies that own provider groups, or provider groups that offer insurance products.

Why You Should Consider Value Based Payment

How well does your current payment methodology work? Have you considered the limitations of your current model?

You may be asking why you should consider VBP – perhaps your organization has a fee-for-service (FFS) model that has mostly worked for you. If you are a Rural Health Clinic (RHC), a Federally Qualified Health Center (FQHC), or Critical Access Hospital, you are receiving specialized payments on a fee-for-service basis that have been critical to operations and growth. Will VBP jeopardize current revenue? Change is hard and subject to uncertainty.

The safety and predictability of strict fee-for-service reimbursement has been challenged during the COVID-19 pandemic. The Centers for Medicare and Medicaid Services(CMS), state Medicaid agencies, and other payers are looking to achieve better population outcomes and cost reductions through payment reform. Patient expectations are evolving, accelerated by the convenience of expanded telehealth. Disrupters are beginning to compete in health care, informed by technology-powered innovations from other service industries. Primary care manpower shortages, which will only worsen in the foreseeable future, will force providers to use the full care team in the most efficient manner, not just the "billable" staff.

This Primer will help you consider the limitations of your current payment model and the benefits and opportunities of a VBP model. Current fee-for-service (FFS) payment methodologies can create incentives for the provision of more services independent of the value of those services to improve health outcomes. This results in escalating health care costs, patient inconvenience, and exposes patients to potential adverse events.[3] FFS payment does not reward providers for coordination of services. This can lead to duplication of services, poor communication among providers and medical errors. FFS models limit health care services to face-to-face (most often in-person), even when virtual care and care by other team members may be clinically appropriate and more convenient for patients to access.[4]

Does VBP benefit patients?

VBP can help you put patients first and improve access to care. Many other service industries have transformed how and when consumers access their service (think online retail, banking from your mobile phone, travel planning, etc.). Health care lags behind these industries in significant ways. For example, prior to the COVID pandemic, how much were you using telehealth to connect with your patients, so they did not have to travel to you?

Despite much attention and effort, as a whole under the current FFS system, primary care has failed to improve control of many common chronic conditions such as hypertension, diabetes and depression for a large portion of patients. High-deductible and large co-payment health insurance policies create barriers to accessing needed services for some, and there is a growing movement among patients to be able to do more for themselves. For example, see the American Heart Association call for patient self-

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[3] https://jamanetwork.com/journals/jama/article-abstract/2752664

[4] https://www.europeanallianceforvalueinhealth.eu/wp-content/uploads/2021/04/JAMA-Reducing-Low-Value-Care-and-Improving-Health-Care-Value.pdf

monitoring with PCP support https://www.heart.org/en/health-topics/high-blood-pressure. However, increasing patient self-management in a FFS model can directly result in reduced revenue for providers.

Does VBP benefit workforce?

We already have an inadequate primary care workforce, particularly in rural areas. Provider shortages in rural areas are projected to worsen as the population ages and the pipeline of new trainees is not large enough to meet the anticipated need. Current FFS payment structures restrict reimbursement to only certain members of the care team and keep those clinicians from delegating responsibility to other care team members, such as Community Health Workers (CHWs), who could do the work just as well and less expensively, and who may have cultural backgrounds more aligned with patients. VBP can create recruitment and retention strategies that allow care teams where providers can practice at the top of their licenses.

National Trends and Experiences in VBP

Are provider organizations across the country moving towards VBP?

According to a CMS 2020 Report to Congress: "Between October 1, 2018, and September 30, 2020, the CMS Innovation Center tested, announced, or issued Notices of Proposed Rulemaking for a total of 38 payment and service delivery models and initiatives under section 1115A authority. In addition, it conducted six congressionally mandated or authorized demonstration projects. The CMS Innovation Center also played a central role in the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) during this period."[5]

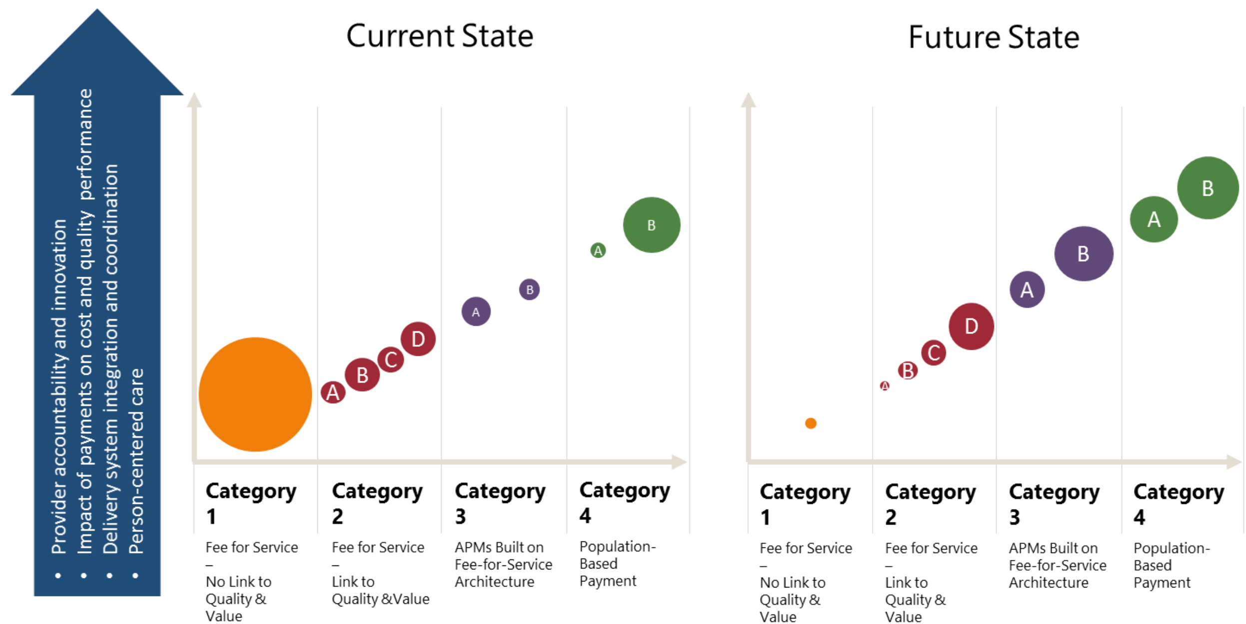
"CMS estimates that during the period of this report more than 27,850,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 528,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives."

The best time to start thinking about how your organization can move into VBP is now. The health care market is changing rapidly and payers, such as the Centers for Medicare and Medicaid Services (CMS), which pays for a lot of the care Medicare and Medicaid enrollees receive, increasingly expect providers to deliver improved patient health outcomes.

For example, Figure 5 shows how large payers like Medicare, Medicaid, and national health plans are reshaping how providers are reimbursed to focus on quality vs. quantity through APMs. The current state of payments today still rests primarily in FFS models that are not tied to any kind of quality or outcomes (Category 1). As payers become more focused on value and quality, they will push providers out of payment models in Category 1 toward those where there is at least some connection to quality and patient outcomes, such as those in the upper levels of Category 2, as well as Category 3 and 4.

[5] **CMS Innovation Center - Fifth Report to Congress (PDF)** *August 2021*

FIGURE 5. BIG HEALTH CARE PAYERS ARE REDEFINING THE FUTURE STATE OF HEALTH CARE DELIVERY AND FINANCING



What have been the results of VBP so far? Are providers and patients benefiting from this methodology?

To date, the savings and quality gains from alternative payment models have been inconsistent and modest. However, a February 2021 brief from the Penn Leonard Davis Institute of Health Economics recommended that CMS accelerate the transformation to VBP, including moving away from voluntary toward mandatory participation, whenever feasible. Even when participation in APMs is not practical for a provider, the paper recommends that CMS support efforts to reduce "the attractiveness of FFS arrangements."[6] This same brief recommends that CMS proactively use APMs to reduce health disparities and tie health equity to financial outcomes.[7] Similarly, in a piece in the *JAMA Health Forum*, the authors discuss additional opportunities to reduce health inequities.[8]

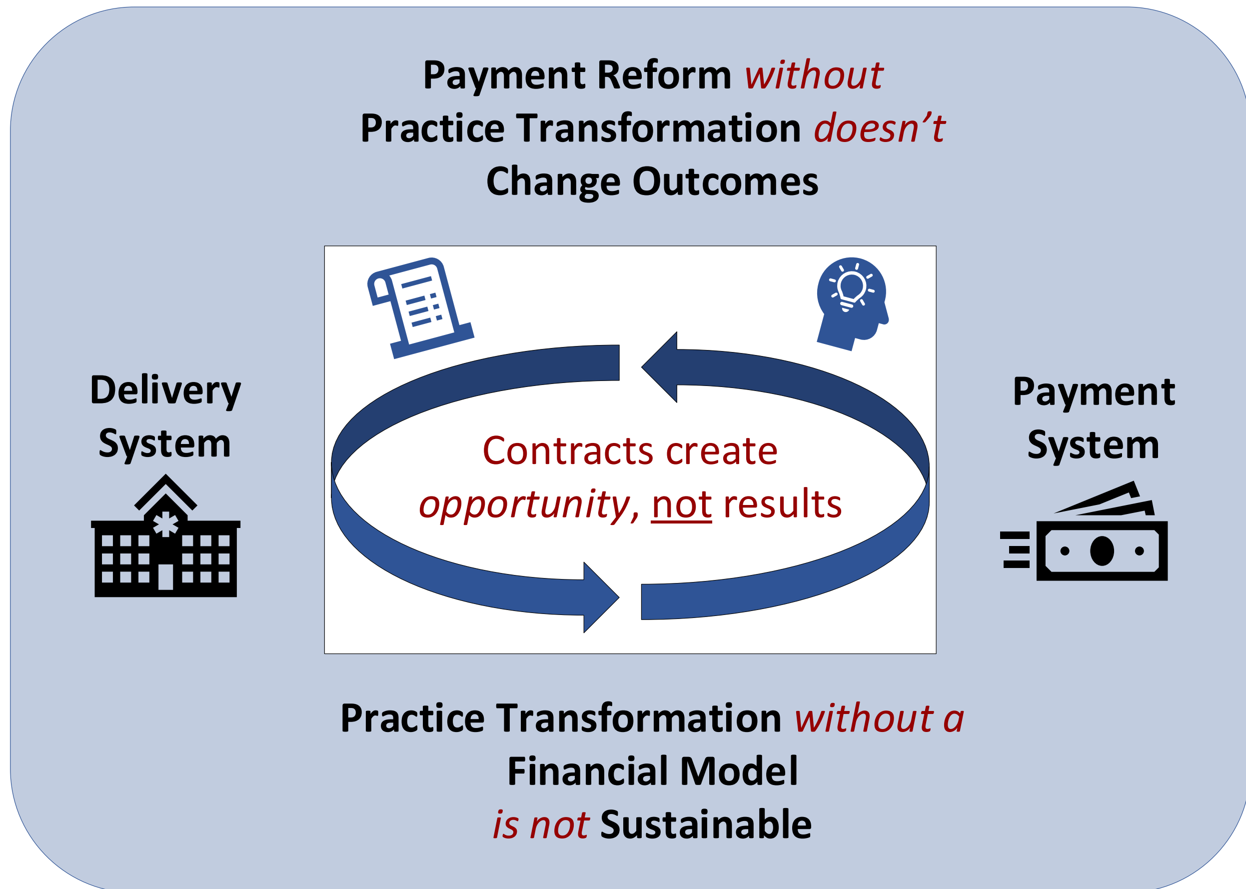
The CMS Innovation Center's 5th Report to Congress notes that: "Since the inception of the CMS Innovation Center, five model tests have delivered statistically significant savings, namely: the ACO Investment (AIM) Model; the Home Health Value-Based Purchasing (HHVBP) Model; the Maryland All-Payer (MDAPM) Model; the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT); and the Pioneer ACO Model."[9]

[6] https://ldi.upenn.edu/our-work/research-updates/the-future-of-value-based-payment/
[7] IBID
[8] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2781101
[9] CMS Innovation Center - Fifth Report to Congress (PDF) *August 2021*

Evaluating Readiness

A critical aspect of planning for VBP is evaluating how prepared your organization is to take on something like this. Figure 6 below shows that VBP is about how all the critical pieces must work together to achieve real payment reform and sustainable practice transformation that makes sense.

