Rhode Island Executive Office of Health and Human Services

Medicaid Managed Care: Alternative Payment Methodology Requirements

1. EOHHS Alternative Payment Methodologies Requirements

Transformation to a value-based health care delivery system is a fundamental policy goal for the State of Rhode Island.

In March 2015 Governor Gina Raimondo issued Executive Order 15-08, establishing the "Working Group to Reinvent Medicaid" to provide recommendations for a restructuring of the Medicaid program. The final report of the Working Group, issued on July 8, 2015, identified the following principles:

1. *Pay for value, not for volume*
2. *Coordinate physical, behavioral, and long-term health care*
3. *Rebalance the delivery system away from high-cost settings*
4. *Promote efficiency, transparency, and flexibility*

Based on these principles, the final report stated the following goals for the Medicaid program:

- *Goal 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total costs of care for their members.*
- *Goal 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.*
- *Goal 3: Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.*
- *Goal 4: Maximize enrollment in integrated care delivery systems.*
- *Goal 5: Implement coordinated, accountable care for high-cost/high-need populations.*
- *Goal 6: Ensure access to high-quality primary care.*
- *Goal 7: Leverage health information systems to ensure quality, coordinated care.*
- *Goal 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings.*
- *Goal 9: Encourage the development of accountable entities for integrated long-term care.*
- *Goal 10: Improve operational efficiency.*[1]

In pursuit of these goals, during FY 2016 EOHHS certified Accountable Entity Coordinated Care Pilots (AE Pilots) and MCOs were required to execute "total cost of care" payment arrangements with certified AE Pilots.

In October 2016, through an amendment to the 1115 waiver, Rhode Island reached an agreement with the Centers for Medicare & Medicaid Services (CMS) providing substantial regulatory and financial support for EOHHS' Health System Transformation Program (HSTP).

Through HSTP, EOHHS has supported the establishment and ongoing development of Comprehensive Accountable Entities (AEs). After the completion of the two-year AE Pilot program, EOHHS launched the

[1] Report of the Working Group to Reinvent Medicaid: Recommendations for a Plan for a Multi-Year Transformation of the Medicaid Program and All State Publicly Financed Healthcare in Rhode Island, July 8, 2015. http://reinventingmedicaid.ri.gov

Comprehensive AE Program on July 1, 2018. AEs are the central platform for transforming the structure of the delivery system as envisioned in the Final Report of the Reinventing Medicaid Working Group. AEs are interdisciplinary provider partnerships characterized by a strong foundation in primary care and inclusion of other services, most notably behavioral health and social support services. AEs are accountable for the coordination of care for attributed Medicaid members and must adopt a population health approach for their attributed membership. EOHHS has certified seven Comprehensive AEs for participation in the program.

EOHHS expects MCOs to continue to engage with certified Comprehensive AEs in the coming contract periods. While there is no certainty as to the share of Medicaid providers who will participate in Comprehensive AEs, EOHHS is confident that MCOs can maintain engagement levels across their networks similar to that of the past several years.

To further align incentives across all parts of the healthcare system, in the coming contract periods EOHHS asks MCOs to establish APM contracts beyond the total cost of care arrangements they have with Comprehensive AEs today. This may include engagement with provider who do not participate in a Comprehensive AE at all as well as engagement to increase incentives for providers already participating in Comprehensive AEs.

The following section describes the APM targets for both total cost of care contracts with Comprehensive AEs and other APMs. Transformation to a value-based health care delivery system is an iterative process and EOHHS reserves the right to periodically modify these Requirements as it deems appropriate.

2. Alternative Payment Methodology Targets

EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.

An Alternative Payment Methodology means a payment methodology structured such that it provides economic incentives, rather than focusing on volume of services provided, focus upon such key areas as:

A. Improving quality of care;
B. Improving population health;
C. Impacting cost of care and/or cost of care growth;
D. Improving patient experience and engagement; and/or
E. Improving access to care.

Managed Care contractors will incorporate value-based purchasing initiatives into their provider contracts. EOHHS is committed to facilitating the creation of partnerships or organizations using accountable delivery models that integrate medical care, mental health, substance abuse disorders, community health, social services and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

EOHHS' contracts with MCOs include defined targets for implementing contracts with alternative payment arrangements. Targets for alternative payment arrangements are as follows:

1. **Total cost of care (TCOC) based contracts with EOHHS-certified Comprehensive Accountable Entities:**

   AE APM Target: In the first contract period (July 1, 2023-June 30, 2024), at least 60% of the medical portion of capitation shall be made pursuant to TCOC contracts with EOHHS-certified Comprehensive Accountable Entities. This provision only applies to MCOs with at least 10,000 enrolled lives.

2. **APM contracts other than TCOC contracts with EOHHS-certified Accountable Entities**

   MCOs shall pursue APM contracts with other providers in alignment with the Healthcare Payment Learning and Action Network APM continuum. In some cases, payments pursuant to these APM contracts will be made for care rendered to Medicaid members who are attributed to AEs, and accordingly such payments may be counted towards total cost of care for those members and be counted toward the 60% of the medical portion of capitation payments that should be paid pursuant to TCOC contracts with AEs. Because there are separate APM targets for TCOC contracts with AEs and the APM categories described below, it is expected that MCOs will count such payments toward both applicable targets.

