VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda

Tuesday, December 10, 2013 1:00 PM – 3:30 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00 – 1:20	Welcome and Introductions a. Member roles and responsibilities	Don George and Steve Rauh	Attachment 1: Agenda (word)
2	1:20 – 1:40	Update on Predecessor Work Group a. Overview of the ACO/SSP purpose and process b. Summary of the Standards and measures	Richard Slusky	Attachment 2: Overview of Shared Savings Programs (powerpoint)
3	1:40 – 1:55	Draft Work Group Charter	Don George & Steve Rauh	Attachment 3: Work Group Charter (word)
4	1:55-2:05	Draft Work Group Workplan	Kara Suter	Attachment 4: Work Group Workplan (word)
5	2:05 – 3:10	Presentation Episodes of Care (EOC)	Kara Suter	Attachment 5: Episode of Care 101 (adobe pdf)
6	3:10-3:20	Public Comment	Don George and Steve Rauh	
7	3:10 – 3:20	Next Steps and Action Items	Don George and Steve Rauh	Next Meeting: January 6th 2-4:30pm

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting: Tuesday, December 10, 2013 – DVHA Lg Conf Rm 312 Hurricane Lane, Williston

Attendees: Don George, Co-Chair; Steve Rauh, Co-Chair;
Members: Melissa Bailey; Heather Bushey; Mike Del Trecco; Lynn Guillett; Paul Harrington; Bard Hill; Sarah King; Sandy McGuire; Todd Moore; Lila Richardson; Kelly Lange; Heidi Hall; Ted Sirotta; Marlys Waller; David Martini; Carrie Hathaway.
Interested Parties: Michael Curtis; Catherine Fulton; Tom Pitts; Howard Shapiro; Barbara Walters; Marie Zura; Alicia Cooper; Diane Cummings; Georgia Maheras; Richard Slusky; Kara Suter; Spenser Weppler; Abe Berman; Lori Collins; Carrie Hathaway; Selina Hickman; Con Hogan; Pat Jones; Marybeth McCaffrey; Beth Tanzman; Michael Baillet; Kate Bazinsky.

Agenda Item	Discussion	Next Steps
1. Welcome & Introductions. Member roles and responsibilities	Don George and Steve Rauh introduced themselves to the Work Group (WG). Kara provided additional information about the purpose of the WG and a description of members and interested partiesThe expectation is that Members will: - actively participate and represent interests of their affiliated stakeholder organizations, - contribute effort on sub- PM Work Groups - Members vote on recommendations to the Steering Committee. When Members cannot attend, their Subs cannot proxy vote.	
2. Update on Predecessor WG a Overview of ACO/SSP purpose & process b Summary of Standards and measures	**Report of the ACO Standards WG to Payment Models WG;** presented by Richard Slusky: An ACO is a group of Providers who organize and agree to be accountable to achieve the triple aim. Participation in a shared savings program is voluntary. Important to note that Payment and Delivery system reform go hand in hand. Providers assume that achieving these efficiencies will reduce their billable revenues, and produce a savings for payers. The ACO Shared Savings Program (SSP) enables Providers, though effective delivery of quality and efficient care to patients, to share in that savings.	
3. Draft Work Group Charter	**Work Group Draft Charter:** The draft Payment Models WG Charter summary focuses on garnering public/private input on programs testing and implementation of three payment models:	

Agenda Item	Discussion	Next Steps
	Pay for Performance, Episodes of Care, and Shared Savings Programs for Accountable Care Organizations. The WG will build upon work of the former ACO standards work group. Discussion reflected some interest in adding in words to describe the inherent challenges to provider/delivery system. Steve Rauh described Charter activity: conducting pilot projects, measuring success, then taking lessons learned and apply more generally. Don George confirmed that the PM WG will create and test pilots. The GMCB offers the nexus to reason the pilots through, and implement them statewide. Todd Moore and Mike DelTrecco expressed concern about how the three payment model programs can exist together. Steve Rauh assured Members that the WG will examine the potential for unintended consequences Paul Harrington asked if the evaluation section could be expanded and more meaningful. Kara Suter suggested that could be fleshed out through the Workplan. Don George acknowledged the challenges to the delivery system, but only thru innovations in care delivery and payment reform can effective change be accomplished bringing affordability and quality.	**Process for submitting Feedback.**
4 Draft Work Group Workplan	**Draft Workplan**: Kara Suter presented the draft workplan focusing on 3 payment models: ACO Shared Savings Program (SSP), Episodes of Care (EOC),Pay for Performance (P4P). Over the next 6 months, the major focus of the Workplan will be on developing an Episode of Care program. Simultaneously, the Work Group will develop a pay-for-performance program. Other WG's may request to put agenda items this Workplan because of the terdependancy with theirs. Todd Moore asked for clarification of the SIM Grant payment reform obligation made to CMMI. Kara responded that Vermont is expected to design the three payment models to be complimentary. The financial and care delivery effects of each require a complicated analysis to disentangle the savings of the three payment models. Don George asked whether there are grant requirements to report on outcome of implementing	

Agenda Item	Discussion	Next Steps
	the three payment methods. Georgia Maheras indicates that there are special requirements to report estimated savings by payer, with CMMI most interested in Medicaid. Don George observed that the three programs are complementary and focusing on the efficiency of any one is not always possible. Todd Moore expressed concerns about how the different payment methods affect administrative load on providers. Don George responded that the WG purpose was to being reasonable about the administrative burden. Kelly Lange suggested it would be very helpful to know the overall timeline of the project to understand better how that factor into the work plan and allow time to review and make changes if needed to ensure progress. THe Chairs will work with VHCIP staff to figure out the best way to have a full meeting discussion around how we work on integration of payment models.	
5 Presentation of Episodes of Care	**Episodes of Care (EOC) 101**; presented by Kara Suter: To define an EOC, it is necessary to identify the patient demographic (eg. age range), the trigger (eg. initial diagnosis), the episode duration (eg. 12 mos), Principal Accountable Provider (PAP); Episode services (eg. office visits, med management, pharmacy claims, etc), the quality measures, any Excluded Services for episode, and payment. The objective is to implement meaningful & sustainable behavioral changes in the delivery of clinical services. Bundled care rewards quality care and introduces "cost risk" to the provider. A Straw Man for VT was created for the WG's consideration. This EOC Straw Man offers a starting point for creating bundled payments which is intended to improve quality and outcomes. 1st year is analytical in nature, w/no explicit financial incentive. Year 2 evaluates EOC's for conversion to bundled payment. Noteworthy, is that payers can unilaterally implement EOC's themselves, but	Please provide comments on the Charter to Kara, Richard and Nelson.

Agenda Item	Discussion	Next Steps
	the VHCIP context allows for all stakeholders to be involved in program design. Don George indicated that work done thus far is a Journey of 1000 miles – specific EOC's will be identified and further defined by the WG. Today's meeting is about launching the EOC as a concept and see where it takes us. Kara continued: Straw Man timeline assumes EOC development work done by October 2014 with implementation of financial incentives in October 2015. Several concerns were expressed about how EOC and P4P can co-exist with the ACO SSP. The WG is charged with assessing EOC and making recommendations.	
6 Public Comment	Tom Pitts' public comment: What will WG vote mean? what are the implications? Nelson LaMothe responded that WG vote to approve specific recommendations to the VHCIP Steering Committee. The recommendations are taken up by the Steering Committee, voted upon, and sent to the Core Team for consideration and approval.	
Next Steps & Actions	Comments on draft Charter and draft Work Plan to be shared w/Nelson, Kara, Richard. Next meeting date January 6, 2:00 – 4:30pm @ 4th Fl Conf Rm, Pavillion Building, Montpelier.	

Att 2

Report of the Accountable Care Organization (ACO) Standards Work Group to the Payment Models Work Group December 11, 2013

Richard Slusky

Director of Payment Reform, GMCB

Shared Savings Programs and Accountable Care Organizations

Accountable Care Organizations

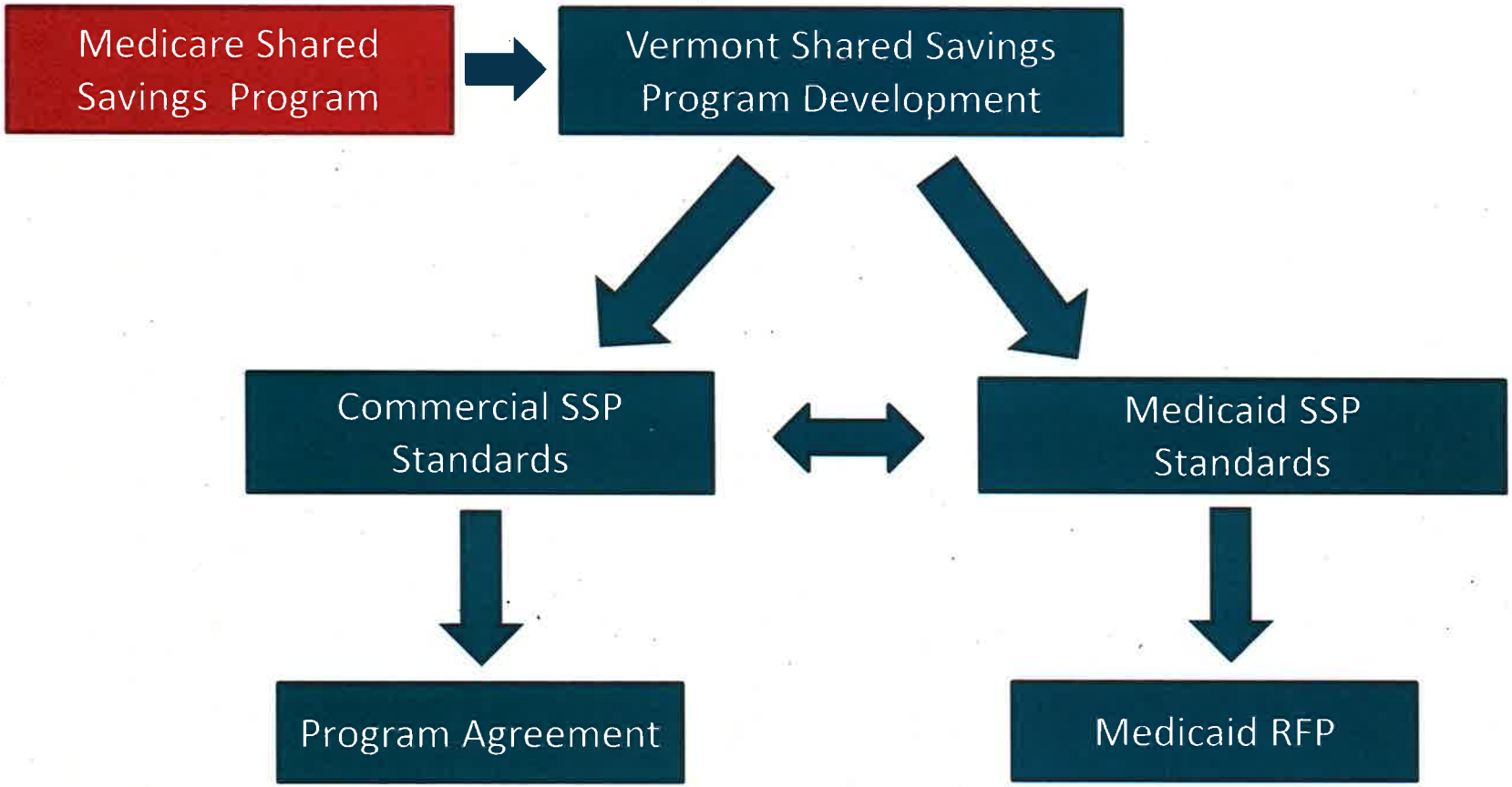
- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population
- ACOs are committed to achieve the "Triple Aim"
  - Improve quality
  - Reduce costs
  - Improve patient access
- These providers work together to coordinate care for their patients and have established mechanisms for shared governance
- ACO participation in a Shared Savings Program is voluntary

Shared Savings Programs

Shared Savings Programs are payment reform initiatives developed by health care payers. Shared Savings Programs may be offered to willing health providers who voluntarily agree to participate with the payer(s) to meet the following goals:

- Promote accountability for the care of a defined population
- Require coordinated care for services
- Encourage investment in infrastructure & care processes
- Payers and providers share a percentage of savings realized as a result of their efforts

