307 CYE 25 – ALTERNATIVE PAYMENT MODEL INITIATIVE – STRATEGIES AND PERFORMANCE BASED PAYMENTS INCENTIVE

EFFECTIVE DATES: 10/01/22, 10/01/23, 10/01/24

APPROVAL DATES: 10/06/22, 01/22/24, 11/05/24

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS-EPD, DCS CHP (CHP), and DES DDD (DDD) Contractors. This Policy establishes requirements for the Alternative Payment Model (APM) Initiative–Strategies and Performance Based Payments (PBP) Incentive. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM Strategies that align with AHCCCS priorities.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

ENCOUNTER A record of health care-related service rendered by a provider, or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.

MEDICAID ACCOUNTABLE CARE ORGANIZATION (MEDICAID ACO)	An entity that enters into Value-Based Purchasing (VBP) arrangement with a Contractor which does the following: 1. Improves the health care delivery system by increasing the quality of care while managing and reducing costs. 2. Enters into VBP contracts with provider groups and/or networks of groups, including creating provider-level financial incentives for improved performance and cost-efficiencies, such as the Accountable Care Organization (ACO) sharing in savings and re-investing VBP earnings in practices. 3. Coordinates the provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM), combined with quality incentives (to ensure both quality outcomes and cost containment). 4. Supports providers participating in APMs by providing services such as, but not limited to data analytics, technical assistance, provider education, care management, care coordination, and provider recruitment. 5. Operates as an intermediary between the Contractor and providers and is not a provider of direct services to members. 6. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS (Refer to ACOM Policy 438).
PERFORMANCE BASED PAYMENT (PBP)	A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures with a tie to quality in accordance with the Alternative Payment Model (APM) strategy selected for the contract.
PERFORMANCE BASED PAYMENT INCENTIVE (PBP INCENTIVE)	A payment from AHCCCS to a Contractor for a portion (up to a specified amount) of the Performance Based Payments (PBPs) paid to providers who successfully met their Alternative Payment Model (APM) targets during the Contract Year. The maximum contribution from AHCCCS under this PCP incentive structure is not intended to limit Contractor PBP payments to providers.
PREMIUM TAX	The tax imposed pursuant to ARS 36-2905 and ARS 36-2944.01 for all payments made to the Contractor for the Contract year.

TARGETED INVESTMENTS (TI) PROGRAM	The Targeted Investments (TI) program requires activities designed to create a system of integrated care to incentivize providers to improve performance and increase physical and behavioral health care integration and coordination for individuals with behavioral health needs through incentive payments. Eligible providers elect to participate in the TI program.
VALUE BASED PURCHASING (VBP)	A form of payment reform that seeks to reward providers for providing high-quality care to members through financial incentives. The financial incentives are tied to improving health outcomes while reducing the cost of care. Value Based Purchasing (VBP) attempts to reduce inappropriate care and to identify and reward the best performing providers.

FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE (LAN-APM CATEGORY 1)

BLOCK PURCHASE PAYMENT ARRANGEMENT METHODOLOGY	A payment methodology where the Contractor pays the provider for a contracted amount in 12 monthly installments and where payment has no relation to quality, outcomes, or efficiency. (LAN-APM Category 1)
FEE-FOR-SERVICE (NO LINK TO QUALITY AND VALUE)	A purchasing strategy in which the Contractor pays the provider a specific rate for every unit of service the provider delivers without regard to quality, outcomes, or efficiency. This strategy utilizes traditional Fee-For-Service (FFS) payments (i.e., payments made for units of service) and is not adjusted to account for infrastructure investments, provider reporting of quality data, or provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality and value are classified in Category 1. (LAN-APM Category 1)

FEE-FOR-SERVICE – LINK TO QUALITY & VALUE (LAN-APM CATEGORY 2)	
FOUNDATIONAL PAYMENTS FOR INFRASTRUCTURE & OPERATIONS	A payment arrangement which includes but is not limited to payments to improve care delivery such as outreach and care coordination/management, after-hour availability, patient communication enhancements, and health information technology infrastructure use. The payments may come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists. (LAN-APM Category 2A)
PAY FOR REPORTING	A payment arrangement in which providers are rewarded with bonus payments for reporting quality data and/or assessed penalties for not reporting quality data. (LAN-APM Category 2B)
PAY FOR PERFORMANCE	A payment arrangement which uses incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as Fee-For-Service (FFS), block purchase payment, or population-based/capitation payment. In some cases, if providers do not meet the quality-of-care targets, their base payment is adjusted downward the subsequent year. In this strategy, payments are not subject to provider performance against aggregate cost targets but may account for performance on a more limited set of utilization measures. (LAN- APM Category 2C)