FIGURE 6. SUCCESSFUL VBP INCLUDES MULTIPLE COMPONENTS



Without both a focus on how you are transforming the way your organization delivers care and how you get paid for it, you cannot sustain operations in a VBP model. You must understand these important aspects of VBP and what they each mean for your organization to successfully achieve your long-term VBP goals. As shown in Figure 1 above, if you think of the VBP continuum as stairsteps, each new level or step requires additional commitment and engagement from your organization than the previous one. It is up to you to decide how far you can and want to go. You do not need to rush to the top of the stairs-it can be a journey over several years. You do not even have to go to the top. You may find that for your organization, somewhere in the middle works the best. The important thing is to follow a process to deliberately determine how far and how fast you want to go, and invest in the time and effort it will take to be successful once you make a decision.

The Primer sections below provide a guide to help you evaluate your organization's readiness to take on VBP. They are designed for you to ask a series of questions, the answers to which will help you better understand what you really want to achieve through VBP and where on the "stairsteps" is the optimal place for you to be to achieve it. Engaging your Board of Directors, executive leaders, clinical leaders, and front-line staff in answering these questions will help you to assess your current strengths, identify readiness gaps, and prioritize steps for moving toward VBP.

The pursuit of value-based payment is a journey. The pace is determined by internal readiness and external contracting opportunities. It usually progresses from reaching population quality targets to managing the continuum of care efficiently. Payers are accelerating the timeline for that progression based on evolving evidence that success is enhanced as providers assume more financial accountability for outcomes. It may take you one to two years to put the pieces in place to make the initial transition to VBP, or even just to move to the next level. The important thing is to start thinking about it and planning for it before you may be required to do so by your primary payers.

Key questions:

Has our organization successfully adapted to the changing health care landscape?

Where are our gaps in patient care, and what new processes have we tried to improve patient care?

Where are our gaps in workforce capacity and what new processes have we tried to support and supplement our workforce?

If we decide to move forward with VBP, what are our strategic goals with this methodology?

How will VBP support our equity goals?

Could VBP help us address these gaps?

Defining your VBP Value Proposition

You are ready to jump into VBP. But *WHY* are you interested in VBP? There are many reasons organizations want to adopt VBP models. For example, the current ways they are getting paid for health care create barriers to achieving the best patient outcomes, or how you get paid today doesn't allow you to use your team members in an optimal way. Maybe you see other health care providers using VBP and you see they are able to make changes that you also would like to make to be more competitive.

These are all great reasons to want to implement VBP models. But first, you need to answer several important questions to help define your VBP value proposition. Wikipedia defines value proposition as, "*a promise of value to be delivered, communicated, and acknowledged. It is also a belief from the customer about how value (benefit) will be delivered, experienced and acquired*."[10]

You need to identify how VBP is going to help you deliver value – to your patients, your staff, your payers, and other important stakeholders. This section includes several key questions to help you define why VBP is important to your organization and what you want to accomplish through it.

Has our organization successfully adapted to the changing health care landscape?

First you need to understand if, and how well, you have been adapting to how rapidly things are changing in the health care landscape. For example, think about how changes in other industries, such as banking and entertainment, have shaped people's expectations. When was the last time you had to go to the bank to get money? Automated Teller Machines (ATMs) located in convenient places mean we can get cash virtually any time without having to go to the bank. Similarly, we now can watch blockbuster movies without leaving the comfort of our own living rooms because we can access them through services like Netflix and Amazon Prime Video.

How have patients' expectations about accessing necessary healthcare changed? The COVID-19 pandemic has made it clear that many people can get care virtually, through telehealth – whether simply via a telephone call or using video platforms such as American Well, Avizia, Carena, Doctor on Demand, and MDLive. Some providers even use email to support patients through secure websites that allow them to access screening and lab results, review diagnosis and treatment

[10] https://en.wikipedia.org/wiki/Value_proposition

information, and schedule appointments at their convenience. Most health plans today allow members to get their prescriptions through the mail. In many places, national drug store chains like Walgreens and CVS are expanding services to include primary care providers who can quickly take care of a variety of basic primary and acute care needs.

These health care delivery changes are impacting patients' expectations about how and when they receive care. You need to identify what your organization is doing to adapt to these kinds of changes in service delivery and patient expectations.

You also need to understand the changing needs of payers. This includes state Medicaid agencies, the federal Medicare program and Medicare Advantage Plans through private insurers, employer health plans, and others. More and more payers are expecting providers to move into alternative payment models (APMs), taking on more responsibility – and financial accountability - for the health outcomes of their patients. You can use these new reimbursement models a defensive tool (helping you to defend your market share and keep patients, or stay in a particular payer network), or an offensive tool (as a way to partner with new payers and build you patient panel). APMs can make offering innovative, convenient, and efficient care models much more feasible for many providers, including your organization.

A Patient Centered Focus

Where are our gaps in patient care, and what new processes have we tried to improve patient care? Could VBP help address these gaps?

This question looks at where you may have gaps in patient care and what kinds of things you have done or could do to close those gaps and improve patient care. This is important to your VBP value proposition because VBP is all about patient outcomes. For primary care providers, this means how to get your patients more engaged in the care and activities that are going to help get and keep them healthier. For example, are all the Medicaid or Medicare patients in your panel accessing appropriate screenings and preventive services available to them? If not, why not?

Patient Engagement

Thinking about the first question you answered above can help identify ways you might more effectively engage patients. For example, could you offer more telehealth services? Would community health workers help you to support more patients at a lower cost? Brainstorm about the things that would be incentives to your patients to more regularly access preventive primary care services.

You will want to look at your quality metrics and closing gaps in care. This might include things like meeting benchmarks for the number of children ages 0 – 5 who have received all their recommended vaccinations, or annual well visits for children and youth, as well as adults. It might be the number of your diabetic patients being managed with lifestyle and medication support, or patients using tobacco products who are referred to a quit line or getting medication to help them quit. If you have not already, you will need to identify the quality measures that are most relevant to your patients and important to your payers and start tracking and reporting them. While most metrics will include those focused on preventive services and management of chronic conditions, think about also establishing some efficiency and patient experience metrics. These might be measures such as time from check-in to when a patient sees the provider or how long it takes to get lab results, and whether patients were comfortable in the waiting room or felt their provider listened to them and answered their questions.

Care Coordination

Many VBP models focus on improving care coordination. Care coordination should improve exchange of patient information among various providers involved in care, reduced duplication of services, and assure that patients are accessing services as recommended. You will want to assess how well you are achieving the core elements of care coordination, based on your primary payers' expectations and requirements, and what improvements you need to make. That might include changes in staffing, improving workflow processes, or updating information systems.

Integrating Behavioral Health

Similarly, you should consider how well you are supporting integration of behavioral health (BH) services for your patients who need them. This includes screening for BH needs – including mental health and substance use disorders (SUD) – and addressing those needs or making referrals and connecting patients to providers who can address those needs. If you do not have integrated BH services, how are you connecting patients to appropriate resources and services? How are you coordinating with BH providers to help patients wholistically with both their physical and BH care needs? If you have integrated BH into your practice, how well is it working for your patients?

Connecting Patients to Social Services They Need

You also should assess how you are supporting patients in accessing necessary social supports they need such as transportation, food, housing, and safe home environments. These social determinants of health (SDoH) can have a significant impact on the overall health and well-being of patients, which means that no matter how good your care is, if they are facing other needs that are not being met, they still may suffer negative health outcomes. That then can affect your success in a VBP model. Screening for SDoH needs and establishing referral relationships with key service providers in your community can make an important difference in your overall patient outcomes.

Helping Patients Self-Manage

One way to help patients achieve better health outcomes is to teach them how to take better care of themselves. This is especially important for patients with chronic conditions that, when not well managed, can lead to serious and costly health emergencies and long-term problems.
Providing tools and techniques that help patients access preventive care, showing them how to do things for themselves at home or in their community, and teaching them how to make informed decisions about their health are important ways to support patients in effective self-management. What are ways that you are helping or could empower patients to do more self-management of their health? How can you support them in making healthy lifestyle choices? What staff do you have that could be most effective in working with patients to improve self-management? What external partners could help you with this?

Optimizing Health Information Technology to Improve Patient Outcomes

Use of new health information technology is an important way to understand how you can take a population health approach to improving the health outcomes of your patients. You will want to assess your technology capability for:

- Real time connectivity to important information such as immunization registries, and your patients' emergency department visits and inpatient admissions

- Aggregation of multiple data sources, including internal data sources such as your EHR and care management systems, if they are separate; it also may include external data sources
- Advanced analytics including use of artificial intelligence such as algorithms to identify care gaps or disease trends among your patients
- Timely reporting that informs decision-making at the point of care
- Analysis of population-level information to inform changes in your system of care

Taking Stock of Your Team

Where are our gaps in workforce capacity and what new processes have we tried to support and supplement our workforce? Could VBP help address these gaps?

In addition to thinking about how VBP can benefit your patients and what changes you may need to make in patient care, you also need to assess how VBP could potentially increase your workforce capacity. For example, there are several staffing and care management models that, under a fee-for-service payment structure, are not very feasible or sustainable. These include nurse triage, collaborative care, and using community health workers (CHWs) to provide some components of patient care. Under APMs, these kinds of staffing structures can work effectively and allow providers to maximize their entire team, using each staff member to deliver the services that optimize their expertise and training.