Development of VT Shared Savings Program



Medicare Shared Savings Program Participation

Currently two Vermont ACOs participate in a Medicare Shared Savings Program; a third ACO has filed for approval:

- Accountable Care Coalition of the Green Mountains (ACCGM), July 1, 2012
- OneCare Vermont, January 1, 2013
- Community Health Accountable Care (CHAC), Proposed for January 1, 2014

Commercial and Medicaid Shared Savings Program Participation

- Potential pool is all Vermont Health Connect enrollees and Medicaid beneficiaries
- Participating payers include BCBSVT, MVP Health Care and Medicaid
- Potential ACOs include OneCare, ACCGM and CHAC
- Goal is to begin operations on January 1, 2014

ACO Standards Work Group

Stakeholder process to develop shared savings program standards and performance measures

ACO Standards Work Group: Purpose

- **Purpose:** To develop standards that will help ensure that Vermont's ACOs improve health care quality, patient experience of care and population health; reduce costs across the health care system; and maintain the financial viability of the state's health care system.
  - Focus on what it takes to be an "approved" ACO in Vermont in the commercial market and for Medicaid.
  - Develop standards for expanding ACOs to Commercial payers and Medicaid
  - Use the Health Insurance Exchange as the vehicle to expand shared savings program

ACO Standards Work Group: Process

- Began meeting in December 2012
  - Focus on ACO Standards and how ACO Success would be measured
  - Meetings held twice monthly (one in person, one conference call)
  - Plan to present recommendations on ACO standards for approval in September 2013
- Will transform to Model Testing Standards Group in December 2013
  - Receive and review reports from the ACO Operations Group
  - Establish standards for additional payment models

ACO Standards Work Group: Composition

- Composition of the Group
  - Payers
    - BCBS
    - MVP
    - Medicaid
  - Associations
    - Vermont Medical Society (VMS)
    - Vermont Association of Hospital and Health Systems (VAHHS)
    - Vermont Information Technology Leadership (VITL)
    - Vermont Program for Quality in Health Care (VPQHC)
    - Vermont Assembly of Home Health Agencies (VAHA)
    - Bi-State Primary Care Association

ACO Standards Work Group: Composition

- Composition of the Group Cont.
  - ACOs
    - Accountable Care Coalition of the Green Mountains
    - OneCare Vermont
  - Government
    - Agency of Administration
    - Department of Financial Regulation
    - Department of Vermont Health Access
    - Blueprint for Health
  - GMCB Member
    - Al Gobeille
- Co-chaired by Richard Slusky and Kara Suter and facilitated by Michael Bailit (Bailit Health)

ACO Standards Work Group will become Payment Model Standards Work Group under SIM

- Expanded membership: will include representatives from DVHA, AHS, Mental Health and Substance Abuse Providers, Home Health, LTSS providers and others
- Expanded scope of recommendations: may include Episodes of Care and Pay-for-Performance

ACO Standards Work Group: Recommended Standards

- Develop standards for expanding ACOs to include Medicaid and Commercial payers
  - The work group has drafted standards in the following categories: (See Handouts for Details on these Standards)

  - **Standards related to the ACO's structure:**
    - Financial Stability
    - Patient Freedom of Choice Standard

ACO Standards Work Group: Recommended Standards

- **Standards related to the ACO's payment methodology:**
  - Patient Attribution Methodology
  - Services to be Excluded from ACO Budget Calculations
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments
- **Standards related to management of the ACO**
  - Care Management (Referred to Care Management Group)
  - Payment Alignment
  - Data Use Standards (Referred to SIM/HIE Workgroup)

ACO Standards Work Group: Next Steps

- Commercial ACO Standards approved by GMCB December 5, 2013
- Participating ACOs and Commercial Payers need to sign Program Agreement --- Due December 31, 2013
- Medicaid SSP contract negotiations underway
- ACO Participant Agreements --- Due January 31, 2014
- Planning to implement Commercial ACO/SSP(s) on the Exchange January 1, 2014
- Planning to implement Medicaid ACO January 1, 2014

Model Testing Standards Work Group

Questions ????

Att 2a

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
November 20, 2013 Draft

The Vermont ACO Standards Work Group has developed and endorsed the following recommendations for consideration by the SIM Payment Models Work Group and the GMCB. While they represent the consensus of the work group as of the above date, the work group considers them subject to reconsideration and modification by the work group's planned successor, the SIM Payment Models Work Group, as new information becomes available and the pilot ACOs and insurers and GMCB gain experience. The work group anticipates that these standards will subsequently become a part of a three-way contractual agreement among the GMCB, the participating insurers and the participating ACOs.

The Standards Work Group has drafted standards for ACOs in the following categories:

- Standards related to the ACO's structure:
  - Financial Stability
  - Risk Mitigation
  - Patient Freedom of Choice
  - ACO Governance

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
  - Care Management
  - Payment Alignment
  - Data Use Standards

The objectives and details of each draft standard follow.

For Discussion Only

I. Financial Stability

Objective: Protect ACOs from the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the ACO can focus on management of performance risk (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition).

A. Standards related to the effects of provider coding patterns on medical spending and risk scores

1. Payers will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.

B. Standards related to downside risk limitation

1. The Board has established that for the purposes of the pilot program, the ACO will assume the following downside risk in each pilot program year:
    - Year 1: no downside risk
    - Year 2: no downside risk
    - Year 3: downside risk not less than 3% and up to 5%

2. ACOs are required to submit a Risk Mitigation Plan to the state that demonstrates that the ACO has the ability to assume not less than 3% and up to 5% downside risk in Year Three and receive state approval. Such a plan may, but need not include, the following elements: recoupment from payments to participating providers, stop loss protection, reinsurance, a provider payment withhold provision, and reserves (e.g., irrevocable letter of credit, escrow account, surety bond).

3. The Risk Mitigation Plan must include a downside risk distribution model that does not disproportionately punish any particular organization within the ACO and maintains network adequacy in the event of a contract year in which the ACO has experienced poor financial performance.

C. Standards related to financial oversight.

1. The ACO will furnish financial reports regarding risk performance to the SIM Payment Model Work Group or its successor[1] and to the GMCB on a semi-annual basis by June 30th and December 31st in accordance with report formats defined by the GMCB.

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. ACOs are required to demonstrate that projected enrollment meets or exceeds a minimum of 5,000 attributed lives in aggregate.

[1] All future references to the SIM Payment Models Work Group should be understand to mean that work group or its successor,

For Discussion Only

2. Participating insurers may choose not to participate with a given ACO should projected or actual attributed lives with that ACO fall below 3,000.

E. The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.

II. Risk Mitigation

The ACOs must provide the GMCB with a detailed plan to mitigate the impact of the maximum potential loss on the ACO and its provider network in Year 3 of the commercial ACO pilot. Such a plan must establish a method for repaying losses to the insurers participating in the pilot. The method may include recoupment from payments to its participating providers, stop loss reinsurance, surety bonds, escrow accounts, a line of credit, or some other payment mechanism such as a withhold of a portion of any previous shared savings achieved. The ACO must provide documentation, of its ability to repay such losses 90 days prior to the start of Year 3.

Any requirements for risk mitigation, as noted above, will be the responsibility of the ACO itself, and not of the participating providers. The burden of holding participating providers financially accountable shall rest with the ACO, and the ACO should be able to exhibit their ability to manage the risk as noted above.

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities.

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;

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c. making meeting minutes available to the ACO's provider network upon request, and
d. and posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

    b. is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

    A "participant" does not need to have lives attributed to the ACO to be considered a participant. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

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The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board, with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution

Patients will be attributed to an ACO as follows: An ACO must have at least 5,000 commercial Exchange pilot lives attributed to the participating insurers and at least 3,000 commercial Exchange pilot lives attributed to one insurer in order to participate in the pilot with that insurer.

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
   - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members to select a primary care provider, attribute those members to that provider.
4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[2] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

For Discussion Only

[2] Should the Blueprint for Health change the qualifying CPT Codes to be other than those listed in this table, the SIM Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381-99387 • Established Patient: 99391-99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401-99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411-99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial

For Discussion Only

CPT-4 Code Description Summary
stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least quarterly.

9. The SIM Payment Models Work Group will reconsider whether OB/Gyns should be added to the attributing clinician list during Year 1.

VI. Calculation of ACO Financial Performance and Distribution of Reconciliation Payments

(See attached spreadsheet.)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.

Years 1 and 2: The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[3], and risk-adjusted for the ACO-attributed population,

[3] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.

For Discussion Only

and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2.

The ACO-responsible services used to define expected spending shall include all covered services except for:

1. services that are carved out of the contract by self-insured employer customers
    - prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following SIM Payment Models Work Group discussion, and
2. dental benefits [4].

Year 3: The Year 3 expected spending shall be calculated using an alternative methodology to be recommended by the pilot participants (insurers and ACOs) and presented to the SIM Payment Models Work Group, and ultimately to the GMCB Board. The employed trend rate will be made available to the insurers prior to the deadline for GMCB rate submission in order to facilitate the calculation of premium rates for the Exchange. It is the shared intent of the pilot participants and the GMCB that the methodology shall not reduce expected spending based on any savings achieved by the pilot ACO(s) in the first two years.

The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.

Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

[4] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

For Discussion Only

As noted above, the Year 3 targeted spending shall be calculated using an alternative methodology to be defined by the GMCB with pilot participant input.

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

Actions Initiated After the Performance Year Ends

Step 3: Determine actual spending and whether the ACO has generated savings.

No later than six months following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using a common methodology across commercial insurers;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000, and
- conversion from allowed to paid claims value.

For Years 1 and 2, insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold. The GMCB and participating pilot insurers and ACOs will reassess this practice during Years 1 and 2 for Year 3.

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer

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basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

In Years 1 and 2 of the pilot:

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending).
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

In Year 3 of the pilot:
The formula for distribution of insurer-specific savings will be the same as in Years 1 and 2, except that the ACO will be responsible for a percentage % of the insurer-specific excess spending up to a cap equal to an amount no less than 3% and up to 5% of the ACO's insurer-specific expected spending.

All participating ACOs shall assume the same level of downside risk in Year 3, as approved by the SIM Payment Models Work Group and the GMCB.

The calculation of the ACO's liability will be as follows:

- If the ACO's total actual spending is greater than the total expected spending (called "excess spending"), then the ACO will assume responsibility for insurer-specific actual medical expense spending that exceeds the insurer-specific expected spending in a way that is reciprocal to the approach to distribution of savings.
- If the insurer-specific excess spending is less than the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 25% of the insurer-specific excess spending.
- If the ACO's excess spending exceeds the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 60% of

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the insurer-specific excess spending over the difference, up to a cap equal to an amount no greater than 5% of the ACO's insurer-specific expected spending.

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap. [5]

Step 4: Assess ACO quality performance to inform savings distribution.

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

Methodology for distribution of shared savings: For year one of the commercial pilot, compare the ACO's performance on the payment measures (see Table 1 below) to the PPO HEDIS national percentile benchmark[6] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

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[5] A reciprocal approach shall apply to ACO excess spending in Year3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.
[6] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

Table 1. Core Measures for Payment in Year One of the Commercial Pilot

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 Nat. 50th: .78 Nat. 25th: .83 *Please note, in interpreting this measure, a lower rate is better.
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 89.74 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
Core - 5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET CMMI	Claims	Nat. 90th: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

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The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The Ladder: In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

Table 2. Distribution of Shared Savings in Year One of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

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Each insurer will calculate the final performance year medical expense six months following the end of the calendar year to allow for completion of the typical time lag in claims payment. The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

Step 6: Process for Review and Modification of the Measures *(still under development)*

VII. Care Management Standards (*still under development*)

Objective: Effective care management programs close to, if not at the site of care, for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. Any standards will be developed by the SIM Care Management Care Model Work Group. For Year 1 of the pilot emphasis will be placed upon member communication and care transitions.

VIII. Payment Alignment

Objective: Improve the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
    a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
    b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be

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incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO Data Use Standards (*still under development*)

1. **Payer Provision of Data to ACOs and ACO Provision of Data to Payers**

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Att 3

Vermont Health Care Innovation Project
Payment Models Work Group
(Formerly ACO Standards Work Group)
Work Group Charter

EXECUTIVE SUMMARY

Garner public-private input on programs testing and implementation of three payment models. The payment models to be tested include Pay for Performance (P4P), Episodes of Care (Bundled Payments) and the Shared Savings Program Accountable Care Organization (SSP-ACO) Model.