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE (LAN-APM CATEGORY 3)	
APMS WITH UTILIZATION-BASED SHARED SAVINGS	A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g., Medicare Comprehensive Primary Care Plus (CPC+) Track 1 program). There are no financial targets in these arrangements; instead, there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to, emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets. (LAN-APM Category 3A)

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE (LAN-APM CATEGORY 3)	
APMS WITH SHARED SAVINGS AND DOWNSIDE RISK	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. (LAN-APM Category 3B)

POPULATION BASED PAYMENT (LAN-APM CATEGORY 4)	
CONDITION-SPECIFIC POPULATION-BASED PAYMENT	A Per Member Per Month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. (LAN-APM Category 4A)
CONDITION-SPECIFIC BUNDLED/EPISODE PAYMENTS	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g., diabetes). The payment considers the quality, costs, and outcomes of a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. (APM Framework Category 4A)
COMPREHENSIVE POPULATION-BASED PAYMENT	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage are predefined and could cover primary, acute, and post-acute care that is not specific to any particular condition. (LAN-APM Category 4B)
INTEGRATED FINANCE & DELIVERY SYSTEMS	A purchasing strategy of prospective, population-based payments structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. Integrated arrangements between the delivery system and the finance system consist of insurance companies that own provider networks, delivery systems that offer their own insurance products, payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships. (LAN-APM Category 4C)

Additional details on the HCP-LAN APM Framework are located at https://hcp-lan.org/

III. POLICY

A. GENERAL REQUIREMENTS

The APM Initiative-Strategies and PBP Incentive discusses the Contractor Learning and Action Network (LAN)-APM strategy VBP/APM Contract requirements, as well as the PBP Incentive. The PBP Incentive is an arrangement under which the Contractor may receive performance incentive funds from AHCCCS related to APM arrangements for the Contractor's providers successfully meeting targets that are aimed at improving performance measures, access to care, and reducing the cost of care. Whereas PBP Incentives represent a payment between AHCCCS and the Contractor, Performance Based Payments (PBP) represent a payment between the Contractor and the provider. Performance Based Payments are non-encounterable payments and do not reflect payment for a direct medical service to a member. This payment shall typically occur after the completion of the contract year but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement. Performance Based Payments shall not include Per Member Per Month (PMPM) payments or other amounts for provider care coordination, case management, care management, or other infrastructure costs.

The Contractor shall meet the APM Strategies qualifying criteria in the section of this Policy titled "Contractor Responsibilities" for the below, and certify as specified in "Contractor Responsibilities":

1. The LAN-APM target requirements.

2. For ACC and ACC-RBHA (excluding provider payments for members with a Serious Mental Illness [SMI] designation and non-integrated members) Contractors only, LAN-APM sub-requirements for Categories 3 and 4.

Refer to Attachment A for the LAN-APM Framework, Strategies, and Categories.

Failure of a Contractor to meet or certify meeting the criteria in a particular contract year for a specific Line of Business (LOB) may result in the assessment of sanctions for ACC, ACC-RBHAs, ALTCS-EPD, CHP Subcontracted Health Plan, and DDD Subcontracted Health Plans up to a maximum of the amounts listed in the table below:

CONTRACTOR/LOB	MAXIMUM SANCTION AMOUNT
ACC	$400,000
ACC-RBHA	$500,000
ALTCS-EPD	$400,000
CHP SUBCONTRACTED HEALTH PLAN	$100,000
DDD SUBCONTRACTED HEALTH PLANS	$100,000

B. CONTRACTOR RESPONSIBILITIES

1. A minimum percentage of the Contractor's total Title XIX/XXI payments to providers (both APM and non-APM, contracted or non-contracted) excluding State-directed payments paid outside of capitation (e.g., lump sum directed payments), shall be governed by APM Strategies for the Contract Year Ending (CYE), according to the table below and shall be assessed based on Contractor's submission of the APM Strategies and PBP Incentive Certification in accordance with instructions in this Policy and in the APM Strategies and PBP Incentive Certification templates that can be found on the AHCCCS website: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html