Taking a Health Equity Approach

How will VBP support our equity goals?

Finally, VBP can be an important pathway to improving your organization's approach to and support of improving health equity among your patients. This can be through services such as screening for and helping to address SDoH through direct services or referrals to trusted partners. It also can be through making sure that your patients have access to accurate information and that you actively counter false information they may have received from other sources. Paying attention to language and cultural differences among your patients, and providing them with feasible and healthy choices and options that meet their needs, will show them that you care about them not only as patients, but as people.

As a grantee under the support of the Georgia Health Policy Center's Community Health Systems Development Office, you have access to many important resources, one of which is [describe Race 4 Equity resource].

Setting Strategic Goals for VBP

If we decide to move forward with VBP, what are our strategic goals with this methodology?

As you begin to answer the above questions, your organization's value proposition should become clear. As this picture emerges, it is time to ask what your long-term VBP goals are, based on all that you have documented. For example, are you ready, and do you want to move from simply pay-for-quality to more sophisticated APMs that will reward you for more efficient population management?

You also must determine if your organization is big enough to effectively support VBP. It is difficult for individual practitioners and small practice groups to make the necessary investment in infrastructure to succeed in VBP on their own, and small patient panels introduce such a significant impact of statistical variation that it becomes difficult to accurately determine and reward high-value care. It may be worth exploring participation in a clinically integrated network. As part of a clinically integrated network, you can align incentives across the continuum of care to improve outcomes, as well as share the cost of new health information technology and analytics that your organization might not be able to manage on its own.

You will want to set VBP goals that are achievable, practical, and will move you toward your long-term vision. The farther along the VBP continuum you want to go, the more time and investment you will need to make to be successful – and the more opportunity you will have to do more innovative care.

Key Questions:

How is our organization currently performing?

Where are our gaps and barriers?

Where are we successful and why?

What trends can we identify, and what are the root causes behind these trends?

What areas do we need to consider further to understand our organization better?

How can we leverage our current payment model as we move toward VBP? What barriers and risks do we need to address?

Understanding Your Organization's Current State

Now that you clearly have established your value proposition and goals for VBP, it is time to assess the current state of your organization. You will want to identify the key aspects of your operations and understand how well you currently are performing so you have a clear picture of the strengths that you can build on, and the weaknesses that you will need to improve to move forward with VBP.

Internal Data

How is our organization currently performing? Where are our gaps and barriers? Where are we successful and why? What trends can we identify, and what are the root causes behind these trends?

It is very important to document how you are performing today so you can identify how and where you will need to make changes to support APMs. This involves collecting and analyzing data. Some of the most important data you will need to review include things like:

- Assigned or attributed patient panels
- Internal EHR-generated data
- Medical claims data
- Pharmacy fill data
- Care management information
- Diagnostic test outcomes
- Patient survey data

Identify the list of key data you want to use, then identify where/how you will get it. Ideally, you should review at least two years' worth of this kind of information; three or four would be even better. This will help you see trends and whether you are making progress, holding steady, or falling behind on important metrics. NOTE: Due to the COVID pandemic, you may need to adjust the data and number of years you review. The data for 2020 and even 2021 may not give you a realistic picture of your organization's operations because they were so unusual.

Using Payer-Generated Reports

You also may be able to get important data from payers with which you are already working. For example, do you work with any Medicaid, Medicare or private health plans that have provider portals where you can pull reports about your patients enrolled with them, or who send you reports about your patients who are enrolled with them? These kinds of reports often benchmark your organization

against others in the plan or nationally, so you can see how well your patients are doing compared to similar practices or clinics. They also can help you track and trend high-cost patients or specialized populations that require customized care. This data is critical to understanding how well you might perform under a VBP model and where you might have gaps in patient care that you will need to address.

Risk Stratification

Most patient risk stratification has historically been based on patient demographics and claims information. There are limitations to most algorithms, so you will want to explore what makes the most sense for your organization and your patient population. This link, FPM Journal-Risk Stratification Article, will take you to an article from the American Academy of Family Physicians' (AAFP) *Family Practice Management* Journal with a good explanation about risk stratification. Similarly, this article (MGMA Article) from Medical Group Management Association covers information about how to choose a risk stratification model.

There is a growing awareness that patient risk for adverse outcomes and high health care costs is only partially determined by patient demographics, disease burden and historical health care utilization patterns. There are social determinants of health (SDoH) that create barriers for individuals to follow their treatment plans and improve self-management. Some risk stratification algorithms are including geographically defined public health information. Better yet, some providers are systematically collecting SDoH information in patient health risk assessments and dynamically stratifying individuals using artificial intelligence.

You may also want to consider whether you want to use prospective or concurrent risk adjustment (RA) methods, or a mix of both. Prospective RA is a proactive approach to identify patient risk by looking at diagnosis gaps for previously known chronic conditions and suspected conditions missing supporting documentation. These gaps are shared with providers to review and close with patients. It is important then to ensure that these identified conditions are properly coded on claims so they can become part of a patient's risk score. An example of using a prospective risk adjustment method is a 55-year-old man who presents with normal blood glucose levels for a check-up today. But a review of his visits over time shows that his blood pressure and cholesterol have been going up every year. This could indicate an opportunity for intervention to prevent the future development of diabetes. Prospective risk stratification requires data and the ability to look at past patient data to identify possible future patient needs.

Concurrent risk stratification algorithms help identify likely high-cost individuals in the current year while prospective risk stratification algorithms help identify who will likely be high-cost in future years. For example, a pregnant woman expected to deliver a newborn in the current year would have a high concurrent risk score but not a high prospective risk score. However, this also requires careful attention to proper coding, as any payments associated with concurrent RA can create incentives for fraudulent coding.

You therefore may want to explore using a combination of both prospective and concurrent RA. To do this, you would use prospective RA to calculate payments for patients with low expected costs – those who do not need a lot of care or expensive services. You would use concurrent RA to calculate payments using the diagnosis of a small number of common, expensive conditions. This could improve predictive

performance while requiring less auditing than a fully concurrent RA model. If you wanted to dig deeper into a particular condition, you could use additional clinical data to analyze selected conditions to further improve predictive potential.

One additional potential challenge for robust risk stratification, especially if your organization is focused on supporting patients with SDoH needs, is the lack of systematically collected SDOH information. Many organizations do not have structured processes or systems for collecting SDoH information in a standardized and quantifiable way. This would mean having a way to capture the information in your EHR, or using some other kind of standard tool for screening and documenting your patients' SDoH needs. A good resource for SDoH screening tools can be found here on the Rural Health Information Hub website.

Accurate Claims Coding

Patient risk stratification and accurate claims coding are fundamental to being able to get actionable data that you can use to make real practice transformation and set the stage for building sustainable reimbursement models. Take your time in developing your organization's risk stratification approach and make sure that your staff understand it and why you are doing it. Then you must ensure that you have team members who know how to accurately code claims based on your risk stratification approach so you are both capturing the right level of information about your patients, and you are getting paid correctly for the services you deliver to them. There are two organizations that can provide much more information about HCC, a critical part of risk stratification. Here are the links that will take you to the websites of the Association of Rural and Community Health Coding (Association of Rural and Community Health Coding), which specializes in working with rural providers; and the American Academy of Professional Coders (American Academy of Professional Coders). You will find more information about the importance of proper coding later in this Primer.

Transparent Reporting

Making the data you are collecting available to your staff is an essential aspect of improving your care delivery and of preparing for VBP. When you begin to do risk stratification and identify areas for improving patient care, look for who your high performers are so you can have them share best practices with others on your team. Without being punitive or making it a "gotcha" exercise, find ways to leverage staff who have been able to maximize their effectiveness using this kind of data to help and teach others. As much as possible, you want to reduce unwarranted variation in how you are delivering care as an organization across all your staff. Sharing the data with staff can help your organization to be more productive. In the same way it also can support accountability within a clinically integrated network of providers. It allows you to see how you compare against others in the network, and creates opportunity to learn from each other and share best practices to improve the network as a whole.

Establishing a Clinical Committee and Subcommittee Structure

Consider whether or not it would make sense for your organization to form a clinical committee to review the risk stratification and other data that you are collecting. This might need to be only a few staff across your organization, or if you are part of a larger clinically integrated network, key team members who can work collaboratively to learn from and with others in the network. A committee focused on these clinical data can support the aggregation of experience from multiple stakeholders to suggest quality and care improvements. Such a group also support agreement on standardized approaches to care. Again, this kind of standardization can help move you more toward reducing unwarranted variations in care delivery among providers in your organization, or across organizations in a clinically integrated network.

Using Data to Inform Contracting Strategy

As you collect, report, and learn from the risk stratification data about your patients, you will want to be able to show current and potential payers the progress you are making as a mechanism for negotiating contracts. This is foundational for being able to get to VBP payment opportunities that are realistic and achievable for your organization. You will need to have benchmarked historical quality, utilization and cost data to support your requests for different payment models that will allow you to continue to make improvements in patient care.

Tracking Performance on APMs

As you negotiate contracts with current or new payers that include APMs, you must make sure to longitudinally track your patient panel to make sure you are closing gaps in care. Over time, you want to know that your patients are using health services they should when they should, and you want to understand your risk-stratified total cost of care. This will help you determine what payment models will work for you, allowing you enough reimbursement to meet your fixed costs, while also allowing you to address the unique needs of your patients and run a thriving practice.

Pros and Cons of Operating Your Own Data Warehouse

One thing you may want to consider is whether or not to have your own data warehouse or central data repository where you can collect, store, and use data for analytics and reporting. It can be expensive to have a data warehouse, but there also can be a return on investment, depending on how much data analysis you need or want to do. You can use a data warehouse to compile data from multiple systems , for example if you have separate EHR and care management systems, or to look at data you may receive from multiple payers. In larger organizations and for clinically integrated networks, a data warehouse enables aggregation of data across both providers and payers to more accurately judge and reward performance and gain insight into special populations.

Critical Areas of Understanding

The previous section more broadly covers the need for patient risk stratification and accurate coding, creating and sharing reports with staff and payers, and using the information you develop to build your case for VBP. This section looks in more detail at the kinds of data you will need to have to establish the most comprehensive picture of your organization and its readiness for VBP.

What areas do we need to consider further to understand our organization better?

As you are thinking about what data you need to better understand your operations, there are several important areas of focus to consider.