PURPOSE/PROJECT DESCRIPTION

This group will build on the work of the ACO standards work group to date and:

- Continue to develop and recommend standards for the commercial shared savings ACO (SSP-ACO) model
- Continue to develop and recommend standards for the Medicaid SSP-ACO model
- Develop and recommend standards for both commercial and Medicaid episode of care models
- Develop and recommend standards for additional pay-for-performance models
- Review the work of the duals demonstration work group on payment models for dual eligibles
- Recommend mechanisms for assuring consistency and coordination across all payment models
- Coordinate with other work groups, particularly the care models work group and the quality and performance work groups
- In developing standards, strive to ensure that the payment models implemented under the SIM grant enable the transformation of care delivery, improve the quality of health care delivery, improve patient experience of care, reduce the rate of growth of health care costs, and maintain the financial viability of the state's health care system
- Serve as the nexus for coordinating evaluation and next steps for all proposed state payment models
- Sub-groups will address risk adjustment, patient protections and appeals
- All actions will be advisory to the SIM Steering Committee and SIM Core Team

Scope of Work

Work Group Objectives/Success Criteria

Objectives should be SMART: Specific, Measurable, Attainable, Realistic and Time-bound. The work group must be able to track these objectives in order to determine if the project is on the path to success. Vague and unrealistic objectives make it difficult to measure progress and success. The objectives will feed into the work plan.

PROJECT JUSTIFICATION

Adapted from Section P of the SIM Operations Plan; only reflects the workgroup role and more recent updates.

This section describes Vermont's plans for completing the "model testing" proposed in our grant application – plans for implementation of payment models that are alternatives to fee-for-service and related health system innovations, including timelines for implementation and metrics for gauging progress.

The State has developed a project plan for testing and implementation of three payment models through 2016. The payment models to be tested include Pay for Performance (P4P), Episodes of Care (Bundled Payments) and the Shared Savings Program Accountable Care Organization (SSP-ACO) Model. More detailed plans and timelines are provided in attachments to the operations plan.

Episodes of Care Payment Model

There is growing evidence that the quality of care of some acute and chronic conditions can be greatly improved by developing a collaborative Episodes of Care (EOC) or "Bundled Payments" program. By providing a forum and data analytics, identifying an "accountable provider(s)" and including financial incentives, providers will have the tools to come together to transform care for certain EOCs thereby increasing quality and reducing variation in cost. After providers improve care and achieve efficiencies, payers may choose to implement a bundled payment for these episodes, which introduces downside performance risk in addition to rewarding good performance.

The SIM Payment Models Work Group will provide key input and make actionable recommendations on the details of the EOC program. Beginning in December the Work Group will provide guidance on the following key elements of the program:

- Defining Objectives of the EOC Program
- Defining the Criteria that will be used to Select Episodes
- Creating Episode Specifications
- Format for Year One of the EOC Program
- Defining Transition Plan to Bundled Payment
- Defining Process for Evaluating and Adding New EOCs

The goal of the Work Group will be to develop a consistent approach, have statewide support, and present opportunities for expansion to multiple sites. The Work Group will develop recommendations for both commercial and Medicaid EOCs. Vermont would expect that EOC initiatives would be considered throughout the 3 year SIM testing phase, and that a structured approach to considering specific EOCs will be developed by the Work Group with recommendations to the GMCB and the SIM Steering Committee for review and approval.

The Work Group will begin discussions of the EOCs in December 2013 and will recommend the implementation of at least three or more EOCs on a broad state-wide basis by Spring 2014. Year One October 1, 2014. This implementation will complement and be done in conjunction with other payment models such as an accountable care organization (ACO).

Shared Savings Accountable Care Organization Model

Vermont has proposed testing a Shared Savings ACO with commercial payers and Medicaid. Vermont providers already have organized ACOs to respond to the Medicare SSP-ACO program, and our testing will utilize those organizations that are willing, as well as any others that form and meet our programmatic guidelines, for an expansion to other payers.

The Work Group's recommendations to date and plans for further work to design and implement the Commercial and Medicaid ACOs are described below.

In addition, the Work Group has made recommendations regarding most elements of the model design, including standards for:

- ACO structure, including financial stability, primary care capacity and patient freedom of choice
- ACO payment methodology, including attribution, covered services, calculation of financial performance and risk adjustment
- ACO management, including alignment of provider payment with the ACO model and distribution of savings

The Work Group has referred two other issues – alignment of care management programs and data use standards – to other SIM work groups.

Pay-for-Performance Payment Model

A. Medicaid Pay-for-Performance Model Development and Implementation

Starting in SFY15, Medicaid plans to use the new annual funds to create a quality pool to fund the P4P programs created. The development of the Medicaid P4P models will leverage the SIM Payment Models Work Group (a reconstitution of the ACO standards work group) and Steering Committee to garner public-private input on Medicaid's P4P programs.

Medicaid plans to hire some contracting resources to assist with the development of its P4P plan in late 2013 followed by discussions of the P4P models within the Work Groups and Steering Committee to occur in the first quarter of 2014.

DELIVERABLES

Standardized set of rules for a Commercial and Medicaid ACO program, standardized rules for the episodes of care and subsequent bundled payments and standardized rules for pay-for-performance models. The areas for potential standards development are as follows:

SUMMARY MILESTONES

TBD

MEMBERSHIP REQUIREMENTS

Members of the Work Group are expected to be active, respectful participants in meetings; to consult with constituents, clients, partners and stakeholders as appropriate to gather input on specific questions and issues between meetings; and to alert SIM leadership about any actual or perceived conflicts of interests that could impede their ability to carry out their responsibilities. Selection is by invitation of self-nomination.

PARTICIPANT LIST (as of November 2013)

M	Member
C	Chair
MA	Member Assistant
S	Staff/Consultants
X	Interested Parties

Last Name	First Name	Title	Organization
George	Don	President and CEO	Blue Cross Blue Shield of Vermont
Rauh	Stephen		GMC Advisory Board
Austin	Carmone		MVP Health Care
Bailey	Melissa	Director of Integrated Family Services	AHS - Central Office
Barrett	Susan	Director of Vermont Public Policy	Bi-State Primary Care
Bushey	Heather	CFO	Planned Parenthood of Northern New England
Cioffi	Ron	CEO	Rutland Area Visiting Nurse Association & Hospice
Curtis	Michael	Director of Child, Youth & Family Services	Washington County Mental Health Services Inc.
DelTrecco	Mike		Vermont Association of Hospital and Health Systems
Fulton	Catherine	Executive Director	Vermont Program for Quality in Health Care
Giard	Martita		OneCare Vermont

Gobeille	Al	Chair	GMCB
Goetschius	Larry	CEO	Addison County Home Health & Hospice
Grause	Bea	President	Vermont Association of Hospital and Health Systems
Guillett	Lynn		OneCare Vermont
Harrington	Paul	President	Vermont Medical Society
Hill	Bard	Director - Policy, Planning & Data Unit	AHS - DAIL
Hogue	Nancy	Director of Pharmacy Services	AHS - DVHA
Jones	Craig	Director	AHS - DVHA
King	Sarah	CFO	Rutland Area Visiting Nurse Association & Hospice
Lange	Kelly	Director of Provider Contracting	Blue Cross Blue Shield of Vermont
Little	Bill	Vice President	MVP Health Care
Mauro	James		Blue Cross Blue Shield of Vermont
McDowell	Sandy		Vermont Information Technology Leaders
McGuire	Sandy	CFO	HowardCenter for Mental Health
Moore	Todd	CEO	OneCare Vermont
Pitts	Tom	CFO	Northern Counties Health Care
Real	Lori		Bi-State Primary Care
Reiss	Paul	Executive Director,	Accountable Care Coalition of the Green Mountains
Richardson	Lila	Staff Attorney	Vermont Legal Aid
Schapiro	Howard	Interim President	University of Vermont Medical Group Practice
Seelig	Rachel	Attorney	Vermont Legal Aid
Stout	Ray	Mental Health & Health Care Integration Liaison	AHS - DMH
Walters	Barbara	Chief Medical Director	OneCare Vermont
Zura	Marie	Director of Developmental Services	HowardCenter for Mental Health
Bassford	Anna		GMCB
Carbonneau	Gisele		HealthFirst
Fargo	Audrey	Administrative Assistant	Vermont Program for Quality in Health Care
Fischer	Cyndy		OneCare Vermont
Hall	Janie	Corporate Assistant	OneCare Vermont
Lee	McKenna		
McGrath	Alexa		Blue Cross Blue Shield of Vermont
Bailit	Michael	President	Bailit-Health Purchasing
Bazinsky	Kate	Senior Consultant	Bailit-Health Purchasing
Cooper	Alicia	Quality Oversight Analyst	SIM - AHS - DVHA
Cummings	Diane	Financial Manager II	SIM - AHS
Flynn	Erin	Health Policy Analyst	SIM - AHS - DVHA
Geiler	Christine	Grant Manager & Stakeholder Coordinator	SIM - GMCB

Lamothe	Nelson	Senior Associate	UMASS
Maheras	Georgia		SIM - AOA
Paumgerten	Annie	Evaluation Director	SIM - GMCB
Poirer	Luann	Administrative Services Manager I	SIM - AHS - DVHA
Reeves	Ann	Senior Policy Advisor	SIM - AHS - DVHA
Sales	George		UMASS
Slusky	Richard	Payment Reform Director	SIM - GMCB
Suter	Kara	Director of Payment Reform	SIM - AHS - DVHA
Wallack	Anya	Chair	SIM Core Team Chair
Weppler	Spenser	Health Care Reform Specialist	GMCB
Backus	Ena	Health Care Reform Specialist	GMCB
Berman	Abe		OneCare Vermont
Collins	Lori	Deputy Commissioner	AHS – DVHA
Donofrio	Michael	General Council	GMCB
Giffin	Jim	CFO	AHS - Central Office
Hall	Heidi	Financial Director	AHS – DMH
Hall	Thomas		
Hathaway	Carrie	Financial Director III	AHS – DVHA
Hickman	Selina	Policy Director	AHS – DVHA
Hindes	Churchill	COO	OneCare Vermont
Hogan	Con	Board Member	GMCB
Jones	Pat	Health Care Project Director	GMCB
Kelley	Kevin	CEO	CHSLV
Kerr	Trinka	Health Care Ombudsman	Vermont Legal Aid
Lovejoy	Nick	Analyst and Data Manager	AHS – DVHA
Martini	David		AOA – DFR
McCaffrey	Marybeth	Principal Health Reform Administrator	AHS – DAIL
Reynolds	David		AOA
Sirotta	Ted	CFO	Northwestern Medical Center
Tanzman	Beth	Assistant Director of Blueprint for Health	AHS – DVHA
Wasserman	Julie	VT Dual Eligible Project Director	AHS - Central Office

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs: Stephen Rauh, Don George

Work Group Staff: Richard Slusky, Kara Suter

Consulting Support: Bailit Health Purchasing. Possibility of additional support available to the work group.

