VT Health Care Innovation Project
Steering Committee Meeting Agenda

December 11, 2013 1:00-3:00 pm
ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:10	Welcome and Introductions	Al Gobeille and Mark Larson	Attachment 1: Agenda
2	1:10-1:15	Minutes Approval	Al Gobeille and Mark Larson	Attachment 2a: September Minutes Attachment 2b: October Minutes
3	1:10-1:20	Core Team Update	Anya Rader Wallack	
4	1:20-2:00	Reports from VHCIP Work Groups: 1. Payment Models Work Group (Don George, Steve Rauh, and Richard Slusky) 2. Quality and Performance Measures Work Group (Cathy Fulton)	Work Group Chairs	Attachment 3a: ACO Program Standards Attachment 3b: ACO Program Measures (powerpoint)
5	2:00-2:10	Discussion of Capacity Grant Program	Anya Rader Wallack	
6	2:10-2:20	Conflict of Interest Guidelines	Georgia Maheras	Attachment 4a: Conflict of Interest Policy Attachment 4b: Appendix of Vermont Conflict of Interest Policies

7	2:20-2:45	Briefing on Episodes of Care Program	Kara Suter	Attachment 5: Episode of Care Powerpoint
8	2:45-2:55	Public Comment	Al Gobeille and Mark Larson	
9	2:55-3:00	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille and Mark Larson	

VT Health Care Innovation Project
Steering Committee Meeting Minutes

Wednesday, September 18, 2013
2:00 p.m. – 4:00 p.m.

Co-Chairs, Al Gobeille and Mark Larson welcomed everyone to the meeting.

Presentation of Revised Commercial Shared Savings ACO Program Standards:

Richard Slusky, GMCB gave a presentation on proposed Commercial ACO Shared Savings Program Standards. The Commercial Shared Savings ACO is one of several models proposed under the SIM grant for implementation in Vermont. The goal is to have the Commercial SSP-ACO operational by January 1, 2014. The full presentation can be found at: http://gmcboard.vermont.gov/sites/gmcboard/files/ACO_Standards_Draft_Compilation_2013.pdf.The standards were developed and endorsed by the Vermont ACO Standards Work Group for review and consideration by the SIM Steering Committee, the SIM Core Team, and the GMCB. Richard outlined the key Commercial ACO Standards: Financial Stability, Risk Mitigation, Patient Freedom of Choice, Governance, Patient Attribution, Shared Savings and Payment Calculation, Care Management, Payment Alignment, and Data Use.

The Steering Committee discussed the proposed standards. These standards will be discussed again at the October Steering Committee meeting. *Key Comments/Concerns/Questions:*

- Commercial ACO will only attribute members in the Exchange which is disappointing because it only represents a subset. Why not all commercial business?
    - Identifiable population
    - Plan benefits are similar
    - Calculation of premiums known in a public setting
- Providers might not distinguish members attributed and capitalization costs will increase with a limited population.
- If the patients attributed must meet or exceed a minimum of 5K, what is the expected enrollment in the Exchange?
    - 105K
- How will quality measures be scored? As factors are being considered should there be a bias toward the ACO receiving money, as there is some concern that the quality metrics could wipe out savings and if overly aspirational it could discourage providers.
    - No decision has been made.
- Need for uniform standards regarding care management, how will roles be defined, reduce communications in order to increase efficiency. Entities providing case management would like some flexibility.
- Conflict of interest policy is missing from the narrative. What is “conflicted”, especially from a consumer prospective?

- How do we make decisions before all the pieces are in place? We shouldn't make decisions without more identification of concerns.
- Medicaid and Commercial ACOs are happening at the same time and there will be a need for in process changes and flexibility. Need to develop a process for mid-course changes and corrections.
- Would the Payer and ACO mediate through the GMCB?
- There needs to be fluidity in membership in work groups and a process for utilizing work group projects and resolving issues.

Debrief on CMS "Reverse Site Visit"and CMS Feedback on Vermont's Operational Plan, Update on Project Governance and Management:

Anya Rader Wallack gave a recap of the "Reverse Site Visit" and noted that CMS had some additional questions about the operational plan. The response to these questions is due by September 27, 2013.

Revised Medicaid Shared Savings ACO Program Standards:

Kara Suter, DVHA reviewed the comments received regarding the proposal for Medicaid ACO Program Standards, consumer representation in ACO governance and decision making, and provider representation in ACO governance and decision making. The Steering Committee discussed the revised Medicaid ACO Program Standards and determined that in order to move forward on the Medicaid ACO RFP process more work was needed on the role of the consumer in ACO governance. A sub-committee will form to deal with this issue and make recommendations to the Core Team. The Medicaid ACO Program Standards will next be reviewed by the Core Team. The RFP for this Program will be released once there is Core Team approval.

Key Comments/Concerns/Questions:

- Please explain the GMCB role on the contract. What would be some contract negotiation items?
- What services are included in total cost for care?
- What are capacity grants?
    - Established to provide money to support organizations - Business acumen
- Because total cost of care will change there is a need for clearer governance standards. It's very important to make sure that we engage the right providers to build the governance structure and the time to do it is in year one so that we can implement in year 2.
- Please quantify the non-care services.
    - Please submit any proposals on quantifying metrics.
- The ACO response time should be expanded from 30 days to 45 days for better relationship building and allow time for model development.
- Will there be quality measures in the RFP? Will be an addendum to RFP.
- Is there an open meeting law for Medicaid Governance?

- The consumer component should be consistent across all ACOs.

Presentation of Proposed Shared Savings ACO Performance Measures:

Pat Jones, GMCB reviewed the proposed performance measures for Vermont Commercial and Medicaid ACOs recommended for year one. The full presentation can be found at: http://gmcboard.vermont.gov/sites/gmcboard/files/Performance_Measures_Summary.pdf. The standards were developed by the ACO Measures Work Group. Due to limited agenda time, the Steering Committee was asked to send any questions regarding these measures to Pat Jones.

Key Comments/Concerns/Questions:

- Are some measures duplicated? How do we identify which ones are?
    - Measures will not be differentiated by source of payment.
- How will measures be reported? Reporting on measures may be difficult for providers. Will measures be reported on a sample or all attributed?
- HEI sub-group to help develop measures and review data system capacity.
- We need to be clear about year 2 impact of new measures.