Your Patients

- The total size of the panel of patients attributed to your organization or assigned to you as their provider
- What your payer mix look like (what percentage of your patients are Medicaid, Medicare, private insurance, uninsured, etc.)
- How many of your patients are engaged in primary care (the percent who have used your services in the past 12 rolling months)
- Information you are getting from patient satisfaction surveys, whether you conduct these or from payers who may be conducting them with your patients
- Your historical quality, utilization, and cost information; you should have this for the past three to five years so you can see the trends over a longer period of time (especially important given that 2020 and 2021 have been unusual years because of the COVID pandemic)

Your Staff

- How many unfilled positions you have, by type, and by how long they have been vacant
- Staff retention rates; how long you are able to keep staff, and whether all care team members feel that their skills are being used optimally
- Staff organizational charts; you may need to implement more team-based care and workflows to support it as your organization moves more toward VBP
- Your current incentive structure and whether it actually incents improved patient outcomes vs. service volume
- Your capability to deliver culturally sensitive care in the preferred languages of your patients (this is an important aspect of engaging members in self-care)

Your Local Market (potential provider partners and payers)

- Payer market shares (are you contracted with the largest payers in your market?)
  - Reminder: markets dominated by a single payer can result in <u>decreased</u> leverage in negotiations
- Internal provider gaps
  - Do you have the providers you need on your team to achieve the patient outcomes you want/need for VBP; gaps in complementary provider types may reduce your ability to achieve desired outcomes
- External provider gaps
  - Are there gaps in providers to which you need to make referrals, whether for health care or social services
  - If you are part of a clinically integrated network, are you filling a critically provider gap that you could use to leverage negotiations with payers
- Existence of local clinically integrated network(s)
  - Is there potential for your organization to join a clinically integrated network

- If you are part of a clinically integrated network, will you be able to compete with other providers in the network, or are there enough covered lives to make competition less important
- When considering joining a clinically integrated network, ask to see their historical performance on APMs; this also will give you an idea of what your benchmark for participation might be

Addressing Current Payment Model Barriers and Risks

Moving from your current reimbursement structure to something new can be daunting. You will want to leverage, as much as possible, how you are getting paid for taking care of your patients today to make the transition to an APM.

How can we leverage our current payment model as we move toward VBP? What barriers and risks do we need to address?

As you explore adopting an APM, consider what about how you currently are getting reimbursed is not working. If you are still in a fee-for-service (FFS) model, what barriers is this creating for you to achieve optimal patient outcomes? For example, is it preventing you from using your full care team in the most efficient way? Maybe it is not allowing you to deliver care in a timely manner or in ways that are most convenient for your patients, such as through telehealth. Think about what kinds of barriers these issues present and what changing how you get paid could help you to address these issues without losing reimbursement.

Current APM Opportunities and Anticipated Future Trends

To understand current APM opportunities, you need to identify the trends happening in your healthcare market. What kinds of APMs are payers offering other providers in your market? Talk to payers about their expectations for VBP contracting in your market. For example, if your state uses managed care organizations to provide Medicaid, ask the Medicaid-participating plans what the state is requiring of them in terms of VBP. Similarly, you can talk with Medicare Advantage Plans about their expectations for VBP with providers in their networks.

If you are able, investigate how your current or potential competitors are using APMs. Your organization will need to be able to retain current patients and attract new patients to compete with other providers using APMs.

Creating a Contracting Term Sheet

You may want to create a contracting "term sheet," a document that spells out your preferred strategies and requirements for the term of the contract. This can be very useful when negotiating with payers about APMs and can help you to know what your boundaries are before you begin talking with payers. A sample Contract Term Sheet can be found in Appendix B. This offers suggested strategies rural providers can use when negotiating contract terms with payers

Infrastructure Investment and Capital Reserves to Assume Risk

You may need to make some investments in infrastructure to be able to support new ways of getting paid. This could include additional:

- Administrative team members, such as data analysts, billing/coding staff or those experienced with negotiating VBP contracts
- Clinical staff, including team members such as CHWs or peer support specialists, as well as clinicians able to redesign and implement new models of care
- Care management staff
- IT staff and IT systems like new business intelligence programs, a data warehouse, care management platform or electronic registry of community-based organizations able to address social drivers of health
- A multi-disciplinary managed care committee charged with monitoring performance
- Reserves to cover potential financial losses in risk contracts

Key Questions:

Are our internal and external stakeholders ready for VBP? What concerns and challenges do we need to address?

Who is affected by our move to VBP? How will this change their current functioning? Are they prepared for these changes? How will their readiness inhibit or facilitate our ability to move to VBP?

Identifying Stakeholders and Partners and Determining Their Readiness

It is important to remember that to successfully move to higher levels on the VBP "stairsteps," you will need to identify partners to help support your efforts. These include both internal and external partners, all of which will have some role to play as you explore how VBP can transform your organization and how you care for patients. These may be partners who share the cost of investment in infrastructure, help to create a large enough patient population to contract with payers for VBP, or to align incentives across the continuum of care needed to improve outcomes and reduce costs. Your organization should choose partners who are committed to value-based care and are willing to make the changes in their care models required to reach the desired patient outcomes.

Who is Ready for VBP?

You will need to determine how ready your partners and potential partners are to support your move into VBP. This will help you understand how much they can assist you, and if you need to identify additional partners.

Are our internal and external stakeholders ready for VBP? What concerns and challenges of theirs do we need to address? How will their readiness inhibit or facilitate our ability to move to VBP? Who else might be affected by our move to VBP? How will this change their current functioning and their relationship to our organization?

As you identify your internal and external stakeholders and what communications they need about your VBP goals, try to think about what challenges they may face in the process. This is especially critical for your internal stakeholders, but also may impact your relationships with external partners. You may be ready to make VBP a part of your organization's financial model, but you must explicitly establish if your key stakeholders are as ready as you. Make time to talk with them about your ideas, what research you have done about VBP in your market, your organization's readiness and challenges that must be addressed, and the value proposition you have developed for why you think VBP is important to pursue. Start with your internal stakeholders.

Internal Stakeholders

- Board of Directors – if your Board is not ready or not convinced that your organization is ready for VBP, you will not succeed in

achieving it. This should be your first stop in the conversation about VBP. Find a champion(s) among your Board members who can help you with critical inputs and information, and who can help make the case to other Board members, as well as other stakeholders, why and how VBP can work for your organization.

- Executive Team – There must be consensus among your executive team that implementing some level of VBP is the right move for your organization. It may take time to reach agreement on what level of VBP is right, but that should come as you work through the preparation steps and answer the key questions laid out in this Primer.
- Clinical Leadership – Your clinical leaders are the foundation of a successful VBP strategy. You won't be able to meet the quality standards or achieve true practice transformation without their full support and buy-in. They also need to be the ones directing the work on clinical drivers such as patient risk adjustments and care delivery improvements.
- Non-Clinical Leadership – Your non-clinical leaders also have a significant role to play. You will need to make infrastructure adjustments and ensure adequate resources to support additional data collection and analysis, proper coding and billing, relationship building with external partners and payers, and communicating with staff and patients why/how the changes you are making matter to them.
- Front-Line Staff – You must not forget that your front-line staff also can significantly impact your ability to achieve the changes that will be needed for you to implement VBP models successfully. They need to understand the value proposition both to the organization as a whole, to them individually, and to your patients. Make the time to regularly update all staff on practice changes and progress toward achieving your VBP goals.

Create a plan for how you will educate each of these internal groups about your VBP goals and why they are important to the organization. Make sure that your communications continue beyond just introducing them to the idea. If you have a strategic plan, consider how VBP fits into it (if it is not already part of it). It requires resources to pursue VBP, and your most important resources are your internal stakeholders. Take the time to ensure they are on board with your VBP plans. This should include laying out your vision for how your model of care can adapt to VBP, and identifying where there are gaps in staff competencies, as well as gaps in supporting systems.

External Stakeholders

External stakeholders can be anyone from specialists or other health care providers in your community, to SDoH service providers, to local community colleges where you might find new staff. You can be creative when thinking about what partners you need or want to work with to expand your capacity and capabilities to be able to support APMs.

Review the data that you have collected and consider what your current gaps are and what other organizations can support you in closing those gaps. For example:

- Do you need to build relationships with housing or food providers? Is transportation an issue for many of your patients?
- Who could help you teach more patients better self-management techniques or support better lifestyle choices for your patients?

- Could you work with a local college or university to engage students in nursing, social work, CHW or CNA programs, or establish a relationship for hiring new graduates?
- Do you need to establish or improve relationships with specialists to assist with patients with certain chronic diseases or for screening services such as mammograms and biopsies?

All of these partners can support your efforts in building toward APMs that allow you more control over how you care for your patients and what you can do for them. In some cases, you may want to explicitly talk with external partners about your VBP goals. You can decide when and how you want to bring them into those discussions. Most importantly, you need to understand where they fit into your plans and what role you want or need them to play.

You will want to identify who else may be important to your success with VBP and how they might be affected if you implement VBP, or how they might impact your ability to implement VBP. This could include your state Medicaid agency and any health care plans that participate in Medicaid. You may have a significant number of Medicare patients, so need to consider how VBP could impact your work with the Centers for Medicare and Medicaid Services (CMS) or any Medicare Advantage Plans in your market. Similarly, if you are part of a larger health system or thinking about joining one you want to consider the impact of VBP.

Asset Mapping Your Stakeholders

As a grantee under the support of the Georgia Health Policy Center's Community Health Systems Development Office, you have access to many important resources, one of which is [describe C4 asset mapping tool resource]. This tool could help you identify who your key external stakeholders are so you can prioritize your need for outreaching and engaging them in your VBP process.

Assessing Critical Components of Care Delivery

Success in VBP depends on how providers adapt their daily operations, the scope and delivery of care, and relationships with their patients. Under VBP models, patients should expect convenient access to care, assistance in navigating healthcare systems to get the care they need, more coordination among the providers taking care of them, more opportunities for shared decision-making about their care, and more productive time with their clinicians. At the same time, VBP creates opportunities for clinicians and provider teams to make caring for patients more rewarding and fulfilling, offer additional kinds of services such as care coordination and SDoH assessment/assistance, and to be innovative in transforming the way they deliver care and get paid for it.

Key Questions:

How will your care delivery model be affected by the move to VBP?

As noted in the introduction, VBP ties reimbursement to care delivery quality and outcomes. APMs are designed to support evidence-based, person-centered, efficient care that contributes to improved quality and positive health outcomes, at an appropriate cost. In 1996, the Institute of Medicine said primary care should ideally be accessible, timely, first-contact, coordinated, long-term, and holistic ambulatory care for most common conditions and most people. They said there also should be minimal obstacles to obtaining primary care. Some 25 years later, has primary care lived up to these expectations?

Between 2008 and 2016, primary care visits by adults were already declining, most pronouncedly among:

- The youngest adults (27.6%)
- Those without chronic conditions (26.4%)
- Those living in the lowest-income areas (31.4%)

At the same time, visits to alterative clinics such as urgent care clinics, increased by nearly 47%.[11] The COVID-19 pandemic accelerated that trend.

How will your care delivery model be affected by the move to VBP?