WORK GROUP PROCESSES:

1. The Work Group will regularly meet twice per month – teleconferencing utilized
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting
6. The Work Group Co-Chairs will preside at the meeting.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

_____ **Date:** _____

Project Sponsor/Title

Att 4

VT Health Care Innovation Project
Payment Models Work Group Work plan

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
DECEMBER					
Review member roles and responsibilities		Meeting 1	Co-Chairs	Planned	Reviewed
Update on Predecessor WG	Prepare historical overview and update	Meeting 1	Richard	Planned	Reviewed
Review WG Charter	Draft Charter	Meeting 1	Co-Chairs	PREPARED	Request Feedback
Review WG Work Plan	Draft Work plan	Meeting 1	Kara	PREPARED	Request Feedback
EOC - Conduct 101	101 Presentation to WG	Meeting 1	Kara	PREPARED	Conduct 101 on EOC Programs
EOC – Scope of Work Consultants	Draft Scope of Work for Consultants	Meeting 1	Kara	PREPARED	Request Feedback
JANUARY					
Adopt WG Charter and WP	Collect feedback and revise	Meeting 2a	SIM STAFF/Ann	Ongoing	WG and WP Adopted
EOC – Define Objectives of EOC Project	Draft Objectives	Meeting 2a	SIM STAFF/Kara	PREPARED	Feedback Requested on Objectives
EOC – Define Universe of Episodes	Prepare List of Universe of Episodes	Meeting 2a	SIM STAFF/Kara	Ongoing	Feedback on List of Episodes
EOC – Define Criteria for Choosing Episodes	Prepare Draft List of Criteria	Meeting 2a	SIM STAFF/Kara	Ongoing	Feedback Requested on Criteria
P4P – Conduct 101	101 Presentation to WG	Meeting 2b	SIM STAFF/Kara	Ongoing	Conduct 101 on P4P Programs
P4P Update on Medicaid P4P; Gauge interest in P4P	Ongoing internal Medicaid work	Meeting 2b	SIM STAFF/Ann	Ongoing	Straw Man v1 Medicaid P4P
Update on other WGs	Collect updates	Meeting 2b	SIM STAFF/PMs	Ongoing	
Possible Speaker	Arrange Speaker and Content	Meeting 2	SIM STAFF	TBD	Speaker
FEBUARY					
EOC – Review Evidence	Prepare Overview of Evidence	Meeting 3a	CONSULTANTS	PLANNED	Matrix of Evidence
EOC – Review National and State Program Specifics	Prepare Overview of National and State Programs	Meeting 3a	CONSULTANTS	PLANNED	Presentation of National and State Programs
EOC – Review Vermont and National Data	Review VT and National Data on: • Prevalence of Disease	Meeting 3a	CONSULTANTS	PLANNED	Presentation on VT and National Data

VT Health Care Innovation Project
Payment Models Work Group Work plan

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
	• Cost Variation • Potential ROI				
P4P Update on Medicaid P4P; Gauge interest in P4P .	Ongoing internal Medicaid work	Meeting 3b	SIM STAFF/Ann	Ongoing	Straw Man v1 Medicaid P4P
Update on other WGs	Collect updates	Meeting 3b	SIM STAFF/PMs	Ongoing	
Possible Speaker	Arrange Speaker and Content	Meeting 3b	SIM STAFF	TBD	Speaker
MARCH					
EOC – Choose EOCs against Criteria	Prepare scoring matrix of EOCs against criteria	Meeting 4a	STAFF/CONSULTANT	TBD	Adopt 3 EOCs
EOC – Introduce Specification Guide	Put together guide for adopting EOC specifications Need to designate appropriate folks to participate (coders, clinicians, etc)	Meeting 4a	SIM STAFF/CONSULTANT	TBD	Specification Guide
P4P Update on Medicaid P4P; Gauge interest in P4P	Ongoing internal Medicaid work	Meeting 4b	SIM STAFF/Ann	Ongoing	Straw Man v1 Medicaid P4P
Update on other WGs	Collect updates	Meeting 4b	SIM STAFF/PMs	Ongoing	
Possible Speaker	Arrange Speaker and Content	Meeting 4b	SIM STAFF	TBD	Speaker
APRIL-JUNE					
P4P- Feedback and Final Recommendations on Medicaid P4P Program	Finalize P4P plan	Meeting 5-8	SIM STAFF/Ann	Ongoing	Medicaid P4P Plan Recommendations sent; achieve approval by Steering Committee April 14, Core Team May 14
EOC – Create EOC Specifications a. Trigger and Length b. Scope of Services c. Scope of Providers d. Payment Model Components 1. Payment Allocation Model	Straw Men	Meeting 5-8	SIM/CONSULTANT	Ongoing	Recommendations sent; achieve approval by Steering Committee August 14, Core Team Sept 14 Learning Collaborative/Year One Program Launch October 1, 2014

VT Health Care Innovation Project
Payment Models Work Group Work plan

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
2. Design Penalties for Poor Performance 3. Design of Outlier Policy 4. Framework for Provider Participation in Year One Program and Assignment of Accountability 5. Implementation Plan for Transition to Bundled Payment e. Update Plan					
AUGUST					
ACO Program Update Plan Begins					

Att 5

What is an Episodes of Care Program?

The Basics: Framework for an EOC Program

What is an episode of care (EOC)?

All related services for:

- one patient
- a specific diagnostic condition
- from the onset of symptoms until treatment is complete

Bundled Payments for Care Improvement (BPCI) Initiative: General Information
http://innovation.cms.gov/initiatives/bundled-payments

Example from Arkansas

ADHD EOC

Patient Demographic: Ages 6 – 17

Episode trigger: Initial diagnosis ICD-9 codes 314x

Episode duration: 12 months

PAP: Psychiatrist or Clinical Psychologist

Episode services: All office visits, excluding initial assessment, medication management, psychotherapy and all pharmacy claims.

Episode quality measures: Continuing Care or Quality Assessment certification

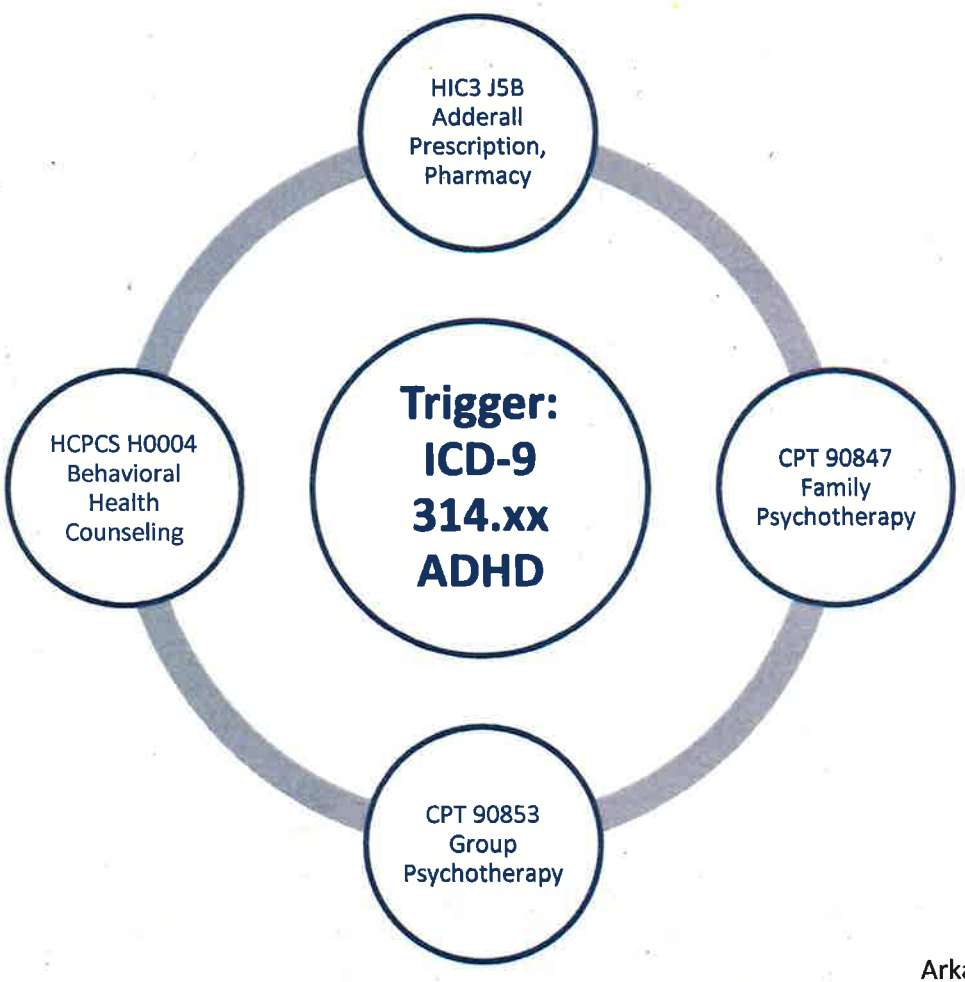
Exclusions: Behavioral Health comorbidity

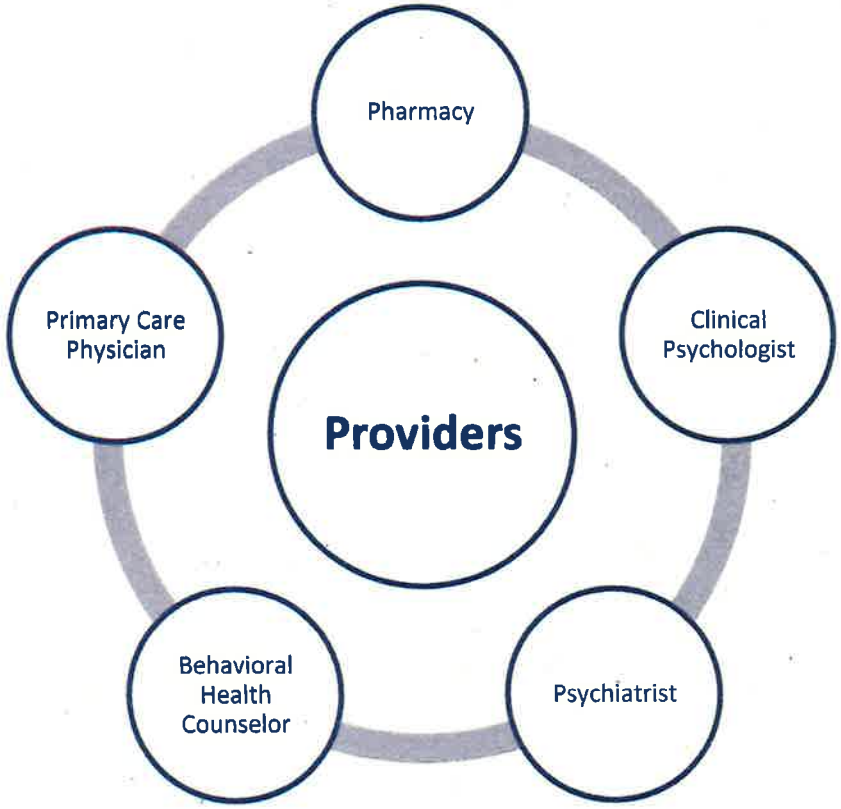
Payment: Depending on severity, patient will enter Track I or II which determines the threshold. Track 1 $1,547 - $2,223, Track 2 $5,403 - $7,112.

Arkansas Health Care Payment Improvement Initiative
http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example from Arkansas

ADHD EOC





Arkansas Health Care Payment Improvement Initiative
http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example from Arkansas