The ACO Measures Work Group will continue its work on September 30th and the joint meeting of the ACO Standards and Performance Measures meets on October 7th. The Revised ACO Program Standards and Performance Measures will be ready for endorsement by October 16, 2013.

Discussion of Potential Measures for the Vermont SIM "Driver Diagram"

There was a brief discussion of the Driver Diagram. We will discuss this in more detail at the October Steering Committee Meeting.

Next Steps:

The next Steering Committee meeting will take place Wednesday, October 16th from 1:30 p.m. - 3:30 p.m. in the DVHA Large Conference Room at 312 Hurricane Lane.

SIM Steering Committee
Meeting Notes for
Wednesday, October 16, 2013

At approximately 1:30 p.m., Co-Chairs, Al Gobeille and Mark Larson welcomed everyone to the meeting.

General Project Update and Report from the Core Team:
Anya discussed:

- Conflict of Interest Policy – November rollout for Steering Committee and Work Groups
- Budget percentage allocated to Type 1 and Type 2 expenditures
- Grants Criteria – Core Team to review in November

Reports from Innovation Project Work Groups:

A. Payment Models – status update from Don George, update on the Commercial ACO Standards from Richard Slusky, update on Medicaid ACO RFP from Erin Flynn.
    a. *Key Comments/Questions:*
        i. Modify the preamble to reflect any workgroups instead of just successor work groups.
        ii. The model is too rigid with regard to implementation of downside risk.
B. Quality and Performance Measures – status update from Cathy Fulton
C. Duals Demonstration – no work product, status update only
D. Health Information Exchange – no work product, status update only
E. Care Models and Care Management – no work product, status update only
F. Population Health – No work product, status update only
G. Workforce Steering Committee – status update at November meeting of the Steering Committee.

Presentation of Commercial SSP Recommended Performance Measures:
Pat Jones, GMCB gave a presentation on proposed Commercial ACO Shared Savings Program Performance Measures. The measures were developed and endorsed by the Vermont ACO Measures Work Group for review and consideration by the SIM Steering Committee, the SIM Core Team, and the GMCB. Pat outlined the criteria for selecting measures, the work group's process, the measure sets, measure use terminology, recommended year 1 payment and reporting measures, as well as the potential impact of payment measures. The Steering Committee was invited to submit written comments on the Commercial and Medicaid ACO Shared Savings Measure Sets recommended by the ACO Measures Work Group.

    a. *Key Comments/Questions:*
        i. The measure set is too administratively burdensome.

ii. Do we have the capacity to report and collect of all of these measures electronically?
    1. This is being reviewed by the HIE/HIT Work Group.
iii. Can we move towards nutrition and exercise measures and tap into other entities who collect this type of information?

Steering Committee members were invited to submit written comments by the close of business on October 23rd. These comments will then be compiled for the Core Team.

Discussion of Potential Measures for the Vermont SIM "Driver Diagram":

Pat Jones, GMCB presented the Draft – Vermont "Driver Diagram" to the Steering Committee for comment.

Key Comments/Concerns/Questions:

The Driver Diagram is missing the bridge between population measures and patient measures.

What is the capacity to look at sub-populations?

The evaluation vendor should help with this.

What is the value for patients? There is a need to ground the Driver Diagram at a higher level because we get into the weeds quickly.

Adjournment:

At approximately 3:30 p.m., Al Gobeille ended the meeting with a reminder that the next Steering Committee meeting will take place Wednesday, November 20th from 1:30 p.m. - 3:30 p.m. in the DVHA Large Conference Room at 312 Hurricane Lane.

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.

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,

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;

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. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. 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.

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.

[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

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.

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.

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

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

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.

[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

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.

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

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**

Commercial and Medicaid Shared Savings Program: Year 1 Payment and Reporting Measures

Green Mountain Care Board

November 21, 2013

Outline

- Overview of decision points
- Review of Year 1 Payment and Reporting Measures
  - Discussion of new information since 10/10/2013
- Review of Proposal for Evaluation of Reporting Measures
- Review of proposed “Gate and Ladder” Methodology
- Review of recommendations from Core Team

GMCB Decision Points

GMCB Decision Points	New Information Since 10/10/2013 GMCB Measures Update
Proposed Year 1 Commercial and Medicaid Shared Savings Program payment and reporting measures	Yes
Proposal for evaluating reporting measures	Yes
Proposed "Gate and Ladder" methodology to determine impact of payment measures on shared savings	No

Recommended Core Measure Set: Measure Use Terminology

Payment

- Performance on these measures will be considered when calculating shared savings.

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings; ACO submission of the clinical data-based reporting measures may be considered when calculating shared savings.

Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect.

Recommended Year 1 Payment Measures
(Claims data)

Commercial and Medicaid Shared Savings Programs:

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*

Medicaid Shared Savings Program:

- Developmental Screening in First 3 Years of Life

*Related to Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Claims data)

Commercial and Medicaid Shared Savings Programs:

- Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults*
- Breast Cancer Screening*
- Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
- Appropriate Testing for Children with Pharyngitis

*Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Clinical Data)

Commercial and Medicaid Shared Savings Programs:

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
  - HbA1c control*
  - LDL control*
  - High blood pressure control*
  - Tobacco non-use*
  - Daily aspirin or anti-platelet medication*
- Diabetes HbA1c Poor Control*
- Childhood Immunization Status
- Pediatric Weight Assessment and Counseling

*Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Survey Data)

Patient Experience Survey Composite Measures (using same survey fielded by about 70 Blueprint primary care practices):

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care

New Information: Year 1 Commercial and Medicaid Shared Savings Program Payment and Reporting Measures

- The Depression Screening by 18 Years of Age was removed from the Medicaid Shared Savings Program Year 1 Payment Measures.
  - Medicaid claims analysis revealed that providers are not using this code and that data collected on the measure would be inaccurate.
  - The Quality and Performance Measures Work Group was informed that this measure could not be reported on accurately.
  - Screening for Clinical Depression and Follow-Up Plan for persons 12+ is a Year 1 Reporting Measure and MSSP Measure.

