PAYMENT APPROACH

■ Does order of submitting bills affect PAP? (e.g., does the first provider to bill become PAP? Or is it the first provider to see the patient?)

No, the order a provider submits does not affect PAP attribution. The PAP is determined at the conclusion of the episode, and uses claim date of service in all determinations.

■ What if a provider submits claims after the initial calculation of the episode PAP, cost, and report?

Providers will continue to submit claims within each payer’s allowed period. Each episode’s average cost and other metrics will be calculated at least twice: once approximately three months after the conclusion of the performance period and once one year after the initial calculation. If the average cost or quality changes in the claim run-out period, the provider will receive a correction.

■ How is payment recouped?

At the conclusion of each performance period, principal accountable providers (PAPs) deemed responsible for excess costs will see recoupment over a period to be determined by each payer. Medicaid anticipates a recoupment period over the course of the six months following the determination; ABCBS anticipates a period of one year; QualChoice will announce their recoupment period when it is determined.

■ Does the PAP also still bill fee for service (FFS)?

Yes, each provider continues to bill for each service delivered and will be reimbursed according to established fee schedules. The shared savings or excess costs will be determined at the conclusion of the episode and calculated on an average of all of a provider’s cases.

■ Who does the payment go to and how is it paid?

The payment will always go to the provider or provider entity with the financial relationship with the payer.

■ What quality aspects are included in the design?

By design, we incentivize high-quality care with two types of quality metrics built into the initiative model – quality metrics to pass (linked to payment) and quality metrics for reporting and tracking. Initially, where possible, these will be limited to claims-based metrics or, if non-claims based, will be reported through a user-friendly, internet-based provider portal. Each metric linked to payment will have a quality threshold that providers must exceed to be eligible for gain sharing.

■ Under this initiative will private payers have the same reimbursement levels as Medicaid?
No. The private payers taking part in the payment improvement initiative will not change their reimbursement rates as long as there is long-term progress in this initiative. Their goal is to have as many providers share in savings by increasing the cost effectiveness and quality of care in the state.

■ **How are the threshold targets established?**

Thresholds are set independently by each payer based on historical information. Each payer will have separate criteria and considerations and will share these thresholds with PAPs in the quarterly reports. No new efficiencies will be assumed at the onset of the initiative, meaning that for the near term the threshold levels stay the same.

■ **Will the thresholds continually be lowered?**

There are no plans to do that, and there are enough funds in the system now to maintain the levels that have been established. The participating payers will partner with providers to examine the threshold levels year after year.

■ **Who is responsible for monitoring physicians to ensure that they pay other specialists?**

In our program, all providers are paid as they are today. The only change comes at the end of the 12 month performance period when Principal Accountable Providers (PAPs) receive a final determination of gain sharing, risk sharing, or no change to payment. To be clear - this initiative does not have bundled payments (where one provider is paid and is responsible for distributing payments to other providers involved in the care episode). All providers who deliver services submit fee for service claims as they do today. This initiative calls for the PAP to perform or order the correct services, and is designed to reward them for doing so.

■ **Are quality metrics specific to level of licensure?**

No. Quality metrics are grouped by episode not by licensure class.

■ **Are the quality metrics comprehensive enough?**

Quality metrics were developed to account for specific aspects associated with each episode, and were designed to intentionally encourage positive health outcomes. Most episodes use claims data to assess quality and costs. We worked closely with providers and other stakeholders on the design, and where claims data were not sufficient to ensure high quality care we require that providers enter other quality metrics into the provider portal.

- **What is the percentage of gains/loss sharing between providers and payers?**

For Medicaid and BCBS there will be a 50/50 split between providers and payers.