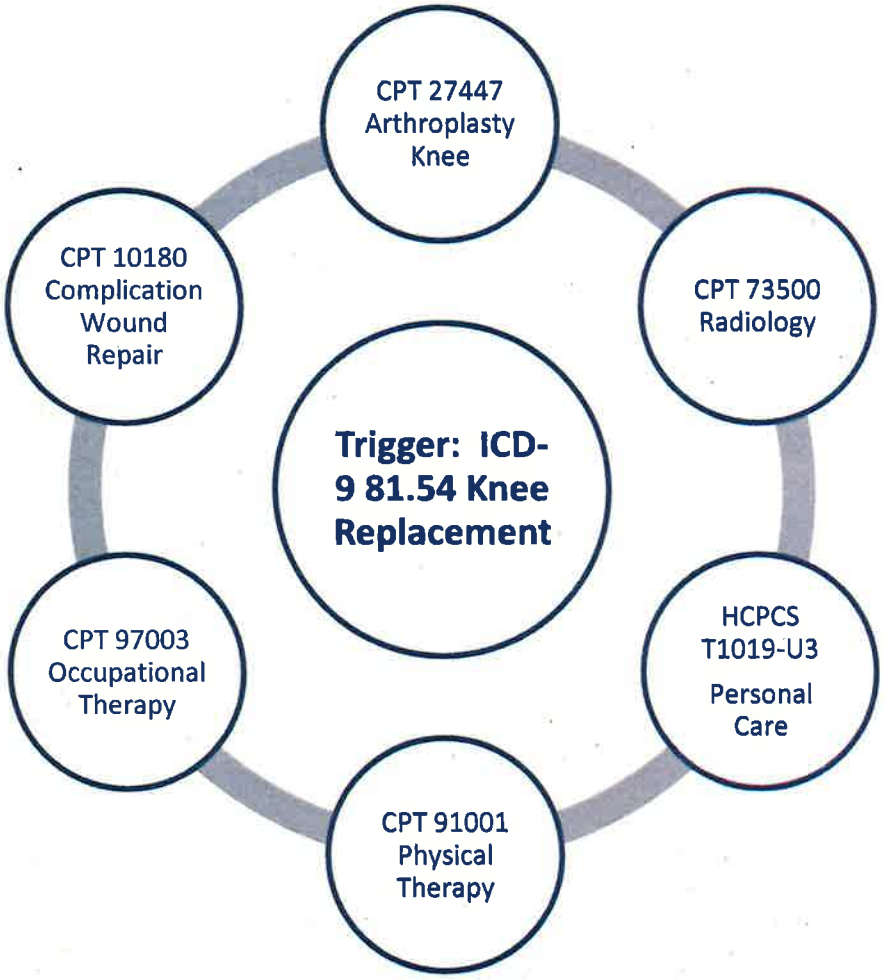
Hip or Knee Replacement EOC

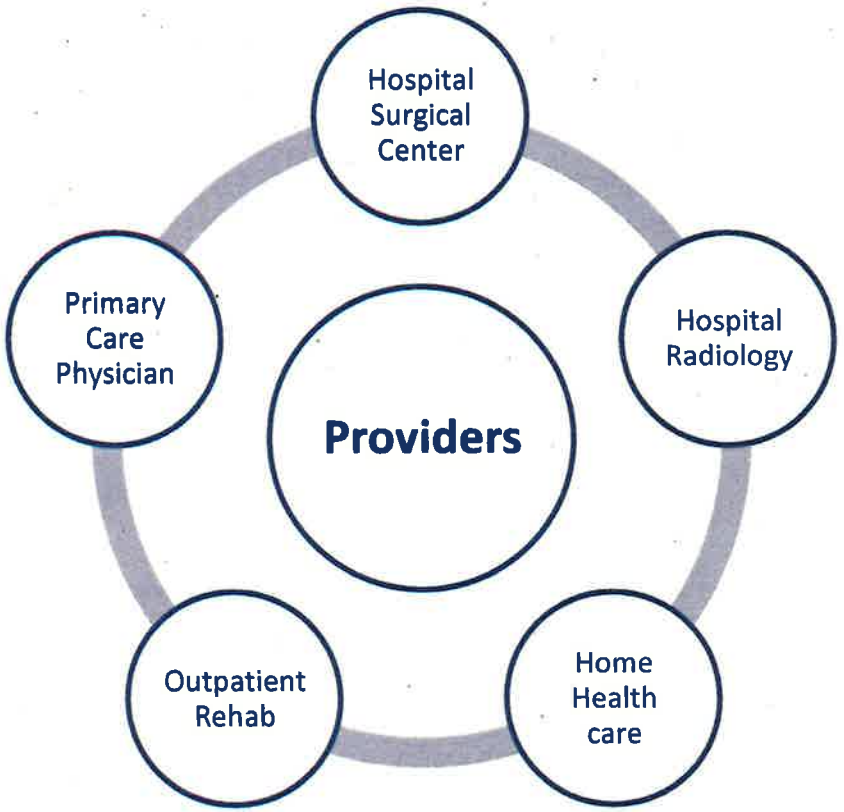
Patient Demographic: Ages 18-65
Episode trigger: A surgical procedure for total hip replacement or total knee replacement.
Episode duration: 30 days prior to admission to 90 days post discharge
PAP: Orthopedic surgeon
Episode services: all facility services, inpatient professional services, and rehabilitation services, as well as any hip/knee-related outpatient labs and diagnostics, outpatient costs, and medications.
Episode quality measures: Readmission rate, use of prophylaxis against post–op DVT / PE, diagnosis of post–op DVT/PE, wound infection rate
Exclusions: Comorbid conditions (e.g. cancer)

Arkansas Health Care Payment Improvement Initiative
http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example from Arkansas

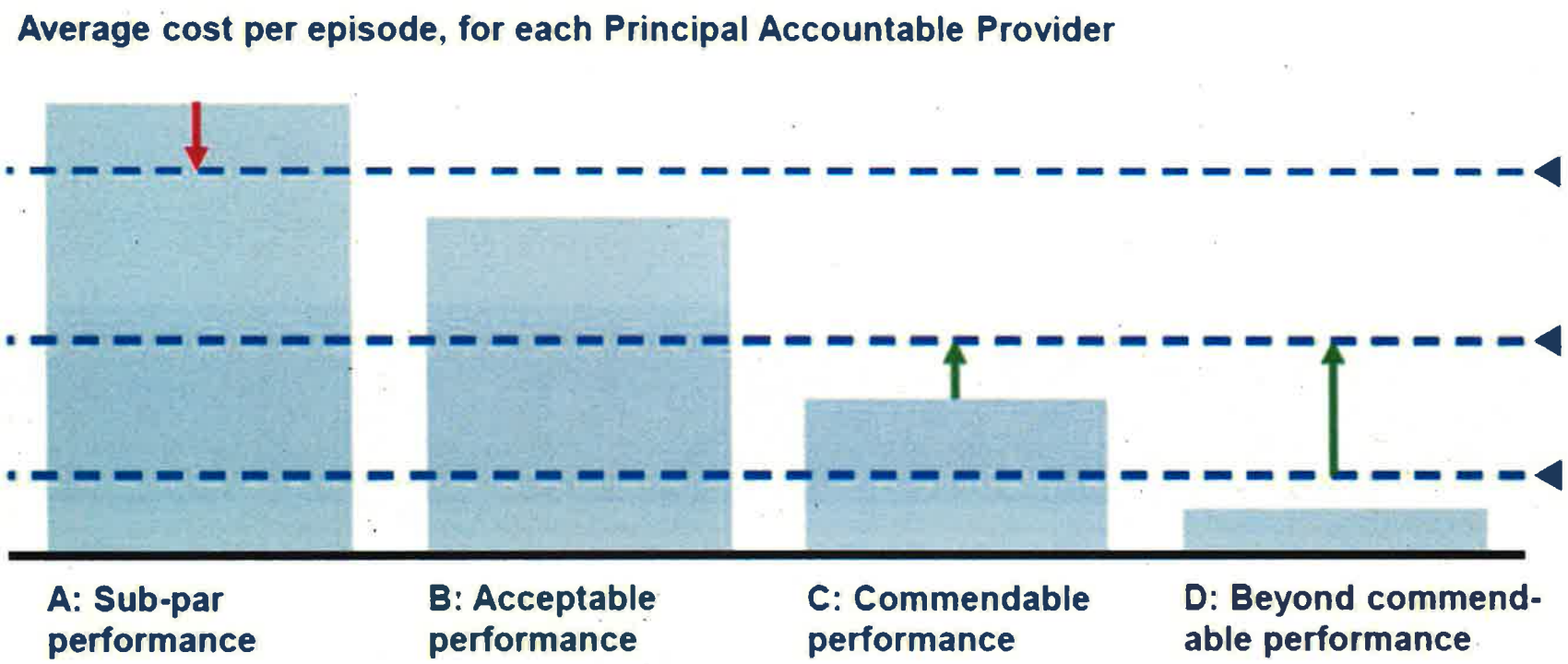
Hip or Knee Replacement EOC





Arkansas Health Care Payment Improvement Initiative
http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example from Arkansas



Why Invest in a Statewide Episodes of Care Program?

The Case for Implementation of an EOC Program

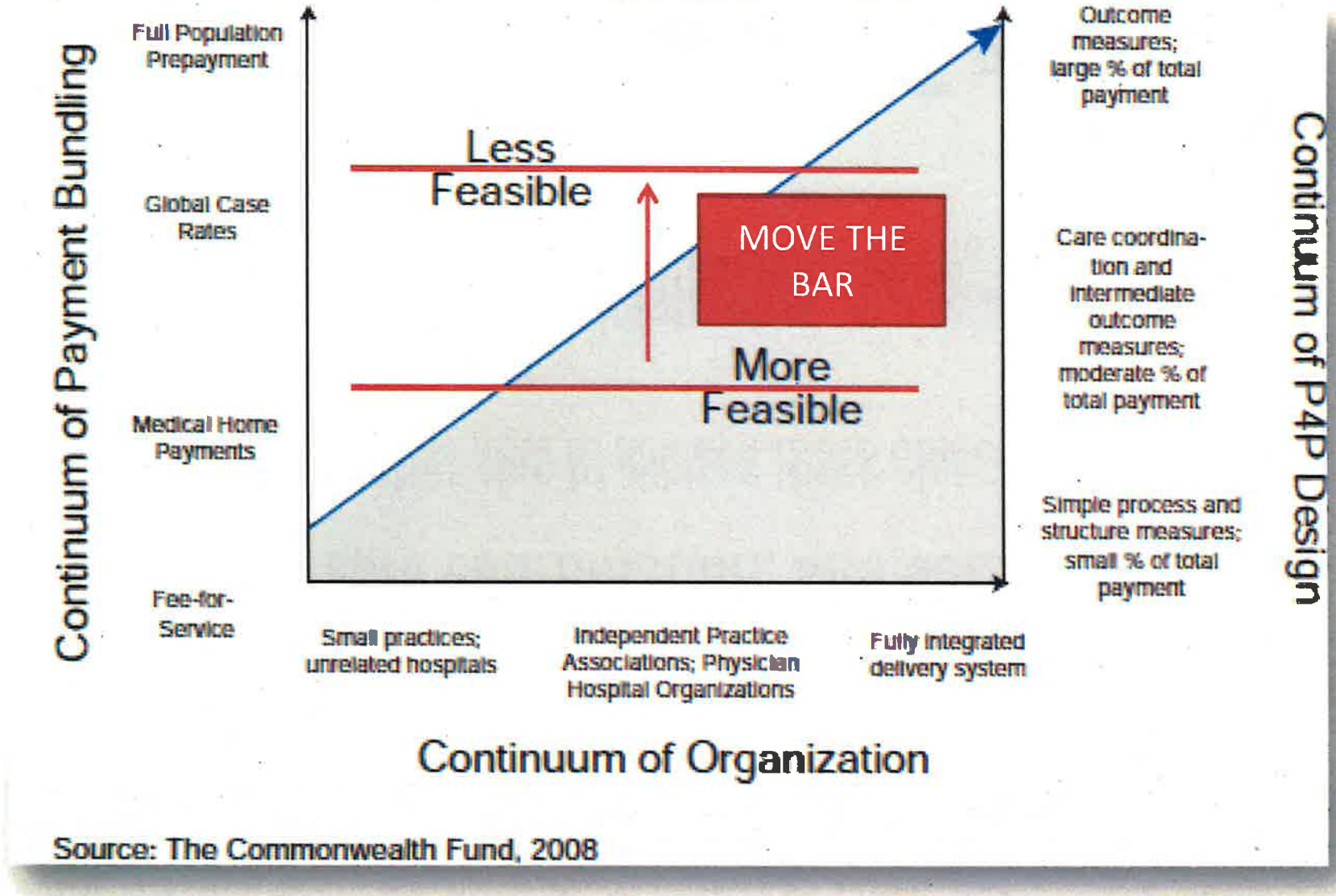
"The ultimate objective of any payment reform is to motivate behavioral change that leads to lower costs, better care coordination, and better quality.

Providers will be better able to achieve these objectives if the payment methodology:

- is clinically meaningful
- communicates actionable information in a form and at a level of detail sufficient to achieve sustainable behavior changes."