New Information: Proposal for Evaluation of Reporting Measures

Proposal from VHCIP Quality and Performance Measures Work Group if measure set not substantively changed; supported by Core Team:

- ACO will make good faith effort to submit all reporting measures completely and in timely manner.
- Reporting will include analysis of barriers and costs to reporting, and plan to mitigate barriers. GMCB will provide guidelines for content and format of analysis and plan.
- Failure to report will have no financial consequences in Year 1 if ACO makes good faith effort to report all measures.
- Recommendations for Years 2 and 3 will be made by Work Group to Core Team and GMCB after considering barriers and costs identified during Year 1.

Impact of Payment Measures: Commercial

Commercial "Gate and Ladder" Approach:

- Compare each payment measure to national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile.

- If ACO does not achieve at least 55% of maximum available points across all payment measures, it is not eligible for any shared savings ("quality gate").

- In proposed commercial SSP "quality ladder," ACO earns:
  - 75% of potential savings for achieving 55% of available points,
  - 85% of potential savings for achieving 65% of available points,
  - 95% of potential savings for achieving 75% of available points.

Commercial Shared Savings Program Ladder (proposed)

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

Impact of Payment Measures: Medicaid

Medicaid "Gate and Ladder" Approach:

- For most measures, compare each payment measure to national benchmark and assign 1, 2 or 3 points based on whether ACO is at national 25th, 50th or 75th percentile.
- For two measures without national Medicaid benchmark (All-Cause Readmission and Developmental Screening), compare each payment measure to VT Medicaid benchmark, and assign 0, 2 or 3 points based on whether ACO performance declines, stays the same, or improves relative to benchmark.
- If ACO does not achieve at least 35% of maximum available points across all payment measures, it is not eligible for any shared savings ("quality gate").
- In proposed commercial SSP "quality ladder," ACO earns:
  - 75% of potential savings for achieving 35% of available points,
  - 85% of potential savings for achieving 45% of available points,
  - 95% of potential savings for achieving 55% of available points.

Medicaid Shared Savings Program Ladder
(proposed)

Percentage of available points	Percentage of earned savings
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

GMCB Decision Points and VCHIP Core Team Recommendations

GMCB Decision Points	VCHIP Core Team Recommendation
Proposed Year 1 Commercial and Medicaid Shared Savings Program payment and reporting measures	Adopt, with the caveat that the VHCIP Quality and Performance Measures Work Group explores adding a substance abuse screening measure to the Payment and Reporting Measure Set
Proposal for evaluating reporting measures	Adopt
Proposed "Gate and Ladder" methodology to determine impact of payment measures on shared savings	Adopt

Work Group Process

- Over the course of nine months (January 2013-October 2013), the multi-stakeholder ACO Measures Work Group engaged in an intensive and inclusive process.

- The Work Group met approximately every two weeks to identify measures and recommend the impact of the selected measures on payment.

Work Group Process (continued)

Work Group members:

- Created "crosswalk" of over 200 measures from numerous measure sets, including the Medicare Shared Savings Program measure set
- Identified priority measures for consideration
- Focused on measures in various domains, with national specifications, with benchmarks, and with opportunities for improvement
- Eliminated measures through application of agreed-upon criteria and extensive discussion
- Expressed support for and concerns about measures
- Compromised
- Expressed widespread support, but not unanimity (see comments)

CONFLICT OF INTEREST POLICY

For

VERMONT HEALTH CARE INNOVATION PROJECT (VHCIP) CORE TEAM, STEERING COMMITTEE AND WORK GROUPS

I. PURPOSE

The purpose of this Conflict of Interest Policy is to ensure the independence and impartiality of the VHCIP Governance Structure, including the Core Team, Steering Committee and Work Groups ("the Committee") when it is contemplating entering into a transaction or arrangement that might benefit the private interest of any Core Team, Steering Committee or work group member. Nothing in this policy shall relieve any person from compliance with additional conflict of interest policies such as the Executive Code of Ethics, state personnel policies, and Agency of Administration bulletins, including but not limited to Bulletin 3.5, Contracting Procedures.

II. DEFINITIONS

1. Interested person: Any member or subcommittee member or other individual in a position to exercise influence over the affairs of the Committee who has a direct or indirect interest, as defined below, is an "interested person."

2. Interest: A person has an "interest" if the person has, directly or indirectly, through business, investment, or family:

    a. An ownership or investment interest in any entity with which the Committee has an transaction or arrangement or is negotiating a transaction or arrangement, or

    b. A compensation or other pecuniary arrangement with the Committee or with any entity or individual with which the Committee has a transaction or arrangement or is negotiating a transaction or arrangement, or

    c. A potential ownership or investment interest in, or compensation or pecuniary arrangement with any entity or individual with which the Committee is negotiating a transaction or arrangement, or

    d. Any other relationship that the person determines may compromise his or her ability to render impartial service or advice to the Committee.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

An interest is not necessarily a conflict of interest and a conflict of interest does not arise where an individual's interest is no greater than that of other persons generally affected by the outcome of the matter.

III. PROCEDURES

1. Duty to Disclose: Any interested person must disclose the existence of his or her interest to the Committee and shall be given the opportunity to disclose all material facts to the Committee.

2. Duty to Voice Concerns: In the event any member becomes concerned that an interested person has an undisclosed interest or is exerting inappropriate influence related to an interest, this concern shall be raised with the Chair of the Core Team and the VHCIP Project Director.

3. Determining Whether a Conflict of Interest Exists: After disclosure of the interest and all material facts, and after any necessary discussion with the interested person, the Core Team shall determine whether the person has a conflict of interest that requires the interested person to remove him or herself from the matter under consideration. In no event shall an interested person participate in the deliberation and/or determination of any matter in which he or she will receive any compensation from the Committee for employment, professional contract, or otherwise.

4. Restriction on Participation: It shall be the responsibility of the Project Director to instruct an interested person on any restriction on his or her participation in any consideration of the subject matter of the conflict of interest, and it shall be the responsibility of the Project Director and all non-interested members of the Committee to enforce such restrictions.