LAN-APM TARGET REQUIREMENTS							
CYE	ACC & ACC-RBHA[1]	ALTCS-EPD	CHP SUB CONTRACTED HEALTH PLAN[1]	ACC -RBHA		DDD	
		ALTCS-EPD MEDICARE ADVANTAGE-DUAL SPECIAL NEEDS PLAN (MA-DSNP)[2]		SMI-INTEGRATED[1]	NON-INTEGRATED	SUB-CONTRACTED HEALTH PLANS[1]	LONG TERM SUPPORT SERVICES (LTSS)
CYE 23	45%	45%/45%	15%	35%	N/A	35%	15%
CYE 24	45%	45%/45%	15%	35%	N/A	35%	15%
CYE 25	45%	45%/45%	15%	35%	N/A	35%	15%

[1] For ACC and ACC-RBHA (including SMI Integrated population) Contractors, and CHP and DDD Subcontracted Health Plans, a minimum of 25% of the percentage requirement noted above shall be with an organization that includes Primary Care Providers (PCPs). ACC-RBHA Contractors shall separately report provider payments for members designated as SMI on the APM Strategies and PBP Incentive Certification related to the use of APM Strategies.

[2] For a MA-DSNP contract for ALTCS-EPD Duals, if a Contractor's MA-DSNP contract serves AHCCCS populations other than ALTCS-EPD Dual members, the Contractor shall split out their MA-DSNP populations served to prove that they have met the minimum percentage requirements for the ALTCS-EPD MA-DSNP population. The Medicaid funded VBP/APM amounts for the ALTCS EPD MA-DSNP population shall be reported in the ALTCS-EPD tab of the APM Strategies and PBP Incentive Certification. The Medicare-funded VBP/APM arrangements with MA-DSNP providers for ALTCS-EPD members shall be reported in the MA-DSNP tab of the APM Strategies and PBP Incentive Certification. The Contractor may count both aligned and non-aligned members in their ALTCS-EPD MA-DSNP population.

2. AHCCCS intends to evaluate the minimum value thresholds annually using a data-driven approach. At this time, AHCCCS anticipates that the minimum value thresholds will remain consistent through CYE 2026 as indicated below:

LAN-APM TARGET REQUIREMENTS (ANTICIPATED)						
CYE	ACC & ACC-RBHA[3]	ALTCS -EPD (EPD/MA-DSNP)[4]	CHP SUB - CONTRACTED HEALTH PLAN[3]	ACC-RBHA SMI-INTEGRATED[3]	DDD SUB-CONTRACTED HEALTH PLANS[3]	DDD LTSS
CYE 26	45%	45%/45%	15%	35%	35%	15%

[3] For ACC and ACC-RBHA (including SMI Integrated population) Contractors, and CHP and DDD Subcontracted Health Plans, the instructions and PCP limit remain the same as in CYE 25 above.

[4] For a MA-DSNP contract for ALTCS-EPD Duals, the instructions remain the same as in CYE 25 above.

3. The following payment methodologies may not be included in meeting the above targets:
   a. Block purchase payment arrangement methodology with no link to quality and value,
   b. Fee-For-Service (FFS) strategy with no link to quality and value (LAN-APM Category 1), or
   c. Foundational payments for infrastructure & operations strategy (LAN-Category 2A).

4. The APM Strategies that incorporate the pay for reporting strategy (LAN-APM Category 2B) shall be considered by AHCCCS to meet the qualifying criteria on a case-by-case basis and prior approval is required. AHCCCS will only consider the approval of LAN-APM Category 2B for expansion to services/service providers/provider types not traditionally utilized for APM arrangements. Any approval of such payment methodologies shall only be for a short-term basis, and Contractors shall request prior approval annually to be reconsidered by AHCCCS. Qualifying APM Strategies utilized shall meet the definitions provided under Section II "Learning Action Network Alternative Payment Models (LAN-APM)" of this Policy. APM Strategies shall be designed to achieve cost savings and quantifiable improved outcomes.

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

5. The Contractor shall maintain a minimum percentage for the usage of APM Strategies in LAN-APM Categories 3 and 4 listed in the table below of total Title XIX/XXI payments governed by all APM Strategies.

Failure to attest to the sub-requirement for LAN-APM Categories 3 and 4 qualifying criteria, through the APM Strategies and PBP Incentive Certification, in a particular Contract year, may result in sanctions up to a maximum of $250,000 per Contractor.