   Any quality measures included in contracts falling into any of the below APM categories must be consistent with the OHIC Aligned Measure Set.

   Non-AE APM Target: Contractors shall meet the targets outlined below, which are designed to increase over time in terms of the proportion of capitation and in terms of the progress along the LAN continuum.

   In this first Contract Period (July 1, 2023-June 30, 2024), there will be no minimum target for the proportion of capitation in each LAN APM category. Instead, MCOs shall use that time to plan, prepare, and begin contracting with providers in order to achieve APM targets in Contract Years 2-5. At the end of the first contract period, MCOs shall report on APM arrangements that they do establish in Contract Year 1, using the template provided by EOHHS.

   Targets are constructed such that targets for lower-level APMs can be achieved through any combination of HCPLAN levels.

	Contract Period 2	Contract Period 3	Contract Period 4	Contract Period 5
LAN Category 2B-C	At least **12%** of the medical portion of capitation shall be made to providers participating in	At least **17%** of the medical portion of capitation shall be made to providers participating in	At least **22%** of the medical portion of capitation shall be made to providers participating in	At least **25%** of the medical portion of capitation shall be made to providers participating in

	Category 2B-C, 3, or 4 contracts	Category 2B-C, 3, or 4 contracts	Category 2B-C, 3, or 4 contracts	Category 2B-C, 3, or 4 contracts
LAN Category 3	At least **7%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **10%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **13%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **15%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.
LAN Category 4	At least **2%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **3%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **4%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **5%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.

Definitions of LAN Categories:

a. **Category 2B-C**: **Fee for service payment linked to quality and value**

This category includes pay-for-reporting (i.e., paying bonuses for reporting data or penalties for failure to report data) and pay-for-performance (i.e., paying for achievement of quality targets).

Note that contracts through which an MCO makes Patient Centered Medical Home payments to a primary care practice are considered Category 2B contracts and should be counted in this category. This would include mandatory payments made through the PCMH Kids program as well as optional payments made to other PCMH practices. To be counted as a Category 2B payment, the practice must meet the definition of a Patient Centered Medical Home set forth in regulations by the Rhode Island Office of the Health Insurance Commissioner.

EOHHS expects that MCOs will use Category 2B payments to bring value-based care to practices and provider types that are not otherwise engaged in APMs. For example, this might include smaller primary care practices that do not participate in an AE or specialist practices. MCOs may not count towards the Category 2 target any contracts with a primary care practice participating in an AE under which the practice can earn pay-for-performance payments based on quality or outcome targets that duplicate any AE targets described in *Accountable Entity Total Cost of Care Requirements* or *Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities*.

b. Category 3: APMs built on fee-for-service architecture

This category includes shared savings with upside-only risk as well as two-sided risk arrangements. Note that TCOC contracts with AEs would fall under Category 3, but for purposes of this Contract are counted separately with their own target under #1 above.

Note that IHH and ACT bundled payment arrangements are considered Category 3 contracts and should be counted in this category.

Other examples include episode-based payments for procedures such as a bundled payment for a hip or knee replacement or for maternity care.

c. Category 4: Population-Based Payment

This category includes condition-specific population-based payments such as per member per month (PMPM) payments for delivery of specialty services for a population living with a specific condition.

This category also includes comprehensive population-based payments, such as primary care capitation, where a primary care practice receives a PMPM payment with no reconciliation based on fee-for-service billing. Hospital global budget arrangements would generally be considered another example of a Category 4 methodology.

EOHHS strongly encourages participating MCOs to establish primary care capitation contracts as one strategy for achieving the category 4 targets. Such contracts must comply with the standards set forth in the OHIC consensus model.

3. Methodology to measure achievement of APM Targets

For all APM targets, the denominator will be the total amount of the Contractor's payments to its network providers. Below, EOHHS sets forth the payments that will count towards the numerator for calculating performance on each target.

1. TCOC contracts with EOHHS-certified AEs

All payments that are counted as part of TCOC, as set forth in Attachment J, "*EOHHS Total Cost of Care (TCOC) Requirements for the AE Program,"* will count towards the numerator for calculating performance on this target.

2. Category 2B: **Fee for service payment linked to quality and value**

All payments made to a provider who is participating in a Category 2B contract will count towards the numerator for calculating performance on this target. For example, if a primary care practice has a pay-for-performance arrangement with the MCO, all payments made to that primary car practice count towards the numerator.

3. Category 3: APMs built on fee-for-service architecture

All episode-based/bundled payments count towards the numerator for calculating performance on this target. For example, if an MCO pays a bundled payment for a knee replacement, that bundled payment counts towards this numerator.

4. **Category 4: Population-Based Payment**

   All capitated payments count toward the numerator for calculating performance on this target.

4. Reporting:

MCOs will be required to complete the APM Reporting Template (see Attachment E) to show their status against these measures. The APM Reporting Template is to be submitted to EOHHS not later than sixty (60) days after the end of each calendar year. For the Contract Period beginning July 1, 2023 EOHHS' contracts with MCOs specify that EOHHS shall withhold 0.05% from capitation payments to MCOs pending demonstration of compliance with these requirements. Upon demonstration of compliance with these targets for the respective quarters, the withheld amount will be paid to the MCOs.