5. Procedures for Addressing the Conflict of Interest:

    a. An interested person shall leave any Committee meeting during discussion of, and the vote on, any transaction or arrangement that involves a conflict of interest and shall otherwise not participate in the matter in any way.

    b. If necessary, the Chair of the Core Team shall appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

    c. After exercising due diligence, including consideration of independent comparability data, valuations, estimates, or appraisals, the Committee shall determine whether the Committee can obtain a more advantageous transaction or arrangement with reasonable effort from a person or entity that would not give rise to a conflict of interest.

    d. If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Core Team shall determine by majority vote (or quorum) of all of the disinterested members (regardless of the number present at the meeting): (1) whether the transaction or arrangement is in the public's best interest, (2) whether the transaction or arrangement is fair and reasonable to the Committee, and (3) whether to enter into the transaction or arrangement consistent with such determinations.

6. Records of Proceedings: The minutes of the Committee or affected sub-committee shall contain:

    a. The names of the persons who disclosed or otherwise were found to have an interest in connection with an actual or possible conflict of interest.

    b. The names of the persons who were present for the discussion and votes relating to the transaction or arrangement, the content of the discussion, including a summary of any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the discussion.

7. Violations of the Conflict of Interest Policy:

    a. If the Committee has reasonable cause to believe that an interested person has failed to disclose actual or possible conflicts of interest, it, through the Co-Chairs, shall inform the Core Team and the Core Team shall afford him or her an opportunity to explain the alleged failure to disclose.

    b. If, after hearing the response of the person and making such further investigation as may be warranted under the circumstances, the Core Team determines that he or she has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate action.

IV. ANNUAL STATEMENTS

a. Each Committee member shall annually sign a statement which affirms that he or she has received a copy of this Conflict of Interest Policy, has read and understands the Policy, and has agreed to comply with the Policy (Attachment A).

V. COMPLIANCE AND PERIODIC REVIEWS:

The Core Team shall make periodic reviews of compliance with this policy.

Adopted by the VHCIP Core Team

Date:

Attachment A:

CONFLICT OF INTEREST POLICY ACKNOWLEDGEMENT

I, _____, a participant in the Vermont Health Care Innovation Project (VHCIP) Grant governance process, acknowledge having received, read, and understood the VHCIP Grant Conflict of Interest Policy dated _____, and agree to adhere to it.

Date: _____ Signature: _____

Name: (print) _____

Appendix: Summary of State Conflict of Interest Policies

Bulletin 3.5 – Applies to all state contracts

"Conflict of interest"- a pecuniary interest of an employee, or the appearance thereof, in the award of performance of a contract, or such an interest, known to the employee, by a member of his/her current or former family or household, or a business associate.

B. Conflict of Interest

Employees with a conflict of interest or an appearance thereof are not permitted to control or influence the bidding process and/or the awarding of contracts. The Executive Code of Ethics (Executive Order #3-45) sets standards that should be used as the primary guide. Additionally, every effort should be made to avoid even an appearance of a conflict of interest in the contracting process. (See Section VI.A.3.c for more discussion of this issue).

VI.A.3.c. Apparent conflict of interest: If a reasonable person might conclude that a contractor was selected for improper reasons, the supervisor should disclose that fact in writing to the Attorney General and the Secretary and document the reasons why selecting the desired contractor is still in the best interest of the State.

VI.D.2. Waivers

The Secretary may waive provisions of this Bulletin on a case-by-case basis pursuant to a written request forma supervisor. Any such request must describe in detail the basis for the request an the specific component(s) of the contracting process for which the waiver is sought and must be granted prior to the signing of the contract by either the State of the contractor. Copies of all waivers granted by the Secretary, and the request submitted therefore, must be retained in the contract file.

Bulletin 5.0 – Applies to all federal grants

"Conflict of interest" means a pecuniary interest of an employee in the award or performance of the grant, or such an interest, known to the employee, by a member of his/her immediate family or household or a business associate.

VII. Conflict of Interest

Employees with a conflict of interest shall not be permitted to control or influence the award of grants. This applies to members of any boards who are involved in any review or selection process for grants. Additionally, every effort should be made to avoid the "appearance" of a conflict of interest in the granting process. An appearance of a conflict is anything that would lead a reasonable person to question whether this grantee was selected for improper reasons.

Bulletin 5.5 – state funded grants – doesn't technically apply, but is illustrative

Conflict of Interest: Employees with a conflict of interest shall not be permitted to control or influence the award of grants. This applies to members of any boards who are involved in any review or selection process for grants.

"conflict of interest" means a pecuniary interest of an employee in the award or performance of the grant, or such an interest, known to the employee, by a member of his/her immediate family or household or a business associate. Additionally, every effort should be made to avoid the "appearance" of a conflict of interest in the granting process. An appearance of a conflict is anything that would lead a reasonable person to question whether this grantee was selected for improper reasons.

Waivers: The Secretary may waive provisions of this Bulletin on a case-by-case basis pursuant to a written request from a supervisor. Any such request must describe in detail the basis for the request and the specific components(s) of the granting process for which the waiver is sought and must be granted prior to the signing of the grant agreement by either the state or the grantee. Copies of any and all waivers approved must be included in the grant file.

Episodes of Care 101

December 10, 2013

Kara Suter

Director of Payment Reform,

Department of Vermont Health Access

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.