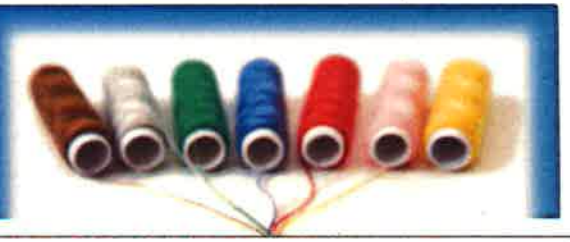
Cutler, David M., Ph.D., and Ghosh, Kaushik , Ph.D. (March 22, 2012) The Potential for Cost Savings through Bundled Episode Payments, *N Engl J Med 2012*; 366:1075-1077. DOI: 10.1056/NEJMp1113361

The Case for Implementation of an EOC Program



Source: The Commonwealth Fund, 2008

The Case for Implementation of an EOC Program



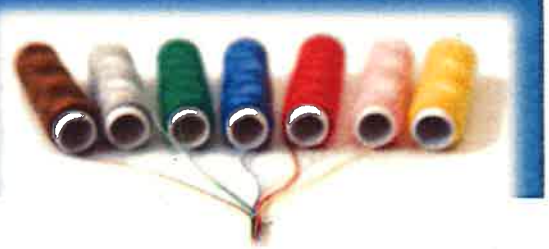
Aggregating payment into clinically meaningful episodes is an important step toward capitation

- Episodes of Care (EOCs) should be chosen based on defined criteria such as:
  - maximizing return on investment
  - evidence-based practice
  - operational feasibility
  - interest among payers and providers
  - opportunity for alignment with other existing pilots or programs

Bundled payments reward quality care and introduce risk to providers

- Incremental introduction of downside risk by converting to a bundled payment for the defined episode of care across payers.
- Scope of financial risk will be limited to subset of costs rather than total spending and therefore, providers bear performance risk but not insurance risk.

Importance of Quality in an EOC Program



Quality Monitoring and Evaluation (M&E) Activities Important

- Performance monitoring must protect against incentive to skimp on services.
- Should be incorporated into program integrity efforts.
- Penalties or other implications of poor performance need to be defined.

National and State Authorities

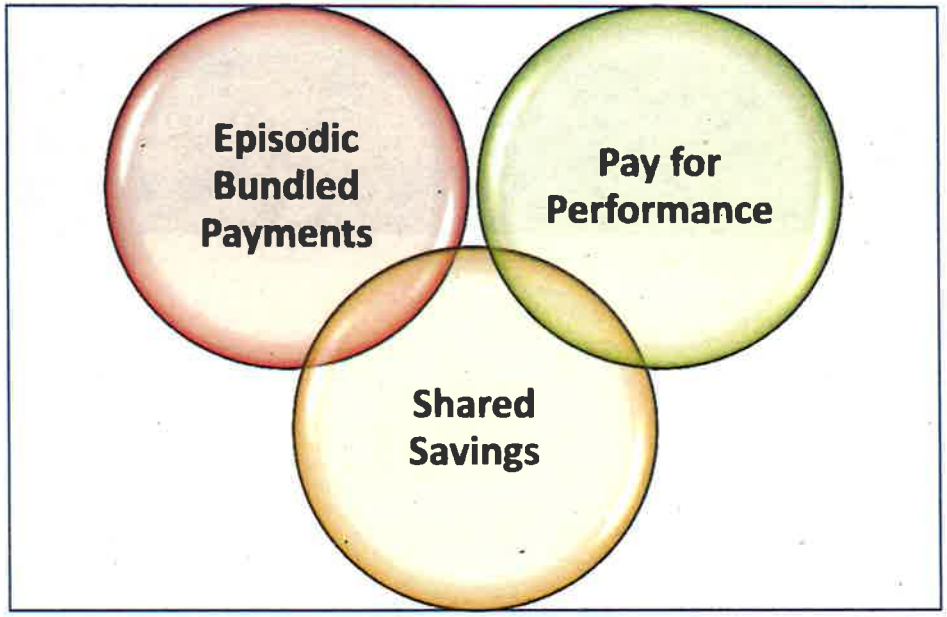
Section 3003 of the ACA requires that "The Secretary shall develop an *episode grouper* that combines separate but clinically related items and services into an episode of care for an individual, as appropriate."

Patient Protection and Affordable Care Act § 3003 Improvements to the Physician Feedback program, (2010)

One of three complementary payment models under VT's State Innovation Model Test Grant

Act 48

Global Commitment (Medicaid) Waiver



Vermont State Innovation Model Operations Plan. August 2013.

Current Evidence from Similar Programs

Experience of EOC Programs Around the Country

- Arkansas Health Care Payment Improvement Initiative
- CMS Bundled Payments for Care Improvement (BPCI) Program
- Medicare Acute Care Episode (ACE) Demonstration
- Prometheus
- Geisinger ProvenCare
- United Health
  - Optum "Centers for Excellence" Program

Recent Evidence in Commercial Sector

- Recent study found episode costs for a set of major medical procedures varied about 2.5-fold, and for a selected set of common chronic conditions, episode costs varied about 15-fold among 250,000 US physicians serving commercially insured patients nationwide.

- Among doctors meeting quality and efficiency benchmarks, however, costs for episodes of care were on average 14 percent lower than among other doctors.

- Some markets exhibited much higher variation in episode costs, but there was essentially no correlation between average episode costs and measured quality across markets.

- The overall analysis suggests that changing incentives through payment reforms [based on focusing on episodes of care] could help to improve performance, but providers are at different stages of readiness for such reforms and thus will often need support in order to succeed.

Health Affairs September 2012 vol. 31 no. 9 2084-2093
http://content.healthaffairs.org/content/31/9/2084.abstract?sid=ddb2e44c-68f5-4dbf-a1c9-deb747287fe9

Other Evidence

Positive Outcomes

Reduced length of stay between .5 – 1 day (ACE, ProvenCare)

Payer savings between 5% to 10% of benchmarked costs (ACE, ProvenCare, Medicare Participating Heart Bypass Center Demonstration)

Reduction in Beneficiary part B copayments (ACE)

Improved Clinical outcomes for CABG surgery and diabetes care (ProvenCare)

Reduced complications and 44% drop in readmissions among CABG patients (ProvenCare)

Negative Outcomes

PAC reduction of use of consulting providers due to complicated billing arrangements (ACE)

Medicare quality metrics have discrete service focus, and does not address care delivered across an entire episode. This hampers measurement and subsequent payments

Low willing provider participation, due to perceived drop in reimbursement (Medicare Cataract Alternative Payment Demonstration)

Retrospective PAP attribution problematic, providers bill with multiple or group tax IDs

Harriet L. Komisar, Judy Feder, and Paul B. Ginsburg, "Bundling" Payment for Episodes of Hospital Care Issues and Recommendations for the New Pilot Program in Medicare, July 2011 http://www.americanprogress.org/issues/2011/07/pdf/medicare_bundling.pdf
Cheryl L. Damberg, et all, Exploring Episode-Based Approaches for Medicare Performance Measurement, Accountability and Payment, Feb 2009

A Straw Man for Vermont?

Straw Man

Launch
Oct 2014

Year One

Focus on Episode of Care and Technical Assistance

Reward is upside only, by generating savings or improving performance

Year Two

Implement Bundled Payment Arrangements for EOCs

Reward is upside by generating savings or improving performance and downside by having to bear risk of costs exceeding paid bundle

EOCs Introduced on a rolling basis, target three EOCs

Straw Man

Step One

Patients seek care and select providers exactly as they do today

Step Two

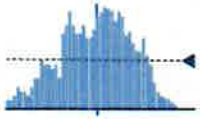
Providers submit claims and receive payment from providers exactly as they do today

Step Three

A 'Principal Accountable Provider' (PAP) is identified from the claims for each episode

Step Four

Costs per episode calculated for each PAP



Step Five

Compare episode costs to average state and national benchmarks and across payers and providers/PAPs

Step Six

Providers rewarded under the shared savings ACO and P4P programs

Step Seven

After year one, EOC converted to a bundled payment for services related to providers involved in the EOC

Penalties for poor performance

Role of the Payment Models Work Group

Recommended Payment Models Work Group Deliverables

1. Objectives of EOC Program
2. Universe of EOCs
3. Criteria for Selecting Episodes
4. Selection of the Episodes of Care
5. Specification of Episode of Care*
6. *Bundled Payment Approach*
    1. *Design Penalties for Poor Performance*
    2. *Design of Outlier Policy*
    3. *Framework for Provider Participation and Assignment of Accountability*
    4. *Implementation Plan for Transition to Bundled Payment*
7. Revision and Update Process Plan

*May be appropriate for convening sub-group of technical appointees due to need for knowledge of medical coding, diagnosis coding and clinical pathways.

Italics: indicate that tasks could be deferred to year 2

Example of Criteria

Example of Criteria for Selection of Episodes

Existing Frameworks, Episodes Selected and Timeline from Arkansas Program

Upper Respiratory Infection	October 1, 2012 to September 30, 2013
Perinatal	October 1, 2012 to September 30, 2013
ADHD	October 1, 2012 to December 31, 2013
Congestive Heart Failure	January 1, 2013 to December 31, 2013
Total Joint Replacement	January 1, 2013 to December 31, 2013
Cholecystectomy	October 1, 2013 to September 29, 2014
Colonoscopy	October 1, 2013 to September 29, 2014
Tonsillectomy	October 1, 2013 to September 29, 2014
ODD	January 1, 2014 to December 31, 2014
CABG	January 1, 2014 to December 31, 2014
PCI	January 1, 2014 to December 31, 2014
COPD	January 1, 2014 to December 31, 2014
Asthma	January 1, 2014 to December 31, 2014
ADHD/ODD Comorbid	First Quarter 2014
Neonatal	First Quarter 2013

Example of Criteria for Selection of Episodes

Exhibit 2.2: Physicians' performance in delivering quality care to children by condition, 2006-2008

Opportunities and successes by condition

Condition	Number of Providers	Opportunities	Successes	Success Ratio	10th Percentile	90th Percentile
Acute Sinustis	40,484	543,577	517,791	95.3%	82%	100%
Asthma	33,642	157,628	118,010	74.9%	0%	100%
Upper Respiratory Infection	33,184	143,506	119,480	83.3%	0%	100%
Pharyngitis	30,470	107,779	85,292	79.1%	0%	100%
Chlamydia Screening	37,594	71,867	25,140	35.0%	0%	100%
Diabetes	7,546	30,983	28,406	91.7%	50%	100%
Acute Otitis Externa	13,778	26,259	23,067	87.8%	30%	100%
Epilepsy	3,559	11,809	8,876	75.2%	0%	100%
Rheumatoid Arthritis	1,178	3,171	2,688	84.8%	0%	100%
Sickle Cell Anemia	785	2,998	2,134	71.2%	0%	100%
Medication Safety Monitoring	619	1,857	1,578	85.0%	33%	100%

"OPPORTUNITIES" & "SUCCESS RATIO"
LIKELIDHOOD OF IMPROVING PERFORMANCE

UnitedHealth Center for Health Reform and Modernization. Working Paper 8, December 2012.

Example of Criteria for Selection of Episodes

Relationship across markets between episode costs and care quality for diagnostic coronary artery catheterization