These trends indicate that individuals are seeking care when and where it is most convenient for them, sometimes even if it

[11] Ishani Ganguli, MD, MPH; Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016. Ann Intern Med, Feb 2020

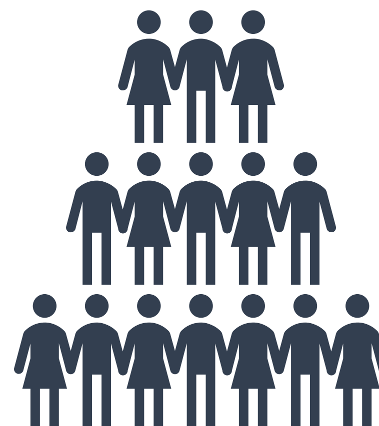
means sacrificing continuity of care. They also are seeking ways to manage their own health better, without having to make a trip to a provider's office.

- How is your organization responding to these patient needs?
  - Are you asking patients to come in when a call or information available to them through a patient portal would have been enough to help them?
  - Are you contributing to your no-show rate by how you provide access?
  - What financial impact does it have on your organization when you improve your patients' ability to self-manage?

This is a good time to evaluate how you are currently delivering care and modifications that could help you succeed in VBP. Many of the changes you will need or want to make to be responsive to your patients are not financially sustainable under traditional FFS payment structures. This makes moving into VBP all the more relevant. As a start, you will need to know more about subsets of your patients that are, or are at risk to become, complex and high cost and what improvements you need to make to address their specialized needs.

Population Health Management

The Institute for Healthcare Improvement (IHI) defines population health as "*the health outcomes of a group of individuals, including the distribution of such outcomes within the group*."[12] This can mean geographic populations or other groups such as employees of a large business, ethnic groups, individuals with disabilities, justice-involved individuals, or any number of other specifically defined set of people. Population health management can be supported through financial models such as APMs that allow providers to take innovative approaches that otherwise may not be financially supported in traditional FFS payment structures.



To be successful in VBP, your population health management must include improving the health outcomes of a defined group or groups of your patients through care coordination and patient engagement. This requires you to ensure that your patients are getting the care they need, when they need it, in the most appropriate setting. Beyond helping them get other health services such as behavioral health and other specialty care, diagnostics and medications, it means making sure that they also have access to social services and supports necessary to help them get and stay healthy, like nutritious food, transportation to health care appointments, and a safe home environment. This coordination of services and supports for your patients is sometimes called community care coordination. It is why it is so important for you to identify external stakeholders and partners who are aligned with and can support your VBP goals. They play a critical role in your ability to coordinate the care and services your patients need and that will impact their health outcomes.

A population health approach can also help your organization proactively reduces disparities and health inequities among your patients. For many providers their patients of color tend to experience a higher

[12] http://www.ihi.org/

burden of disease, disability, and mortality than their white patients. The COVID pandemic has starkly highlighted many of these racial and ethnic differences. For example, a recent Kaiser Family Foundation report showed that in some states, rates of white residents getting vaccinated two to three times higher than rates for Black residents.[13] These kinds of health disparities exist across all kinds of factors and they disproportionately affect certain groups of patients. Population health management strategies can help to identify disparities so providers can develop strategies for reducing and eliminating them. This is where data analytics and risk stratification tools can and should be used inform clinical care teams about the populations with the highest rates of health disparities.

Some of the data points that can help you to understand health disparities include social determinants, comorbidities, including mental health issues. Other data sources include clinical claims and local public health or hospital community health assessments. To better understand disparities related to COVID-19, some providers are using the free Social Vulnerability Index tool, an algorithm developed by the Wisconsin School of Medicine and Public Health, that uses age and a socioeconomic index to measure someone's susceptibility to COVID-19. Collecting information like this about specific groups of patients will allow your care teams to focus on certain populations and conditions to reduce their health disparities. Strategies for reducing health disparities also should include things like hiring and training individuals from the community to be CHWs and building your partnerships with community organizations.

Care Management

Care management includes care coordination of all assigned or attributed individuals, care management of the most complex individuals and managing transitions of care, especially those receiving care in an emergency department, hospital inpatient unit or from a post-acute care provider. Care coordination can often be done by a trained but non-clinically licensed member of the care team, such as a CHW. It includes onboarding of newly assigned members, screening all patients for gaps in preventive services, addressable barriers to accessing care, and helping those with chronic conditions to improve self-monitoring and self-management skills.

For example, nearly half of American adults have high blood pressure, yet an estimated 11 million do not know their blood pressure is too high and are not receiving treatment. Only about 1 in 4 adults with hypertension have their condition under control (below 130/80 mm Hg). Strong evidence shows that self-measured blood pressure monitoring (SMBP), done at home in addition to clinical support, helps people with hypertension lower their BP. That support can be provided virtually by a non-licensed member of the care team such as a community health worker. This is just one example of how you may want to consider alternative ways that you could be delivering care that could have significant impacts on patient health and satisfaction.

Care management of complex, high-risk individuals is more resource intensive, as illustrated below in Figure 7, which lists the keys for delivering person-centered care and foundational to VBP.

[13] https://khn.org/news/article/black-americans-are-getting-vaccinated-at-lower-rates-than-white-americans/?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top

FIGURE 7. REQUIRED CARE MANAGEMENT SERVICES IN THE MEDICAID HEALTH HOMES PROGRAM

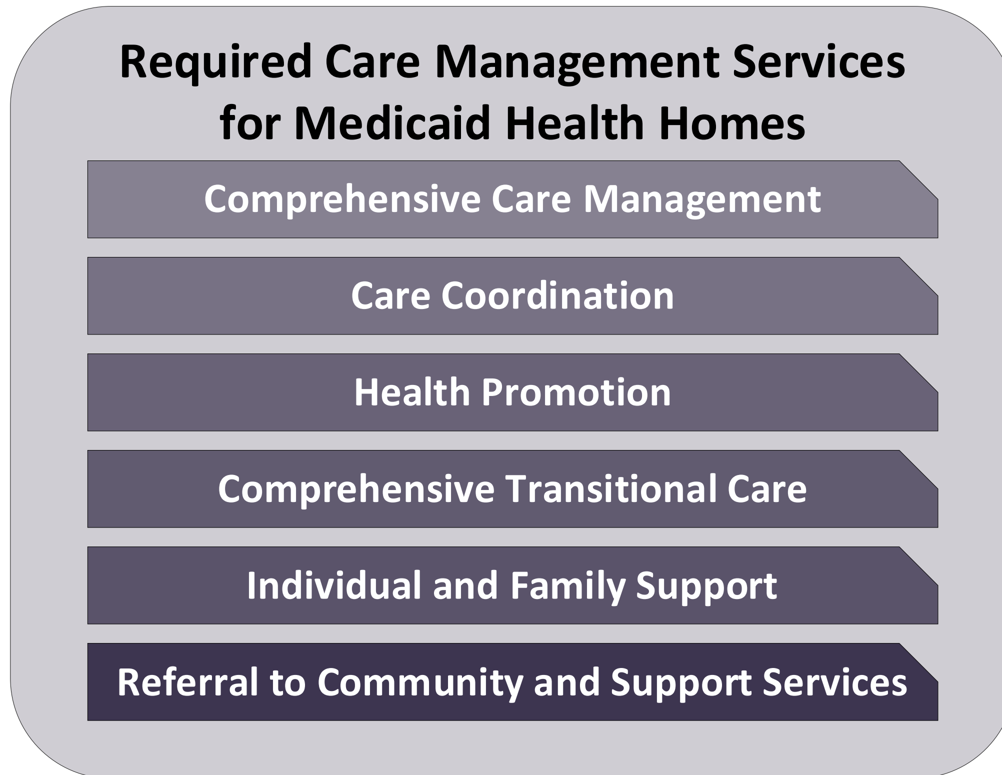
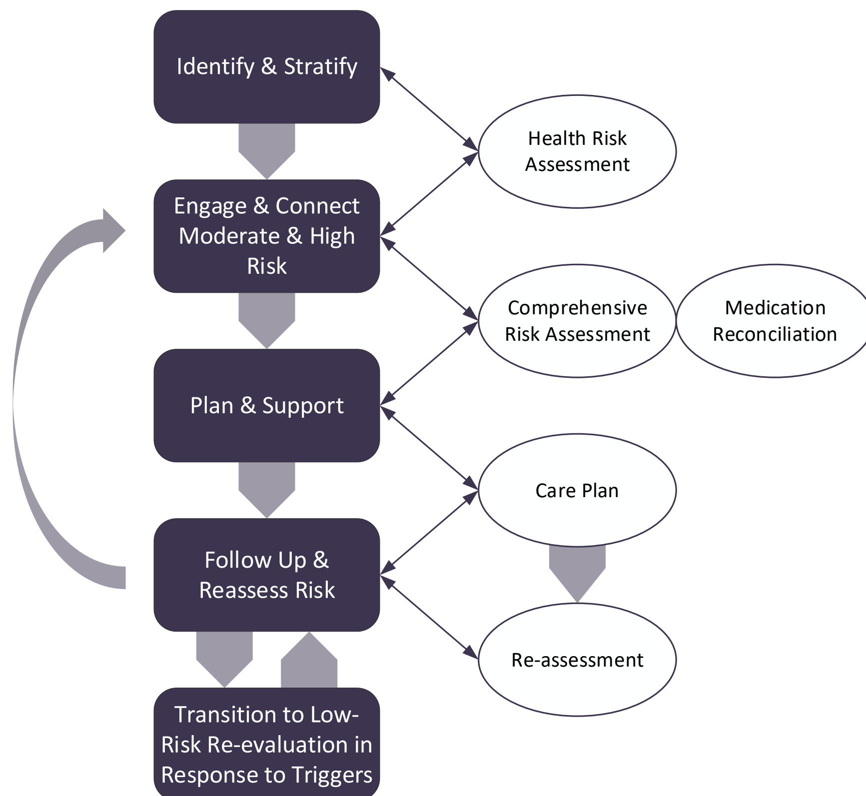


Figure 8 below graphically depicts how you can create a consistent, accountable model of care. Complex care management starts with a screening health risk assessment, then risk stratification to identify the subset of individuals most likely to benefit from complex care management, a more comprehensive risk assessment, creation of an initial care plan with patient self-identified goals, and follow-up to gauge progress and the need to modify the care plan. Comprehensive transitional care includes communication and warm handoffs as patients transition between the community and hospital or post-acute care setting.