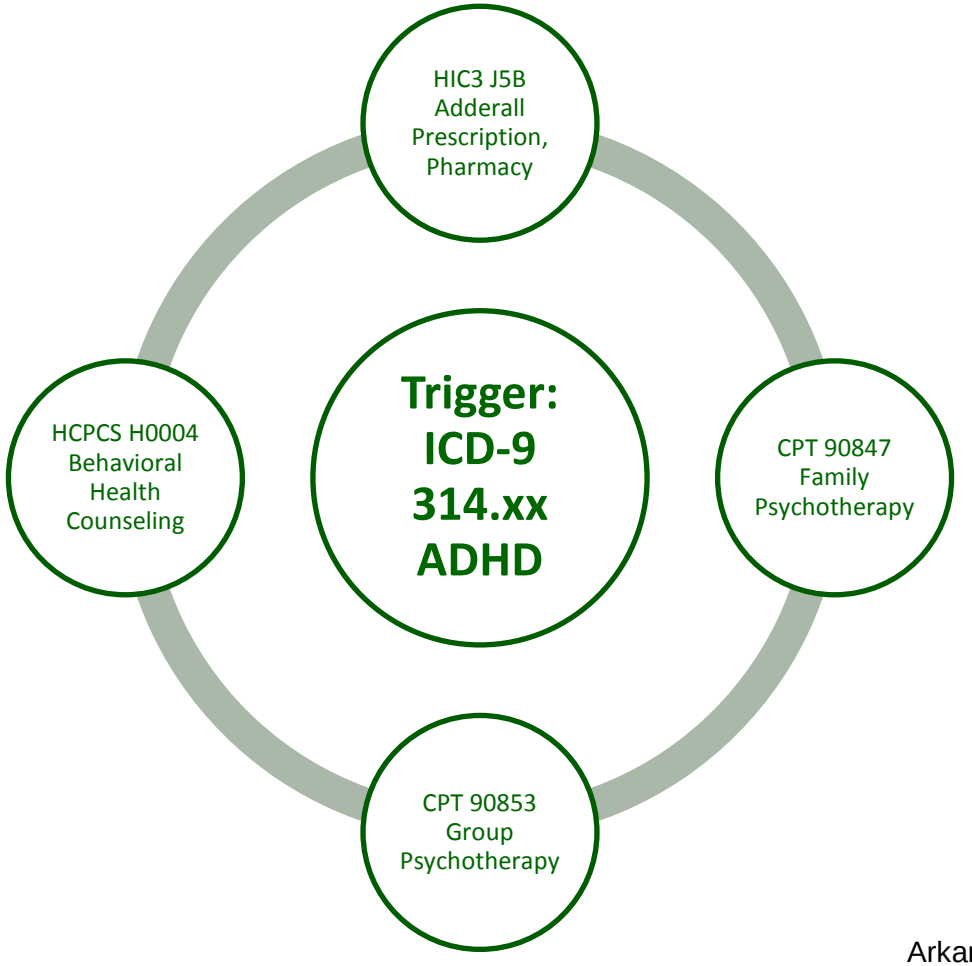
Episode quality measures: Continuing Care or Quality Assessment certification

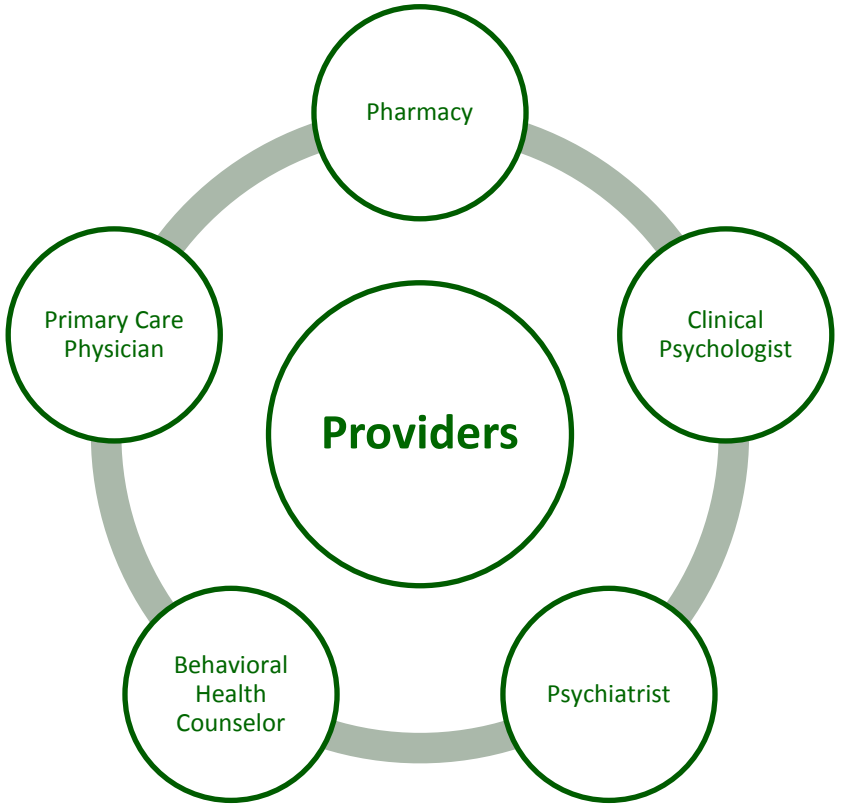
Exclusions: Behavioral Health comorbidity