SUB-REQUIREMENT FOR LAN-APM CATEGORIES 3 AND 4							
CYE	ACC & ACC-RBHA	ALTCS-E/PD (E/PD/ MA-DSNP)	CHP SUB CONTRACTED HEALTH PLAN	ACC- RBHA		DDD	
				SMI-INTEGRATED	NON-INTEGRATED	SUB - CONTRACTED HEALTH PLANS	LTSS
CYE 23	35%	N/A	N/A	N/A	N/A	N/A	N/A
CYE 24	35%	N/A	N/A	N/A	N/A	N/A	N/A
CYE 25	35%	N/A	N/A	N/A	N/A	N/A	N/A
CYE 26 Anticipated	35%	N/A	N/A	N/A	N/A	N/A	N/A

AHCCCS anticipates that the required percentage of APM Strategies in LAN-APM Category 3 and Category 4 of total Title XIX/XXI payments governed by all APM Strategies be maintained in CYE25 for ACC and ACC-RBHA Contractors, excluding provider payments for members designated as SMI.

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

7. The same dollar shall not be counted under multiple contracts. Additionally, one contract shall not be counted under multiple APM strategies. If a payment model includes more than one LAN APM Category component, the Contractor shall report the provider contract payments under the LAN APM Category where the provider has the greatest potential to earn additional funds based on performance.

8. The Contractor may use performance measures for providers other than the measures identified in ACOM Policy 306 as part of the Contractor's APM strategies. In order for a Contractor's APM arrangement to count towards the targets and criteria in this Policy, Contractors shall include the following:
   a. For ACC, ACC-RBHA (limited to the Contractors' ACC population only), and ALTCS-EPD, two or more ACOM Policy 306 performance measures if two or more ACOM Policy 306 measures are applicable to the provider and/or payment model,
   b. For CHP and DDD, two or more applicable measures from the current Centers for Medicare and Medicaid Services (CMS) Core Set of Child or Adult Health Care Quality Measures for Medicaid,
   c. In addition to 9a. above, for ACC, ACC-RBHA (limited to the Contractors' ACC population only), and ALTCS-EPD, the Contractor may also align additional measures with the current CMS Core Set of Child or Adult Health Care Quality Measures for Medicaid, and
   d. AHCCCS strongly encourages the Contractor to align provider performance measure calculations to adhere to the measure stewards' technical specifications, to the extent feasible.

9. It is AHCCCS' intent, beginning in CYE 26 or later, to require the Contractor to:
   a. For the ACC-RBHA members with an SMI designation, include two or more performance measures that may be used in ACOM Policy 306 for CYE 26 in the Contractor's APM arrangements if two or more measures are applicable to the provider and/or payment model. The performance measures for the ACC-RBHA members with an SMI designation will be made available on the AHCCCS website: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html,
   b. Require that the APM includes at least one TI performance measure for applicable qualified providers,
   c. Review and amend PCP assignment in relation to each member's utilized PCP provider group Tax Identification Number (TIN) and/or facility to reconcile assignments at least quarterly,
   d. To allow PCPs and other providers participating in APMs to request clarifications and/or changes in their assigned/attributed members for certain circumstances as defined by the Contractor,
   e. To honor and act on member requests to change their PCP, including promptly communicating with members letting them know if and when their assigned PCP has been changed or the reasons for which their assigned PCP was not changed,
   f. AHCCCS strongly encourages the Contractor to align APM performance measure calculations to adhere to the measure stewards' (e.g. National Committee for Quality Assurance [NCQA]) technical specifications, to the extent feasible. Increase the number of performance measures within a Contractor's APM arrangements that align with ACOM Policy 306 and/or CMS Core Set of Child or Adult Health Care Quality Measures for Medicaid over time,
   g. Address health disparities, identified through the use of stratified performance measure data and/or other strategies including but not limited to multivariate analyses, sensitivity analyses, and member satisfaction, as a component of the value-based purchasing model,

h. Meet health disparity reduction targets established by AHCCCS for increasing community engagement, reducing gaps, incentivizing providers who increase training and recruitment to improve cultural competency, connecting members of smaller (under-threshold) communities with linguistically and culturally responsive providers, and/or other strategies to reduce disparities, and
i. Demonstrate progress toward reducing health disparities to receive non-financial incentives from AHCCCS.