Figure 8. A consistent and accountable model of care, Medical Home Network



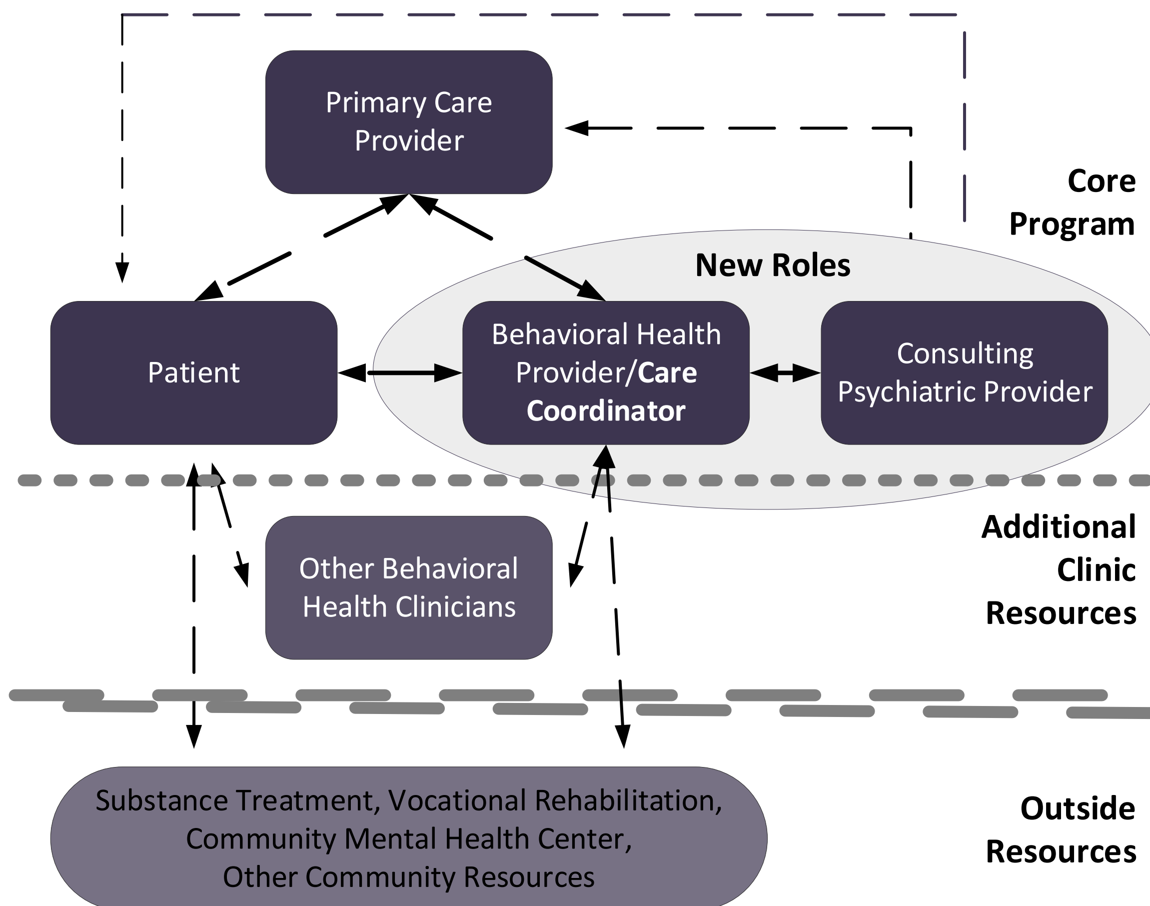
Pursuit of Delegated Responsibility vs. Collaboration with Payer-Employed Care Managers

Another consideration as you explore APMs is whether or not you can and want to pursue full responsibility for care management for patients, or if you could work effectively with external care managers, such as those employed by a managed care plan. Health plans are reluctant to delegate care management to a provider until that are certified by National Committee for Quality Assurance (NCQA) as a care management entity. That is a two-to-three-year, resource intensive process so most providers choose to collaborate with health plan care managers.

Primary Care/Behavioral Health Integration

More and more providers are identifying integration of behavioral health with primary care as a critical need among their patients. This kind of integration offer significant opportunities for designing collaborative care models that can be highly successful under APMs. Figure 9 below shows an example of a collaborative care model also used by Medical Home Network (MHN) to incorporate behavioral health into their primary care practices. Over the past four years, MHN has treated more than 3,700 depressed members in the collaborative care model using a trained care coordinator with 55% achieving at least a 55% reduction in their initial PHQ-9 score and 34% achieving remission.

Figure 9. Behavioral health integrated care collaboration model, Medical Home Network



Process Mapping Your Care Model

As a grantee under the support of the Georgia Health Policy Center's Community Health Systems Development Office, you have access to many important resources, one of which is [describe Stratis Health process mapping tool resource]. This tool can help you identify opportunities for process and quality improvement that could be important to your VBP strategy.

Key Questions:

Is your current technology infrastructure prepared for a move to VBP?

If yes, how can you leverage this infrastructure to facilitate your transition?

If no, what changes can you make to ensure you are ready for the transition?

Assessing Technology Infrastructure

It will be difficult to successfully move into VBP and APMs without the support of technology. If you have read any of the other sections of this Primer, you will see that good data is critical to building an understanding of who your patients are and what they need. Your staff need this information to be able to most effectively serve and support your patients, and you need this data to know how to build the right staff.

Current IT Systems and Gaps

You will need to start by doing an assessment of your current health information technology (HIT) infrastructure. This, in turn, will help you to identify where you have strengths and where you have gaps.

Is your current technology infrastructure prepared for a move to VBP? If yes, how can you leverage this infrastructure to facilitate our transition? If not, what changes can you make to ensure you are ready for this transition?

Chances are, you already work in some type of an EHR – electronic health record – system. Over the past decade, even most smaller rural providers have transitioned to some type of EHR. That also may be the extent of your technology. You also may be working in an older or less flexible system that makes it difficult to capture information such as a patient's SDoH needs or behavioral health assessments. Whatever your current systems are, you will want to assess whether you have the right technology you need to be able to support APMs. For example, do you have:

- Full utilization of your EHR by clinicians and other staff
- An EHR that integrates with your revenue cycle systems such as chart documentation and coding
- Population Health tools and capabilities
- Connectivity to your state or regional Health Information Exchange
- A case/care management system
- Systems that can collect and report information such as:
    - Cost of care per patient encounter/timeframe/etc.
    - Top chronic conditions among patients
    - High cost, high utilization patients
    - Trends in patient utilization
    - An avoidable complications inventory
    - Identification of your top payers (all payers)
    - Quality metrics

You will want to be able to collect, report, and trend data such as the effectiveness of care for your patients, access and availability of care to your patients, and how satisfied your patients are with their care. As you identify the specific metrics you want or need to capture to implement APMs, you can compare your metrics with a list of where you will get the data. For example, you can make a table like the one below to document where you will find the data needed to support your metric, if it is available electronically or not, and what you would need to do to make the information actionable or useful to tell you if you are improving or not.

Metric	Data Source(s)	Available Electronically?	Steps to Convert to Actionable Information
Reduce number of falls among patients age 75+	• Fall assessment questionnaire (EHR)	• Yes; standardized and reportable	• Run quarterly report of patients assessed for fall risk
	• Observed instability	• Yes; but as notes in patient chart	• Create checkbox in EHR for observed fall risk
	• Patient stated concerns	• Yes; but as notes in patient chart	• Create checkbox in EHR for patient noted fall risk
	• Fall prevention program (referral)	• Yes; referral tracking	• Run quarterly report of referrals to fall prevention program
	• CHW home visits	• Yes; but as notes in patient chart	• Create dropdown menu for CHWs to input assessment of fall risk/mitigation strategies

Writing down what systems and tools you have to get the data you need will give you a clear picture of where you have technology gaps and what steps you will need to take to close those gaps. Some solutions may be simple, especially if they involve small numbers of patients or making minor adjustments in your EHR. Others may require you to invest in new technologies and even in new people, who can help you develop your data analytics capabilities.

Data Sharing/Information Exchange Capacity and Gaps

In addition to the data that you are collecting internally, you may need to get information from other providers or other community sources. You also may need to share information with others. Most states now have regional or statewide Health Information Exchanges. Consider working with and HIE so you will be able to see important information about your patients. Under the CMS mandate that went into effect on May 1, 2021, hospitals must make a reasonable attempt to notify a patient's primary care provider, practice group, or clinic of an admission, discharge or transfer – known as an ADT report. This includes Critical Access Hospitals (CAHs).[14]

[14] https://www.cms.gov/files/document/faqs-interoperability-patient-access-and-cop-event-notifications-may-2021.pdf

There are many other opportunities to share information that can help you stay informed about your patients' care, as well as give important information to other providers who may be working with your patients. For example, virtually every state has an immunization registry, where providers can document when a child has received their recommended shots. Many of these registries also include information for adult vaccinations. Given that many parents either do not want or cannot keep track of a paper immunization record, having access to this information through a registry can save time and potential over- or under-vaccination. Similar registries have been created for patients with a host of chronic diagnosis and are valuable tools in supporting effective management of those patients.

Some data sharing may come at a cost to you, for example, the cost of building the data transfers or normalizing data with different names or values from multiple providers into standardized reports. There may be options for mitigating these costs, especially if you are working with health plans or health systems that also have APMs. As you begin to assess your patients and develop the metrics that you think are the most important to helping them achieve better overall health, you will start to see where there are gaps in what information you have and what you need. Make a list of gaps and ideas for how you will close them. This can be a simple roadmap to follow for improving your data sharing capabilities.

Technology Resources for Rural Providers

There are a number of good resources related to HIT specifically for rural providers. One such valuable resource is the Quality Payment Program Website for the Office of the National Coordinator for Health Information Technology (ONCHIT), which can be found here: https://hlthmgt.sharepoint.com/201262/Shared%20Documents/VBP%20Primer%20Draft/GA%20Policy%20Center%20VBP%20Primer%20080421.docx. This website is designed to help small, underserved and rural providers participate in the CMS Quality Payment Program for Medicare. It offers both program and practice-level supports, including how to implement a certified EHR. ONCHIT also has tools to assist providers with needs such as population health management, such as using population health tools, strengthening care management, and using patient registries.

An additional HIT resource is the Rural Information Hub website at: https://www.ruralhealthinfo.org/topics/health-information-technology. It includes a comprehensive overview of HIT, as well as links to funding, models, events, and other resources to support HIT enhancement for rural providers. The National Rural Health Resource Center also has a list of HIT resources on its website at: https://www.ruralhealthinfo.org/topics/health-information-technology.

Finally, many rural communities still lack adequate Internet connectivity and are in WIFI "dead zones." Many states have specific programs and initiatives targeting building additional internet access in rural areas. The National Conference of State Legislatures includes information about broadband task forces, commissions and other authorities in all 50 states on their website here: https://www.ncsl.org/research/telecommunications-and-information-technology/state-broadband-task-forces-commissions.aspx

The US Department of Agriculture (USDA) also is investing heavily in broadband access across the country. This website has information and resources for improving Internet connectivity in rural communities: https://www.usda.gov/broadband. Another resource for finding funding to expand broadband access is the National Telecommunications and Information Administration: https://broadbandusa.ntia.doc.gov/resources/federal/federal-funding

Key Questions:

Is your current financial and operational infrastructure prepared for a move to VBP?

If yes, how can you leverage this infrastructure to facilitate your transition?

If no, what changes can you make to ensure you are ready for the transition?