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





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

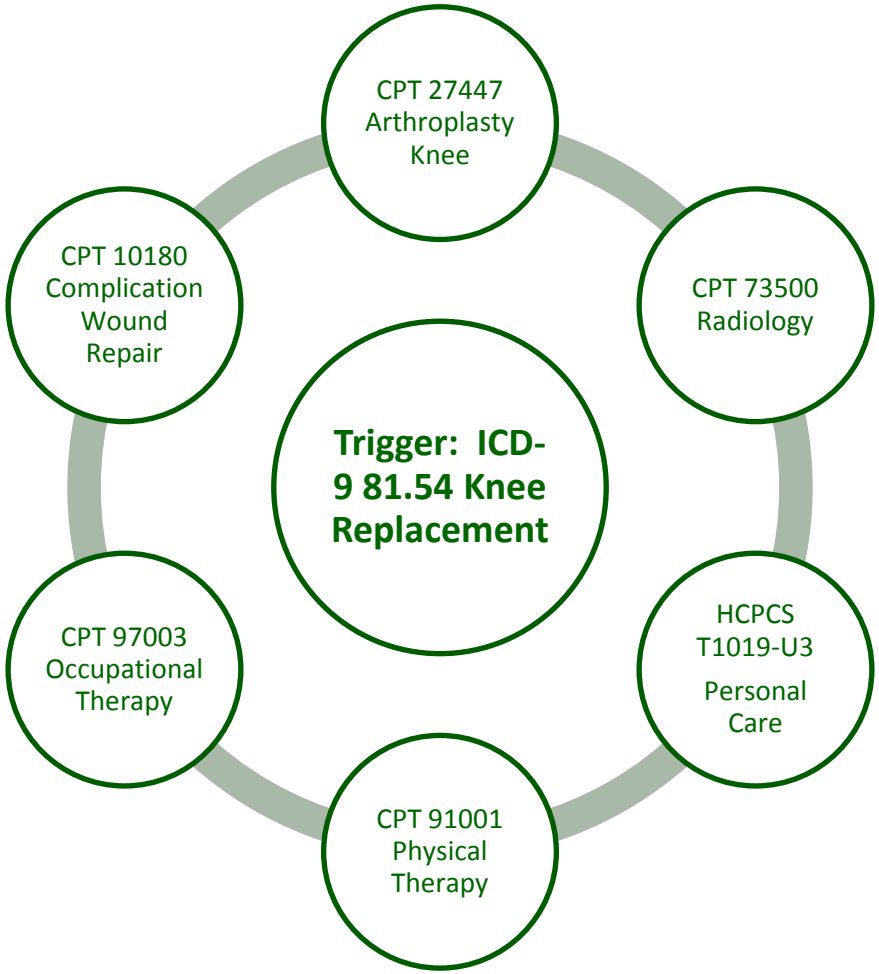
Example from Arkansas

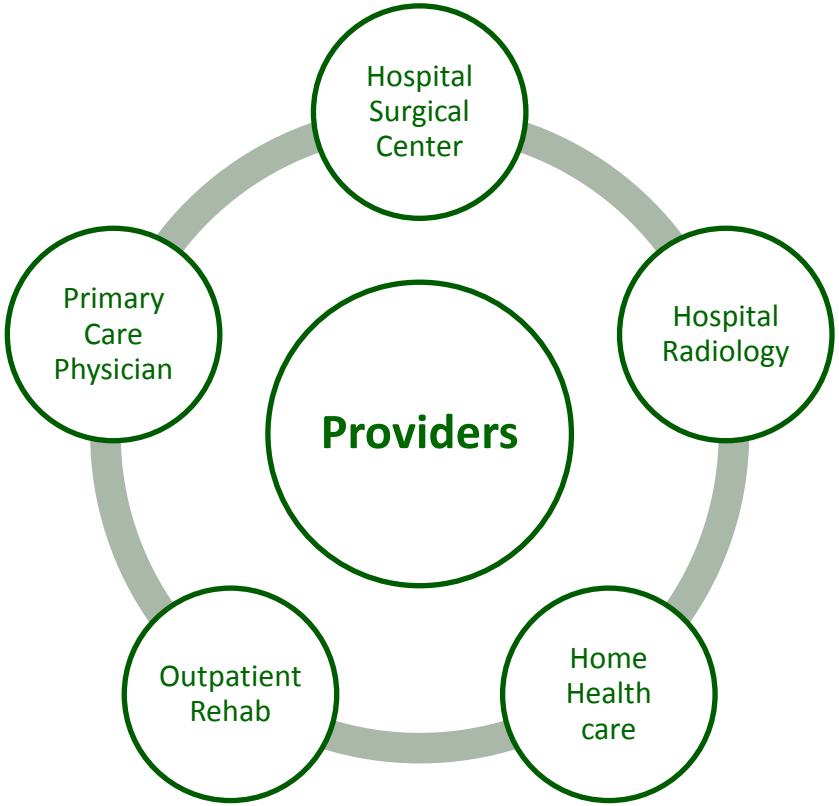
Hip or Knee Replacement EOC

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

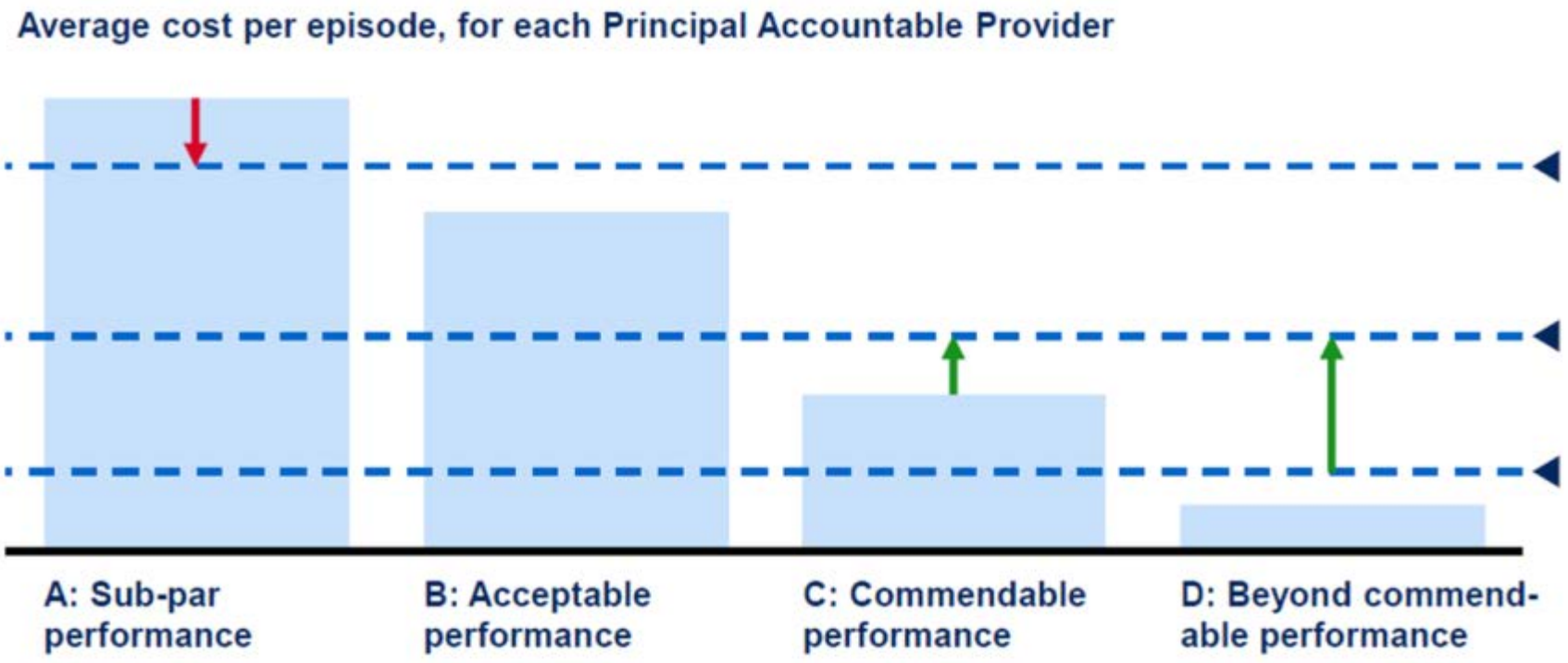
Example from Arkansas





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

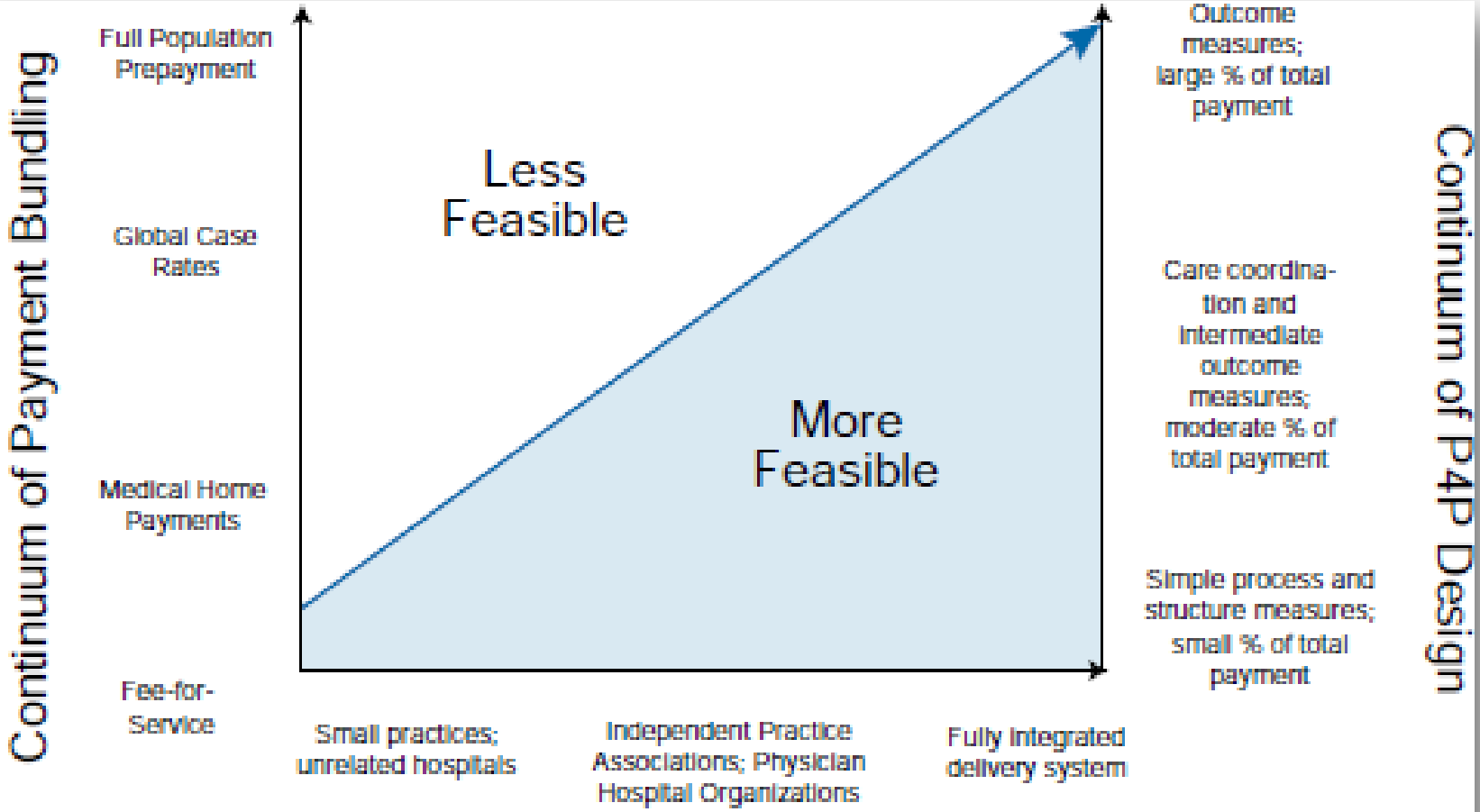