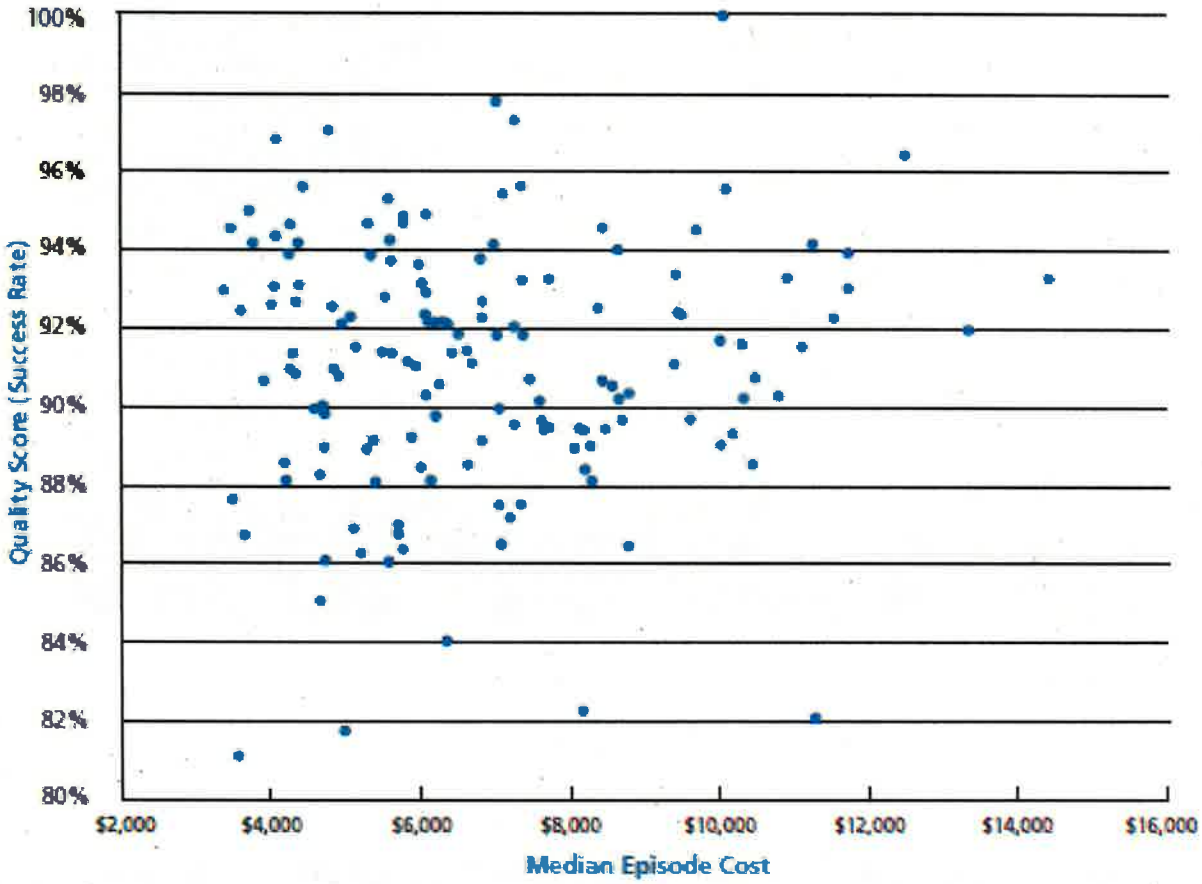
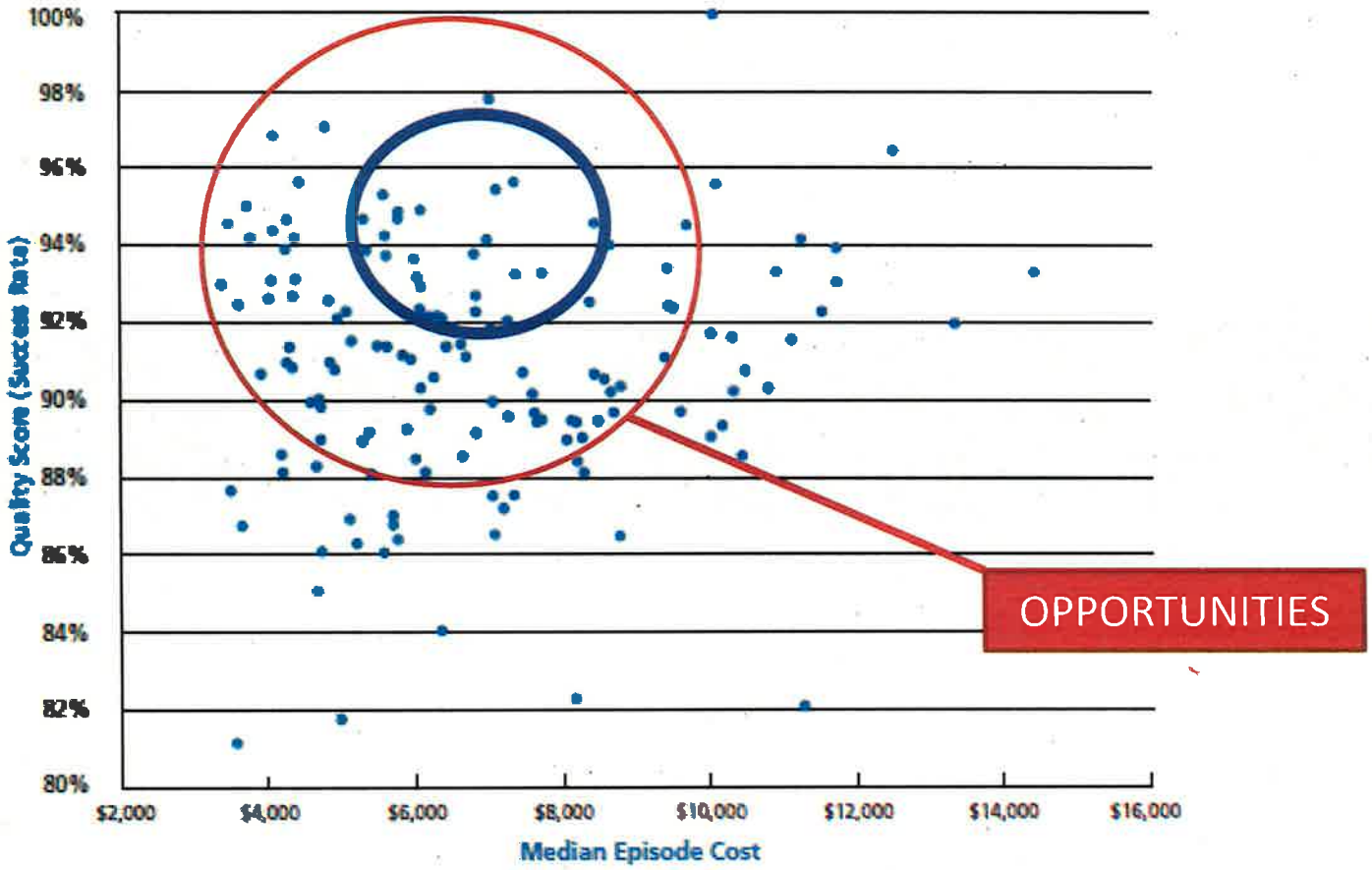


Figure 2.2; Source: UnitedHealth Group analysis of data from the UnitedHealth Premium Physician Designation Program (see endnote 15)
Note: Each point represents a hospital referral region, which is a widely used method to define markets for medical care; see Appendix A for further discussion.

MORE VARIATION, THE LARGER THE OPPORTUNITY

Example of Criteria for Selection of Episodes

Relationship across markets between episode costs and care quality for diagnostic coronary artery catheterization



MORE VARIATION, THE LARGER THE OPPORTUNITY

Figure 2.2; Source: UnitedHealth Group analysis of data from the UnitedHealth Premium Physician Designation Program (see endnote 15)
Note: Each point represents a hospital referral region, which is a widely used method to define markets for medical care; see Appendix A for further discussion.

Note animation was added to cited figure.

Role of the Staff, Consultants and other WG's in Supporting the Payment Models Work Group

Recommended Payment Models Work Group Webinars or Speakers

- Rutland CHF Bundle Payment Pilot Representative
- CMMI BPCI Representative
- Arkansas SIM/EOC Representative
- Medicare Acute Care Episode (ACE) Demonstration Representative
- Geisinger ProvenCare Representative
- Prometheus Representative
- CHCS or other SIM Technical Assistance Provider

Recommended Payment Models Work Group Deliverables

Deliverables that could be referred to other SIM workgroups.

Quality and Performance Work Group

- Quality and Performance Plan
- Monitoring and Evaluation Plan
- Revision and Update Process Plan

Care Models Work Group

- Provider Technical Assistance Plan: Learning Collaborative(s), Practice Facilitation, Tool Kits and Provider Reports

HIE Work Group

- Claims and Clinical Data Integration
- Reporting Plan to Support Quality and Performance Plan
- Coordination with Other HIE Initiatives

Example of Consultant & Staff Materials from Arkansas Program

2 Perinatal Care algorithm summary (1/3)

Medicaid Perinatal Care episode v1.0

Triggers	A live birth on a facility claim
PAP assignment	For each episode, the Principal Accountable Provider (PAP) is the provider or provider group that performs the delivery.
Exclusions	Episodes meeting one or more of the following criteria will be excluded: A. Limited prenatal care (i.e., pregnancy-related claims) provided between start of episode and 60 days prior to delivery B. Delivering provider did not provide any prenatal services C. Episode has no professional claim for delivery D. Pregnancy-related conditions: amniotic fluid embolism, obstetric blood clot embolism, placenta previa, severe preeclampsia, multiple gestation ≥3, late effect complications of pregnancy/childbirth, puerperal sepsis, suspected damage to fetus from viral disease in mother E. Comorbidities: cancer, cystic fibrosis, congenital cardiovascular disorders, DVT/pulmonary embolism, other phlebitis and thrombosis, end-stage renal disease, sickle cell, Type I diabetes
Episode time window	Episode begins 40 weeks prior to delivery and ends 60 days after delivery; for the initial performance period, only deliveries on or after Jan 1, 2013 will be eligible for episodes
Claims included	All medical assistance with a pregnancy-related ICD-9 diagnosis code is included. Medical assistance related to neonatal care is not included.
Quality measures	*Quality measures "to pass":* 1. HIV screening – must meet minimum threshold of 80% of episodes 2. Group B streptococcus screening (GBS) – must meet minimum threshold of 80% of episodes 3. Chlamydia screening – must meet minimum threshold of 80% of episodes *Quality measures "to track":* 1. Ultrasound screening 2. Screening for Gestational Diabetes 3. Screening for Asymptomatic Bacteriuria 4. Hepatitis B specific antigen screening 5. C-Section Rate
Adjustments	For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted to reflect risk and/or severity factors captured in the claims data for each episode in order to be fair to providers with high-risk patients, to avoid any incentive for adverse selection of patients and to encourage high-quality, efficient care. Episode reimbursement attributable to a PAP for calculating average adjusted episode reimbursement are adjusted based on these selected risk factors. Over time, Medicaid may add or subtract risk factors in line with new research and/or empirical evidence.

Arkansas Health Care Payment Improvement Initiative
http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example of Consultant & Staff Materials from Arkansas Program

Perinatal Care algorithm summary (2/3)

Medicaid Perinatal Care episode v1.0

Trigger codes	Each episode is anchored around a live birth. The live birth is identified by a claim with either of the following procedure codes and a ICD-9 V-code for live birth **CPT procedure codes:** 59618, 59620, 59622, 59514, 59515, 59510, 59610, 59612, 59614, 59409, 59410, 59400 **ICD-9 procedure code:** 74, 74.1, 74.2, 74.4, 74.99, 72, 72.1, 72.21, 72.29, 72.31, 72.39, 72.4, 72.51-72.54, 72.6, 72.71, 72.79, 72.8, 72.9, 73.5, 73.59 **ICD-9 V-code for live birth:** v270, v272, v273, v275, v276
Exclusion codes	List of prior diagnoses and meds that would disqualify a patient from the episode **ICD-9:** 250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.41, 250.43, 250.51, 250.53, 250.61, 250.63, 250.71, 250.73, 250.81, 250.83, 250.91, 250.93, 282.6x, 277.0x, 641.0x, 641.1x, 642.5x, 648.5x, 651.1x, 651.2x, 651.4x-651.9x, 652.6x, 655.3x, 670.2x, 670.3x, 671.3x-671.5x, 673.1x, 673.8x, 674.0x, 677.7x, 585.6, 228.x, 209.7x, 209.0x-209.3x, 209.7x, 140.x-208.x, 230.x-239.x These codes represent the set of business and clinical exclusions described previously
Codes to assign PAP	**CPT codes for delivery :** 59409, 59410, 59514, 59515, 59612, 59614, 59620, 59622 **ICD9 procedure codes for delivery:** 74, 74.1, 74.2, 74.4, 74.99, 72, 72.1, 72.21, 72.29, 72.31, 72.39, 72.4, 72.51, 72.52, 72.53, 72.54, 72.6, 72.71, 72.79, 72.8, 72.9, 73.5, 73.59 **CPT codes for global bundle:** 59400, 59510, 59610, 59618, 59425-59426
Reporting codes	CPT codes associated with each reporting metric **CPT codes for HIV test:** 80055, 84181, 84182, 86701, 86702, 86703, 87300, 87390, 87391, 87534, 87535, 87536, 87537, 87538, 87539 **CPT codes for GBS test:** 86403, 87070, 87071, 87075, 87077, 87081, 87147, 87149, 87449, 87653, 87797, 87798, 87800, 87801, 87802 **CPT codes for Chlamydia test:** 87110, 87270, 87320, 87451, 87490, 87491, 87492, 87797, 87798, 87799, 87800, 87801, 87810 **CPT codes for bacteriuria test:** 81002, 87086 **CPT codes for gestational diabetes test:** 82950 **CPT codes for Hep B test:** 80055, 80074, 86704, 86705, 86706, 86707, 87340, 87341, 87350, 87515, 87516, 87517 **CPT codes for ultrasound:** 76801, 76802, 76810, 76811, 76812, 76813, 76814, 76815, 76817, 76805, 76816, 76818, 76819, 76825, 76826, 76827, 76828 **CPT codes for C-section:** 59510, 59514, 59515, 59618, 59620, 59622