10. In order to count toward meeting the qualifying criteria, APM Strategies shall be evidenced by written contracts with providers. Contracts with providers must include clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that the provider must meet to receive the payment. For those contracts executed prior to April 1 of each contract year, AHCCCS shall count the APM Strategies for the time period in the contract year for which the Contract is in effect. For those contracts executed after April 1 of each contract year, AHCCCS shall count the value of the APM Strategies for the time period from the execution date forward for which the Contract is in effect. Refer to Future Federal Requirements section.

11. The Contractor shall certify and attest to AHCCCS that these requirements shall be met by submitting the APM Strategies and PBP Incentive Certification as an executed electronic copy in Excel format as follows:
    a. The APM Strategies and PBP Incentive Certification (Initial) by the due date specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables,
    b. The APM Strategies and PBP Incentive Certification (Interim) by the due date specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables, and
    c. The APM Strategies and PBP Incentive Certification (Final) by the due date specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables.

12. The Contractor shall report the PBP on an accrual basis. When reporting PBP on the APM Strategies and PBP Incentive Certification, the Contractor shall appropriately allocate PBP between the lines of business when these payments to providers impact multiple lines of business. The Contractor shall not report PBP amounts for unearned incentives. The provider shall successfully meet its contracted goals/measures with a tie to quality and/or metrics to receive a PBP. If these goals/measures with a tie to quality and/or metrics are not met, this is considered an unearned PBP (e.g., a provider did not meet its contracted medical loss ratio target or a provider did not meet its contracted performance measure target) and shall not be reported on the APM Strategies and PBP Incentive Certification. The Contractor shall report the percent of planned and actual PBP between TI participants and non-TI participants in the final APM Strategies and PBP Incentive Certification. The Contractor shall not include in the APM Strategies and PBP Incentive Certification PBP paid using MA-DSNP funding or for the MA-DSNP earned portion of the PBP. The PBPs shall not include Per Member Per Month (PMPM) payments or other amounts for provider care coordination, case management, care management, or other infrastructure costs. The Contractor shall include in the APM Strategies and PBP Incentive Certification the upside risk/shared savings amounts of PBP, as well as deductions and recoupments from providers for downside risk. See Future Federal Requirements section.

13. For ALTCS-EPD and ACC-RBHA Contractors: APM Strategies and PBP Incentive Certification contains two tabs to be submitted as an executed electronic Excel copy as listed below in accordance with the Section on Contractor Responsibilities for APM Strategies and PBP Incentive Certification.

CONTRACTOR	POPULATIONS	
ALTCS-EPD	EPD	MA-DSNP
ACC-RBHA	ACC	SMI-Integrated

14. The DDD shall include the APM requirements to DDD Subcontracted Health Plans and submit the APM Strategies and PBP Incentive Certifications on behalf of the DDD Subcontracted Health Plans. The DDD Subcontracted Health Plans shall use the DDD Subcontractor tab on the APM Strategies and PBP Incentive Certification. The CHP shall include the APM requirements to the CHP Subcontracted Health Plan and submit the APM Strategies and PBP Incentive Certifications on behalf of the CHP Subcontracted Health Plan.

15. AHCCCS reserves the right to request an audit of the Certifications included in the APM Strategies and PBP Incentive Certification. The Contractor, upon the request of AHCCCS, shall provide documentation of APM contracts and payments to providers, including supporting calculations, for PBP. This may include but is not limited to documentation related to the Contractor's validation of provider-level quality measure data and the Contractor's oversight process of APM contracts.

    The Contractor shall submit the APM Quality Reporting Narrative Report to describe and compare performance on quality measures as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS strongly encourages the use of supplemental data sources (standard and non-standard), in accordance with associated measure steward technical specifications and national auditing standards, for calculating and reporting performance on quality measures. The Contractor shall use the APM Quality Reporting Checklist and associated templates to address all elements listed within deliverable submissions. The APM Quality Reporting Checklist and associated templates will be made available on the AHCCCS website: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html.

16. During contract year 23 and each subsequent contract year, the Contractor shall:
    a. Develop and submit the APM Strategic Plan Template and the APM Strategic Plan Attachment, as specified in the Contract Section F, Attachment F3, Contractor Chart of Deliverables, generally describing the Contractor's APM approach for the next three years, including proposed annual percentage targets for provider payments within APMs by LAN APM categories, expected percentage of medical expenses to be paid out in PBPs, and an approach to identify quality measures to be included in APMs for the next three years,

b. Participate in at least annual meetings with AHCCCS, Medicaid Accountable Care Organizations (Medicaid ACOs), and larger providers, to discuss APM policies, results, opportunities for improvement, and challenges to date, and

c. Report and present annually to AHCCCS on changes in performance on APM targeted measures, as well as APM quality and cost-effectiveness results, potential modifications to the Contractor's multi-year APM Strategic Plan, and challenges to date.