"The ultimate objective of any payment reform is to motivate behavioral change that leads to lower costs, better care coordination, and better quality.

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

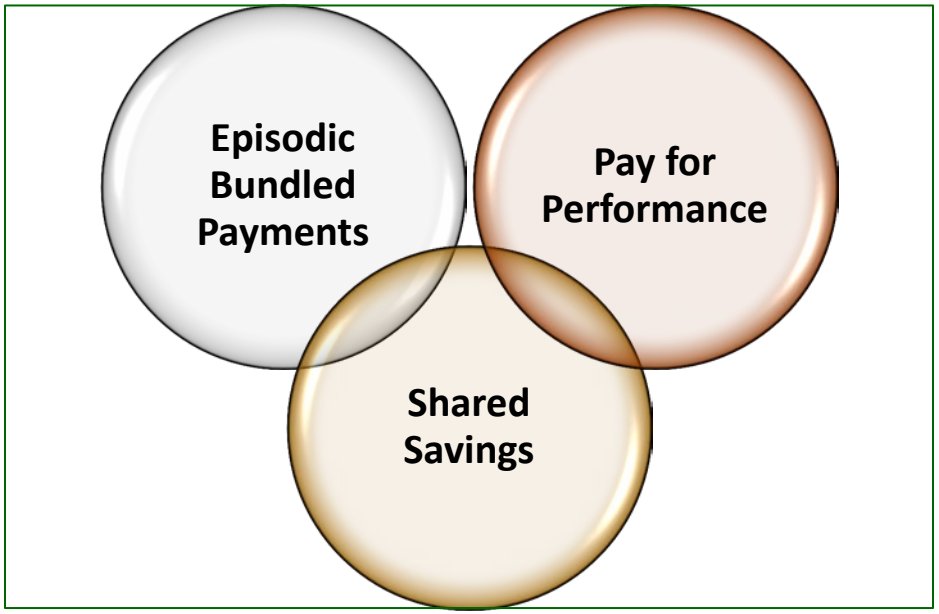
Section 3003 of the ACA requires that "The Secretary shall develop an *episode grouper* that combines separate but clinically related items and services into an episode of care for an individual, as appropriate."