Arkansas Health Care Payment Improvement Initiative http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example of Consultant & Staff Materials from Arkansas Program

Perinatal Care algorithm summary (3/3)

Medicaid Perinatal Care episode v1.0

Included claim codes	List of ICD-9 and AHFS codes that should be included in episode **ICD-9:** 640-648, 650, 652, 655, 656, 659, 661, 670, 677, 6410-6413, 6418-6427, 6429-6432, 6438-6442, 6450-6453, 6460-6489, 6522, 6555, 6557, 6563, 6568, 6595, 6597, 6598, 6612, 64000, 64001, 64003, 64080, 64081, 64083, 64090, 64091, 64093, 64100, 64101, 64103, 64110, 64111, 64113, 64120, 64121, 64123, 64130, 64131, 64133, 64180, 64181, 64183, 64190, 64191, 64193, 64200-64204, 64210-64214, 64220-64224, 64230-64234, 64240-64244, 64250-64254, 64260-64264, 64270-64274, 64290-64294, 64300, 64301, 64303, 64310, 64311, 64313, 64320, 64321, 64323, 64380, 64381, 64383, 64390, 64391, 64393, 64400, 64403, 64410, 64413, 64420, 64421, 64500, 64501, 64503, 64510, 64511, 64513, 64520, 64521, 64523, 64600, 64601, 64603, 64610-64614, 64620-64624, 64630, 64631, 64633, 64640-64644, 64650-64654, 64660-64664, 64670, 64671, 64673, 64680-64684, 64690-64694, 64700-64704, 64710-64714, 64720-64724, 64730-64734, 64740-64744, 64750-64754, 64760-64764, 64780-64784, 64790-64794, 64800-64804, 64810-64814, 64820-64824, 64830-64834, 64840-64844, 64850-64854, 64860-64864, 64870-64874, 64880-64884, 64890-64894, 64900-64904, 64910-64914, 64920-64924, 64930-64934, 64940-64944, 64950, 64951, 64953, 64960-64964, 64970, 64971, 64973, 64981, 64982, 65100, 65101, 65103, 65110, 65111, 65113, 65120, 65121, 65123, 65130, 65131, 65133, 65140, 65141, 65143, 65150, 65151, 65153, 65160, 65161, 65163, 65170, 65171, 65173, 65180, 65181, 65183, 65190, 65191, 65193, 65200, 65201, 65203, 65210, 65211, 65213, 65220, 65221, 65223, 65230, 65231, 65233, 65240, 65241, 65243, 65250, 65251, 65253, 65260, 65261, 65263, 65270, 65271, 65273, 65280, 65281, 65283, 65290, 65291, 65293, 65300, 65301, 65303, 65310, 65311, 65313, 65320, 65321, 65323, 65330, 65331, 65333, 65340, 65341, 65343, 65350, 65351, 65353, 65360, 65361, 65363, 65370, 65371, 65373, 65380, 65381, 65383, 65390, 65391, 65393, 65400-65404, 65410-65414, 65420, 65421, 65423, 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V230-V234, V2341, V2342, V2349, V235, V237, V238, V2381-V2389, V239-V242, V260-V262, V2621 , V2622, V2629, V263, V2631-V2635, V2639, V2641, V2642, V2649, V265, V2651, V2652, V2681, V2682, V2689, V269-V277, V279, V28, V280-V286, V2881, V2882, V2889, V289, V617, V6511, V7240-V7242, V824, V8901-V8905, V8909 **AHFS:** 040000, 040404, 040408, 040412, 040416, 040420, 040492, 040800, 049200, 080800, 081202, 081206, 081207, 081208, 081212, 081216, 081218, 081220, 081224, 081228, 081404, 081408, 081416, 081428, 081432, 081492, 081600, 081604, 081692, 081804, 081808, 081820, 081824, 081828, 081832, 081840, 081892, 082000, 082400, 083004, 083008, 083092, 083600, 084000, 089200, 100000, 120400, 120804, 120808, 121200, 121204, 121208, 121212, 121600, 121604, 121608, 122000, 122004, 122008, 122012, 122020, 122092, 129200, 160000, 200404, 200408, 201204, 201214, 201218, 201220, 201600, 202400, 202808, 202816, 240400, 240404, 240408, 240492, 240600, 240604, 240605, 240606, 240608, 240692, 240800, 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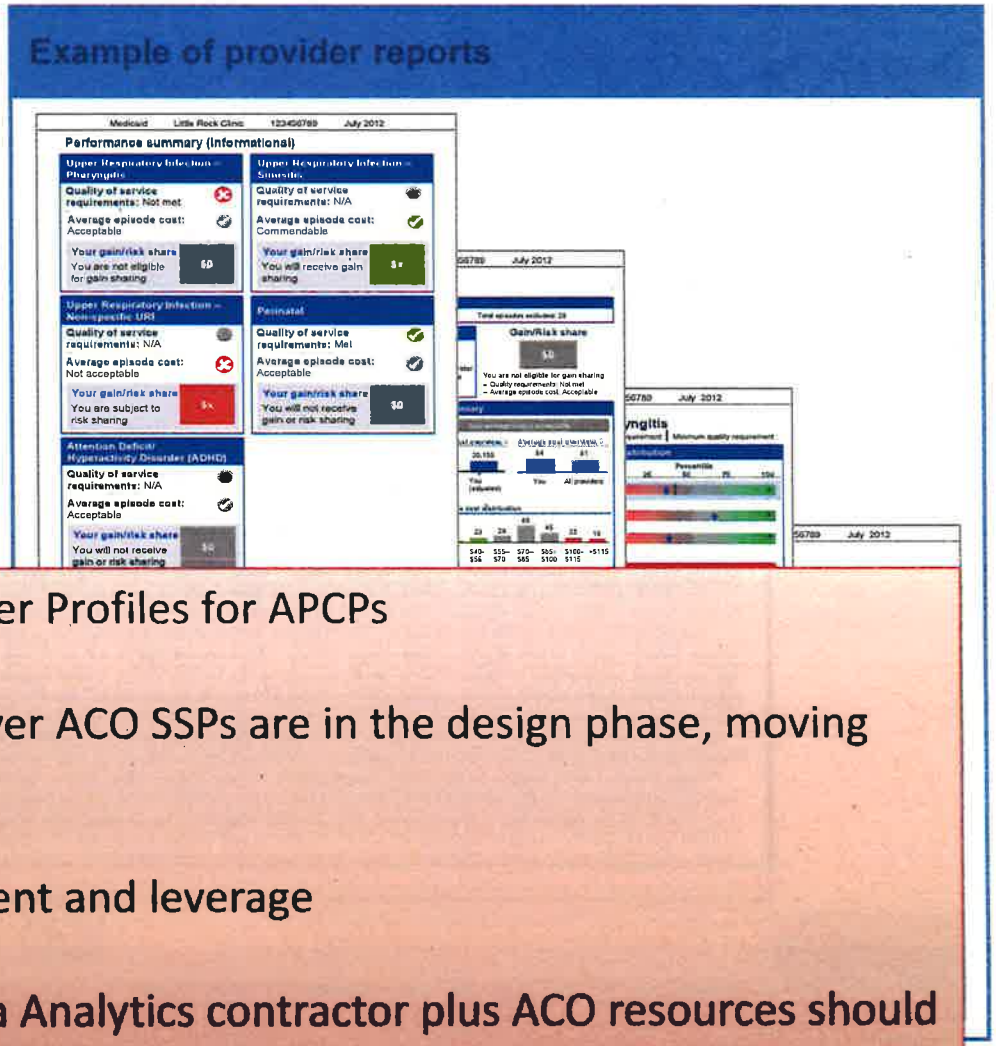
Arkansas Health Care Payment Improvement Initiative http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Example of Consultant & Staff Materials from Arkansas Program

Reports provide performance information for PAP's episode(s):

- Overview of **quality** across a PAP's episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP's average episode cost



Blueprint for Health Produces Provider Profiles for APCPs

Reports planned under the multi-payer ACO SSPs are in the design phase, moving towards finalization

Reports under EOC should complement and leverage

Current vendors, the State-wide Data Analytics contractor plus ACO resources should at minimum coordinate these activities

Arkansas Health Care Payment Improvement Initiative http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

DETAILS OF OTHER PROGRAMS

Arkansas SIM Model

Summary: Care delivery strategy for episode cased care delivery, evidence based, shared decision making, team based care coordination, and performance transparency. Use of one Principal Accountable Provider. Works with multiple payer participation.

Payments

Claims paid through FFS, then retrospective reconciliation and payment

Owner

Arkansas State Medicaid, through the CMMI SIM grant. Commercial Payer Participation

Timeline

Launched 2013, from 6 to 15 pilots by 2015

Provider Risk

Upside potential and downside risk based on average cost of care. Stop loss protection of 10%

Reference: Arkansas Health Care Payment Improvement Initiative
http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx

Bundled Payments for Care Improvement (BPCI) Program

Model 2: Retrospective Acute & Post Acute Care

Summary: ACA initiative designed to provider coordination comprised of 4 models focused on inpatient care with retrospective varying bundled payment arrangements.

Rutland Hospital is coordinating care for congestive heart failure (CHF) patients in Model 2.

Length

Either 30, 60, or 90 days after hospital discharge

Owner

One of four models sponsored by CMMI part of CMS

Payments

Claims paid through IPPS, then retrospective reconciliation and payment

Timeline

Phase 1 (January-July 2013), "no risk preparation" period

Phase 2, (July 2013 expected start), "risk-bearing implementation" period

Provider Risk

Upside potential and downside risk based on average cost of care

Reference: http://innovation.cms.gov/initiatives/bundled-payments/

Medicare Acute Care Episode (ACE) Demonstration

Summary: Care delivery strategy for episode cased care delivery, evidence based, shared decision making, team based care coordination, and performance transparency. Use of one Principal Accountable Provider. Works with multiple payer participation.

Payments

- Global Payment to PAP

Owner

- **Health Care Incentives Improvement Institute**

Beneficiary Incentive

- Medicare savings may cover beneficiary copays

Provider Risk

- Upside potential and downside risk based on average cost of care

Reference: Medicare's Acute Care Episode (ACE) demonstration project http://innovation.cms.gov/initiatives/ACE/

Prometheus

Summary: Risk adjusted prospective payment system. Use of one Principal Accountable Provider. Works with multiple payer participation. Uses 21 evidence-informed case rates, including inpatient, acute, chronic and outpatient, based on cost model not historical costings. Financial incentive to prevent avoidable complications through 'potentially avoidable complications' allowance payment.

Payments

Regionally adjusted EOC base payment ("evidence informed case rate") with retrospective adjustment.

Owner

Health Care Incentives Improvement Institute, with support from Robert Wood Johnson Foundation

Provider Risk

Upside potential and downside risk based on average cost of care

Reference: François de Brantes, M.S., M.B.A., Meredith B. Rosenthal, Ph.D., and Michael Painter, J.D., M.D., Building a Bridge from Fragmentation to Accountability — The Prometheus Payment Model,, *N Engl J Med* 2009; 361:1033-1036September 10, 2009DOI: 10.1056/NEJMp0906121 http://www.nejm.org/doi/full/10.1056/NEJMp0906121

Geisinger ProvenCare Process

Summary: Established evidence-based practices, risk-based pricing and patient engagement for Coronary Artery Bypass surgery. Fixed rate covers all services including complications. PAPs follow 40 clinical processes for all patients, ensure surgery is appropriate, shared decision-making process with the patient, and post-discharge follow-up to ensure compliance with medication and rehab.

Length

Begin 30 days prior to admission, end 90 days after discharge

Owner

Geisinger Health System

Timeline

Launched 2006, extended to 9 EOCs

Payments

Retrospective bundled DRG to PAP, who then pays other providers

Provider Risk

Upside potential and downside risk based on average cost of care

Reference: Geisinger ProvenCare http://www.geisinger.org/provencare/process.html