C. AHCCCS RESPONSIBILITIES

1. The Contractor shall be eligible to earn PBP incentive payments based on the PBP made by the Contractor to providers. AHCCCS will consider Contractor payments as PBP where providers successfully meet their contracted performance targets as part of APM Strategies. No PBP incentive payments shall be made by AHCCCS for PBP made by DDD and CHP Subcontracted Health Plans or PBP made by any Contractor with EPD/MA-DSNP funding. Upon receipt and review of the final APM Strategies and PBP Incentive Certification, AHCCCS will perform testing of the PBP amounts reported by the Contractor prior to payment of the PBP incentive, including a review of the Contractor's documentation of APM contracting, the Contractor's payments to providers for PBP, and the Contractor's PBP calculations and allocations by line of business. The PBP incentive payment will be adjusted for premium tax. AHCCCS will not adjust PBP payments to the Contractor after the final payment is made due to changes in accrual by the Contractor except in cases where amounts must be recouped.

   AHCCCS reserves the right to perform a look-back and adjustment of the previous year's PBP accrual in a subsequent year's payment.

2. For any APM contract that is effective for a period other than the contract year, AHCCCS will allow PBP to be reported in the year to which the PBP Incentive is attributable. For example, a contract effective from July 1, 202X to June 30, 202Y will have three months (July 1, 202X – September 30, 202X) in the 202X lump sum payment and nine months (October 1, 202X – June 30, 202Y) in the 202Y lump sum payment.

3. The Contractor is not required to meet the APM Strategies qualifying criteria for LAN-APM target requirements and sub-requirements for LAN-APM Categories 3 and 4 (for ACC and ACC-RBHA Contractors) in order for the PBP Incentive to be paid to the Contractor.

4. AHCCCS will limit the PBP Incentive to the Contractor to no more than 0.75% of medical payments (APM and non-APM contracted and non-contracted), excluding State-directed payments paid outside of capitation (e.g., lump-sum directed payments). The maximum contribution from AHCCCS under this PCP incentive structure is not intended to limit Contractor PBP payments to providers. AHCCCS will exempt Contractors from the 0.75% PBP Incentive limit if the Contractor is a state agency, and the Contractor provides the State share of funding for their PBP Incentive.

5. AHCCCS will test the total amount of the PBP Incentive due to the Contractor to ensure that the Federal limit of 5% of the approved capitation payments attributable to the members or services covered by the incentive arrangements is met. Any amount in excess of the limit shall be reduced to bring the final payment due within the Federal requirement. Federal regulation requires that all incentive payments made under this Policy as well as any other incentive arrangements made under the Contract or another Policy combined shall not exceed this 5% limit, thus the test of the 5% limit will include both the PBP Incentive included in this Policy and the QMP Incentive payments specified in ACOM Policy 306.

6. AHCCCS reserves the right to periodically request ad hoc data for data-informed decision making, as specified in the Contract.

7. AHCCCS shall review the LAN-APM target requirements and sub-requirements for LAN-APM Categories 3 and 4 on an annual basis and may adjust percentages or change the LAN-APM strategies requirements listed in the section of this Policy on Contractor Responsibilities, in subsequent years, as is in the best interest of the AHCCCS Program and/or the State. AHCCCS intends to notify the Contractor of the changes in any APM targets no less than two months prior to October 1.

8. AHCCCS shall review APM reporting on an annual basis and meet with Contractors to review substantive changes no less than two months prior to the due date for each report.

D. FUTURE FEDERAL REQUIREMENTS

It is AHCCCS' intent, beginning in CYE 26 to require the Contractor to meet the following requirements listed in the Medicaid Managed Care Rules that are effective for the rating period on or after 7/9/25 (i.e., CYE 2026) related to Contractor APM contracts with providers:

1. The APM contracts must have a defined performance period (Calendar Year) that can be tied to the applicable Medical Loss Ratio (MLR) reporting period (CYE).

2. The APM contracts must be signed and dated by all appropriate parties before the commencement of the applicable performance period.

3. The Contractor shall not use attestations as supporting documentation for provider incentive data used for incentive calculations.

4. The APM contracts must specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to the successful completion of the metrics defined in the VBP contract, including a date of payment.