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

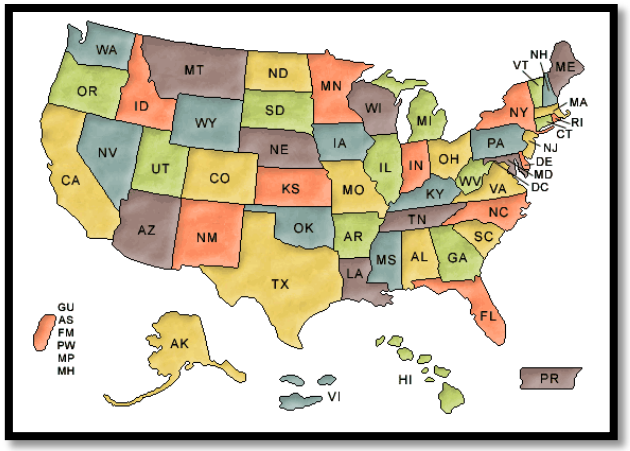


Vermont State Innovation Model Operations Plan. August 2013.

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.

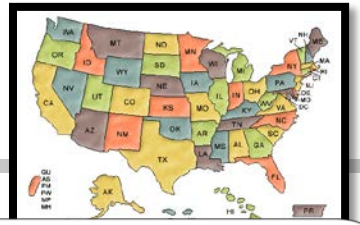
- Among doctors meeting quality and efficiency benchmarks, however, costs for episodes of care were on average 14 percent lower than among other doctors.

- 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

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**

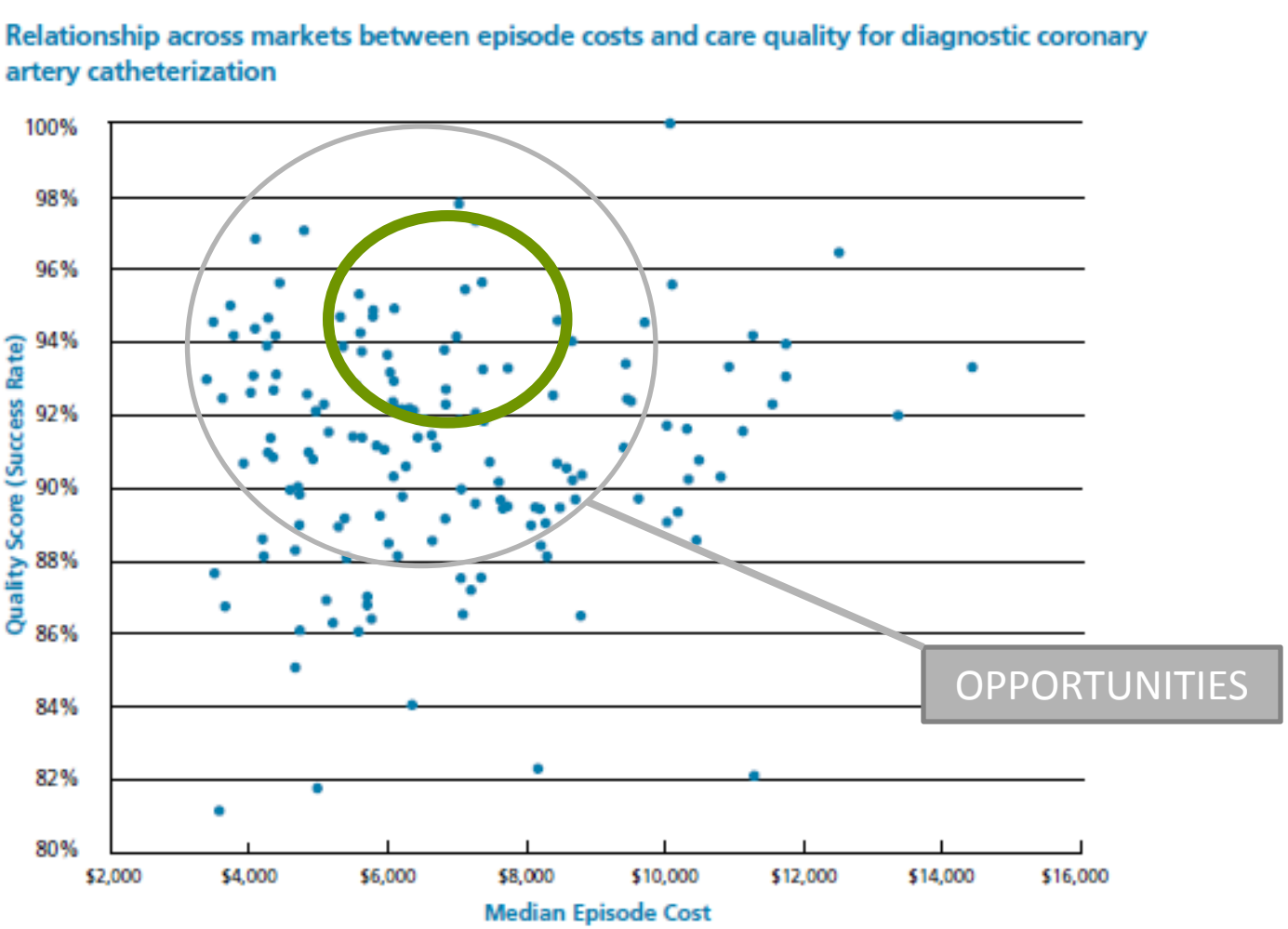
Opportunities and successes by condition

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



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.

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

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