Assessing Financial and Operational Readiness

Making the transition to VBP requires that your organization have sufficient financial and operational resources, support, and strategy to successfully undertake this journey. The outline below is a helpful guide in asking the right questions so that your organization can assess if the time is right to commence this journey now, or if additional planning and support may be necessary.

Is our current financial infrastructure prepared for a move to VBP? If yes, how can we leverage this infrastructure to facilitate our transition? If not, what changes can we make to ensure we are ready for this transition?

It is essential to have a sound strategic plan to pursue VBP. That includes an assessment of current fiscal competencies, financial reserves and a system for monitoring performance. It also includes a contracting plan that takes these factors, as well as operational and clinical readiness into account. It will require aligning staff compensation with success as measured by accessing those incentive payments. It often requires participating in clinically integrated networks (CINs) that share the expense of infrastructure and any financial risk. Pertinent questions to ask your organization include:

1. Do you have strategic plan to pursue value-based payment?
2. Does your organization have the financial and operational wherewithal to support a transition to VBP? If not, what strategies will support securing necessary resources to pursue this transition?
3. Have you assessed the financial investment needed to succeed under VBP arrangements?
    a. Have you set aside resources to pay for that financial investment?
    b. Have you performed a short and long-term return-on-investment (ROI) analysis of a VBP transition plan?
4. Do you have a good contracting strategy in place that will allow progression to more advanced alternative payment methodologies with your largest payers?
    a. Do you have a plan to accept and mitigate financial risk in your value-based payment contracts?
5. Do you train providers on proper coding and documentation practices?
6. Do you have an incentive compensation program for providers? Does the program include incentives for non-provider staff?

   a. Does the program only incent productivity or is it also aligned with existing quality, utilization, and cost incentive programs in payer contracts?
7. Do you utilize a cost-based charge structure?
8. Can you calculate/monitor the total, annual cost per patient?
9. Do you have participation agreements with an IPA or ACO?
10. Do you have agreements with third party payers that include quality incentive payments?
11. Do you have surplus-sharing or risk arrangements with third party payers?
    a. If yes, have you been successful in accessing/receiving quality incentive payments?
12. Do you have systems in place that are able to track financial performance unique to VBPs?

Financial Infrastructure and Gaps

Taking stock of your organization's infrastructure is critical in determining whether you are prepared and ready to undertake the transition to VBP. Many healthcare providers are already struggling with operating margins, cash flow, reimbursement levels, and other critical financial measures of success. A transition to APMs typically takes several years, during which, for example, you may need to invest in organization infrastructure for enhanced data capture, make billing and coding improvements, add support resources, and make a full transition to an EHR. Identifying these types of necessary investments and putting strategies in place to fill deficits is one of the most critical steps on the path to VBP.

Financial Resources and Gaps

In addition to a comprehensive infrastructure assessment, it is imperative that you review the current financial strength and viability of your organization to ensure that resources are available to sustain the transition to VBP. Examples of financial status include:

- Days cash on hand
- Operating margin
- Days in accounts receivable (A/R days)
- Days in accounts payable (A/P days)
- Debt load

Indications of strength from these key performance indicators (KPI) will provide confidence that your organization can sustain normal ups and downs from financial operations without placing excessive stress on organizational fundamentals, e.g., cash and debt.

Operational Infrastructure and Gaps

As part of your financial assessments, you also should identify how well your organization's operations are prepared to take on VBP. Some examples of operational readiness indicators:

- Clinical and support staffs' knowledge of VBP
- Case management, coding/documentation knowledge and experience
- Level of technology adoption/EHR utilization by providers and support staff
- Use of patient outcome quality measures/metrics
- Practice efficiency and financial status
- Billing effectiveness and efficiency
- Overall practice tolerance level transitioning to VBP over several years

- Comfort level with practice and outcome data analysis and reporting
- Level of practice integration with referral entities – upstream and downstream, e.g., ambulatory, acute, and post-acute behavioral health
- Patient turnover (left practice) measures, and patient leakage out of network

Special Considerations for FQHCs and RHCs

Under any kind of AMP, **FQHCs and RHCs must receive no less than what they would have under PPS**. FQHCs and RHCs also retain the right to opt in and out of an APM. These provisions provide special protections for FQHCs and RHCs.

Current payment relationships that FQHCs and RHCs have in place can remain (e.g., wrap flow of payments from Medicaid agency directly or as pass through a health plan). There is no recoupment for FQHCs or RHCs under an APM; reconciliation payments are made only if required to assure at least PPS equivalency. However, prospective adjustment can be based on performance on quality metrics.

The Value of Providing SDoH

As has been described elsewhere in this Primer, working with your patients to support their SDoH needs can be critical to helping them get and stay healthy. However, it can be difficult to know what kinds of supports to provide, and even more difficult to understand the cost of providing these services. As a grantee under the support of the Georgia Health Policy Center's Community Health Systems Development Office, you have access to many important resources, one of which is [describe CIS SDoH value assessment resource]. This tool can be useful to help you determine the cost of providing SDoH services you provide or want to provide. Knowing what it costs you can arm you with information needed to negotiate how you can cover these costs in an APM.

Potential Pitfalls

What can we learn from comparable organizations who have moved from FFS to VBP?

The good news is that provider experience in pursuing VBP is well documented, especially in the past 10 years under the leadership of the Center for Medicare and Medicaid Innovation (CMMI). There have been many pitfalls and lessons learned, from which you can benefit, including:

1. It is not enough to sign a VBP contract. To succeed, requires transforming care delivery and creating new workflows both internally and with external partners.
2. Payers must align with each other to send a uniform message about what is valued. Providers can only focus on a few continuous quality improvement (CQI) projects at a time.
3. Investments in analytics must produce actionable information to inform decision makers at the point of individual patient care, as well as those making broad system of care changes.
4. Providers cannot serve two masters at the same time. If their priority is to maximize FFS revenue, they will not make the necessary investments in changing care delivery that are needed to succeed in VBP.
5. Providers take VBP more seriously when they hold some financial accountability for outcomes; but they should not be put at risk if they are not prepared to handle it in terms of readiness or financial reserves.

As you consider VBP, there are some precautions you can take to make sure you are moving at the right pace for your organization. For example, to implement Category 2 APMs* with a payer, you will want to:

- Start the program in year one using statewide benchmark as baseline
- Make sure you are not subject to outcomes for patients who are transferred to you from other PCPs when it is too late to impact performance
- Ensure your payment is not held hostage to total plan performance
- Make sure the payer cannot terminate your APM midyear
- Agree on detailed terms before signing a contract

*Category 2 AMPs include: Foundational payments for infrastructure and operations, pay for reporting (P4R), and pay for performance (P4P).

For providers who have implemented Category 2 APMs and are interested in moving to Category 3 AMPs*, some ways to mitigate risk are:

- Clearly demonstrating your ability to generate shared savings before progressing to shared risk
- Ensuring your panel size is big enough to minimize the impact of statistical variation in performance
- Negotiating a minimal loss ratio (MLR)
- Negotiating stop loss and risk corridors
- Considering clinical and financial integration with non-PCP partners
- Taking risk only for services you can reasonably impact
- Building an adequate reserve pool

- Not allowing P4P costs be counted as a cost when there is a separate source of revenue (i.e., a premium withhold)
- Taking a multi-payer approach
- Acting now as if you were taking capitated risk

*Category 3 APMs include: Shared savings (upside risk only), Shared savings with downside risk.

Taking the Next Steps

After these considerations we have determined that we want to transition to a VBP model. Now what?

A good place to start is to watch the recorded VBP Presentation, ***Value-Based Payment: Is it Disrupting Health Care for the Better? Role of Alternative Payment Models From a Clinician's Perspective***, that accompanies this Primer. Then take a look at the **Excel VBP Worksheet.** A shortened version of the Primer, it includes the key questions you should answer about your readiness for VBP. Next, start thinking about the most important ways you can positively impact your patients' care. Once you know which patients you can impact the most, put together a plan for how you will measure that impact. For example:

- Agree on a manageable number of metrics (start small)
- Choose metrics that you can impact (where there is room for improvement, access to timely information, you can change with care management and/or your clinical model)
- Choose a set of metrics that has direct financial implications for a payer (premium withhold, member auto assignment)
- Gauge current performance vs. target performance
- Understand the magnitude of potential financial impact on your payers

Then, have a conversation with one of your payers to talk about what an APM might look like for your organization. Some important considerations for you to cover with them are:

- Agreement on a minimum number of how patients will be attributed to you
- Defining the specific population(s) that will be included and what services will be included
- Establishing benchmarks, how often they will be reset, and annual trending
- If and when you can get updates from them on patients who are out of compliance with your established metrics; at minimum you should expect monthly updates
- Taking a hybrid approach to measuring performance, or at least a reconciliation and appeal mechanism
- Potential for tiered payments based on improvement and attainment
- Payment potential adequate to engage your full care team, including staff such as CHWs, and to cover SDoH services and supports you are or want to provide

From there, you can work through the specifics with your staff and with the payer to lay out a plan and timeline for getting started. If you have already begun the VBP journey and are ready to start on the next leg, you can follow a similar process, modifying the questions based on your current APM level and the next level you want to reach.

Additional Resources

Specific GHPC Grantee Resources

In 2020, the Georgia Center for Health Policy Community Health Systems Development team established the Rural Advisory Council (RAC) to develop a variety of resources to support its Federal Office of Rural Health Policy grantees. Each of the consulting organizations participating in the RAC developed tools that can be helpful to providers as they explore VBP and how it might work for them. These have been noted throughout the Primer, and links to each resource are provided here, with a short description of the tool and the organization that developed it.

- RC4 Innovations – Community Asset Mapping Tool, Stigma Communications Guide
- CSI Solutions - SDoH Value Calculator
- Race 4 Equity - Social Determinants of Health and Racial Equity Tool and Staff Conversation Guide
- Stratis Health – Quality Improvement Process Mapping Tool

[Talk to Rachel and Tanisa about how to incorporate these tools]

VBP Resources

The Health Care Payment Learning and Action Network (HCP LAN) has created a roadmap to APMs that could be very useful to understand different types of APMs, including population-based models and clinical episode models. Their roadmap includes promising practices gathered from interviews with payer and providers who were participating in 10 APMs. https://hcp-lan.org/apm-roadmap/

The Rural Health Value initiative is a national effort funded since 2012 by the Federal Office of Rural Health Policy with the RUPRI Center for Rural Health Policy Analysis and Stratis Health.

https://ruralhealthvalue.public-health.uiowa.edu/TnR/vbc/vbctool.php

Appendices

Appendix A: Glossary of Terms

Acronym	Term	Description
ACO	Accountable Care Organization	An organization of clinically integrated health providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO´s patients.
AHRQ	Agency for Healthcare Research and Quality	The lead federal agency charged with improving the safety and quality of America´s health care system.
APM	Alternative Payment Model	A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
CAHPS	Consumer Assessment of Healthcare Providers and Systems	Surveys consumers and patients to report on and evaluate their experiences with health care. A survey maintained by AHRQ, as seen above.
CBO	Community Based Organization	CBOs are non–profit groups that work to improve the well–being of their local residents. Specifically, these organizations provide a wide variety of social and support services to individuals, families, and populations that range across housing, job placement, transportation, legal services and mental health services.
CIN	Clinically Integrated Network	A selective partnership of providers collaborating to deliver evidence-based care, improve quality, efficiency and coordination of care, and demonstrate value to the market.
CMMI	Centers for Medicare and Medicaid Innovation	As part of the Centers for Medicare and Medicaid Services, CMMI supports the development and testing of innovative health care payment and service delivery models.
CMS	Centers for Medicare and Medicaid Services	The federal agency responsible for administering Medicare and overseeing state administration of Medicaid. CMS signed the 1115a waiver, which allowed for the funding for the DSRIP program.
CQI	Continuous Quality Improvement	Management of population/members through provider alerts, decision tools/dashboards, registries, enhanced access to data.
EHR	Electronic Health Records	Electronic database that stores confidential patient information.
EOC	Episodes of Care	A defined set of services provided to treat a clinical condition or procedure.
FFS	Fee–for–service	A payment model where services are unbundled and paid for separately. In health care, it gives incentive for physicians to provide more treatments because payment is dependent on quality.

Acronym	Term	Description
FQHC	Federally Qualified Health Centers	They are federally funded health centers or clinics that focus on serving underserved areas and populations.
HEDIS	Healthcare Effectiveness Data and Information System	The Healthcare Effectiveness Data and Information System, is a tool used by more than 90 percent of America´s health plans to measure performance on important dimensions of care and service. NCQA collects HEDIS data on behalf of CMS. There are multiple measures that change annually. Data Collection, comes directly from health plans and PPOs through the Healthcare Organization Questionnaire and collects HEDIS non-survey data through the Interactive Data Submission System (IDSS)
HH	Health Home	The Medicaid Health Home program was created through Section 2703 of the the Affordable Care Act of 2010; Medicaid Health Home providers are expected to operate under a "whole person" philosophy and integrate and coordinate all primary, acute, behavioral health, long term services and supports and social determinants of health to treat the whole person.
HIE	Health Information Exchange	HIE allows health care professionals and patients to appropriately access and securely share patient medical information electronically.
HIT	Health Information Technology	The exchange of health information electronically, with the goal to improve quality of care by reducing costs, errors, and inefficiency.
IPA	Independent Practice Association	A corporation (nonprofit or for–profit) and/or LLC that contracts directly with providers of medical or medically related services, or another IPA in order to contract with one or more MCOs.
IPC	Integrated Primary Care	VBP arrangement that includes: behavioral health, primary care, effective management for chronic disease, etc. It is designed to incentivize primary care providers (PCPs) to collaborate with behavioral health and other specialty medical and community–based providers to improve the quality of preventative care.
LTSS	Long Term Services and Supports	LTSS encompasses the broad range of paid and unpaid medical and personal care assistance that people may need – for several weeks, months or years – when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability
MCO	Managed Care Organization	Managed Care is a health care delivery system organized to managed cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies. VBP contracts will be created between MCOs and VBP contractor. MCO manages several contracts that tie together the financial and quality performance of multiple providers.
MLTC	Managed Long–Term Care	A system that streamlines the delivery of long–term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long–term care plans.
MPC	Multi-Payer Collaborative	An initiative among multiple payers, such a Medicare, Medicaid, and private insurance plans. Examples of multi-payer collaboratives include the Vermont All Payer ACO Model, and the Pennsylvania Rural Health Model.

Acronym	Term	Description
NCQA	National Committee for Quality Assurance	A private, not–for–profit organization dedicated to improving health care quality. Maintains the HEDIS Score and researches quality measures, as well as providing accreditation and certification around quality.
NPI	National Provider Identifier	NPI is a unique identification number for covered health care providers. NYS Medicaid will transition to the use of NPI for all providers. NPI will assist NYS ability to recognize and properly reimburse claims.
PAC	Potentially Avoidable Complications	A number of complications or events that may occur during or within 30 days of a stay in a hospital. These complications are considered avoidable with proper medical care.
PCMH	Patient Centered Medical Home	A model of the organization of primary care that delivers the core functions of primary care, including: comprehensive care, patient centered care, coordinated care, accessible services, and quality and safety.
PFR VBP Measures	Pay for Reporting	A more extensive set of measures that is predominantly process based and required for monitoring and process improvement (e.g., in diabetes care, reporting % of patients with blood pressure in control).
P4P	Pay for Performance	The payment model in which providers are reimbursed based upon the quality of care provided
P4V	Pay for Value	P4V programs reward health care providers with incentive payments for the quality of care they deliver. Essentially VBP is a P4V program.
PMPM	Per Member Per Month	Refers to the dollar amount paid to MCOs each month by NYS. PMPM is under a capitation revenue stream or cost for each enrolled member each month.
PMPY	Per Member Per Year	Refers to the dollar amount paid to MCOs each year by NYS. PMPM is under a capitation revenue stream or cost for each enrolled member each month.
PPC	Prenatal and Postpartum Care	Monitoring health prior, during, and after birth of both the mother and child.
PPR	Potentially Preventable Readmissions	Part of the nationally recognized measures for avoidable hospital use. PPRs measure readmissions to a hospital following a prior discharge from a hospital and that is clinically–related to the prior hospital admission.
PPS	Performing Provider System	Entities that are responsible for performing a DSRIP project. DSRIP eligible providers, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group.
PQI	Prevention Quality Indicators	A set of measures developed by the federal AHRQ or used in assessing the quality of outpatient care for "ambulatory care sensitive conditions". These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.
PSN	Provider Service Network	A list of doctors, other healthcare providers, and hospitals that plan contracts to deliver healthcare to its members.
QIP	Quality Incentive Program	An incentive program that incentivizes health plans and their providers to improve the measurement and delivery of health care enrollees. Currently, the

Acronym	Term	Description
		QIPs have a defined methodology to determine the percentage of the potential financial incentive that a plan receives.
RHIO	Regional Health Information Organization	A multi–stakeholder organization created to facilitate a health information exchange among stakeholders of that region´s healthcare system.
SDoH	Social Determinant of Health	Conditions in which people are born, grow, live, work. Their circumstances are affected by the distribution of money, power, and resources. VBP contractors in Level 2 or Level 3 agreements will be required statewide to implement at least one SDH intervention. DOH has created a reporting template that will be used to measure progress.
TCGP	Total Care for General Population	A VBP arrangement by which party(ies) contracted with an MCO assume(s) responsibility for the total care of an attributed population
TCOC	Total Cost of Care	Typically, this refers to the total cost of a population and what it costs to care for them medically.
VBP	Value Based Payments	A methodology of arrangements which incentivize value and quality of care, in contrast to the current arrangement of incentivizing quantity of care.

Appendix B: Example Provider Contract Term Sheet

TERM	STRATEGIES
Term of Agreement	
	Reset annually
	Modification mid-year only by mutual consent
	Termination mid-year only by mutual consent except for breach of contract
Information Exchange	
Member rosters	Delivered electronically to the organization for their assigned members by the first of the month
Inpatient authorizations	Delivered daily to the organization for their assigned members; includes authorizations for transfer to post-acute care facilities
Care management	Sharing of care plans of members in the health plan's high-risk care management program; delegation once NCQA certified
Performance on quality metrics that have financial implication	Access to performance on the health plan's provider portal that indicates overall score and allows drilldown to the member level and benchmarked against plan-wide performance
Total cost of care report	Monthly report of MLR with a calculated IBNR
Utilization reports	Monthly report of ED utilization (separated by potentially avoidable or not), hospitalization rates, hospitalization rate for ambulatory sensitive conditions, all-cause 30-day rehospitalization rates and benchmarked against plan-wide performance
High-cost member list	List of members with a rolling 12-month total cost of care of more than $100,000
Frequent ED utilizer list	List of members with four or more ED visits in a rolling 12-month period
Medication possession ratios	List of members whose medication possession ratios are less than 80% for agreed upon high impact medications such as controller meds for asthma, insulin, and psychotropic medications
Raw claims data	When able to import, at least monthly medical claims data, ideally with pricing, and daily pharmacy fill data
Member Assignment	
	Prospective based on member choice and attribution algorithm
	Rolling 6-month retrospective claims analysis to prospectively adjust assignment based on plurality of PCP visits with tie going to PCP with latest visit
Payment for Direct Services	
	Fee-for-service at market rates
	Willing to explore primary care capitation
Foundational Payments for Infrastructure, Operations and Care Coordination	
	PMPM payment to cover these services; cost may be charged as an expense when calculating shared savings
Pay for Performance	
Funding potential	1-2% of MLR target
Choice of metrics	Selection of 5-6 metrics from an IPA generated list that are a subset of metrics which have financial implications for the health plan; may be efficiency as well as HEDIS quality metrics
Data collection method	Ability for provider to submit supplementary data to demonstrate compliance

Performance targets	Credit for significant improvement (closing gap between historical performance and attainment target) with enhanced credit for reaching the attainment target
Payment methodology	Fee-for-service add-on payment with an annual bonus when performance target is achieved
Treatment of cost when calculating shared savings	Cost may be charged as an expense when calculating shared savings
Shared Savings/Risk	
Defined population	Assigned members for every month of assignment
Minimum assigned membership	2,000
Service exclusion	LTSS
Setting the baseline (% premium vs. historical spend)	Medical loss ratio that is a 1% improvement over historical experience but never <85%
Risk adjusted benchmark	Yes
Trending the benchmark	Benchmark is increased proportional to increase in premium but low cost of care providers will receive a greater increase than the high cost of care providers to reduce the PMPM medical spend variation over time
Claims run out period/IBNR	Six months with IBNR calculation using actuarially sound principles
Minimal savings threshold	None
Minimal loss ratio	Ideally 2% but not if requires a symmetrical minimal savings ratio
High-cost claimants	$100,000-$150,000 threshold with 100% coverage of claims overage
Shared Saving %	50% with willingness to accept 40% for shared savings arrangement and 50% when moves to shared risk
Shared Risk %	Willing to entertain shared risk after at least two years of success in a shared savings arrangement and with adequate reserves; 25% downside risk in the first year progressing to 50% in Year 2
Shared Savings Qualifiers	Composite scoring following the principles outlined above for pay-for-performance
Financial Impact of Performance on Shared Savings Qualifiers	To receive a Shared Savings Payment, the organization must earn a quality score of equal to or greater than 50%. For each additional 10% above the 50% threshold, the organization will be eligible for an additional 2% of additional Shared Savings percentage.
Risk Corridor	Shared Losses will be limited to the lessor of reserves or 3% of the amount funding the pool multiplied by the risk share. Shared savings corridor set at 3%.