Toolkit for Implementing an Episode-of-Care Program

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Table of Contents

Introduction 3

Instructions 4

Step 1: Choose and Define an Episode 5

Step 2: Calculate the Budget 11

Step 3: Determine the Risk Model 14

Step 4: Incorporate Quality 16

Step 5: Contract with Providers 23

Glossary of Terms 29

Introduction

Welcome to the ACAP Toolkit for Implementing an Episode-of-Care Program. This toolkit is tailored specifically to ACAP member plans that are interested in implementing an episode-of-care payment (sometimes called bundled payment[1]) with their contracted providers to improve quality of care and reduce the costs associated with unnecessary care.

As of January 1, 2015 three states have mandated the use of episode-of-care payments (either with providers or managed care organizations (MCOs)) and many more states are, or are considering, mandating Medicaid MCOs to use alternatives to fee-for-service payment. The Association for Community Affiliated Plans (ACAP) sponsored a Bundled Payment Learning Collaborative (Learning Collaborative) during the summer and fall of 2014 involving nine member MCOs. The Learning Collaborative was designed to explore episode-of-care payment as an alternative to fee-for-service payment via a series of five webinars. The webinars provided information on key decisions that MCOs need to consider in order to implement episode-of-care payment arrangements. The webinars are available to ACAP member plans through this website. In addition to the webinars, the Learning Collaborative members received a set of recommendations about which episodes to consider when implementing an episode-of-care program, based on a significant claims data analysis of Learning Collaborative member plans. Recommended episodes included pregnancy and delivery, asthma and diabetes. Lastly, Learning Collaborative members received a simple financial planning tool that can help MCOs determine the necessary investment in resources, estimated savings and return on investment that can be expected from implementing an episode-of-care program.

This Toolkit provides interested ACAP members with relevant information to implement an episode-of-care program and is meant to guide Medicaid plans with step-by-step instructions on what analyses should be conducted and what considerations and decisions need to be made in order to begin a successful episode-of-care program. Information for this Toolkit was collected through three years of research with health plans and providers who have implemented or attempted to implement an episode-of-care program. We draw upon their successes and lessons learned to create these instructions.

[1] Bundled payment is an often used term to refer to episode-of-care payment, but because bundled payment suggest a prospectively delivered payment when most episode-of-care payment programs are paid retrospectively, we find it more accurate to use the term "episode-of-care" and will do so throughout this toolkit.

Instructions for the Toolkit

This Toolkit is organized into the following five main action items that are essential for implementing an episode-of-care program.

1. Choosing and defining an episode
2. Calculating the budget
3. Determining the risk model
4. Incorporating quality
5. Contracting with providers

Each step includes an introduction of why the step is necessary, plus key action items or questions that should be considered when working through each of the five steps.

Throughout this document, the following icons are used to indicate key parts of the Toolkit.

Checkboxes indicate action items. Once you've completed the task, you can click on the box to mark it complete.

This icon indicates a cautionary note that plans should carefully consider when building their episode-of-care program.

This icon indicates a best practice or a suggested approach based on research of episode-of-care programs in practice or in the literature.

Lastly, a glossary of definitions is provided. Terms that are appear **like this** are defined in the glossary.

As a supplement to this Toolkit and available for your review, there are five previously recorded webinars that cover much of the information in this Toolkit, and recommendations regarding which episodes are the most relevant for Medicaid plans to focus upon based data from nine ACAP plans.

Step 1: Choose and Define an Episode

The first step in implementing an episode-of-care program is to choose and define an episode that is relevant to your population.

An **episode-of-care payment** is a fixed dollar amount that covers a set of services over a defined period of time. Generally, there are three types of episodes:

- ✓ **Procedural Episode**, involving a health care procedure with a defined beginning and end time (e.g., knee replacement);
- ✓ **Chronic Condition Episode**, involving a disease state that is not bound to a time period (e.g., diabetes); and
- ✓ **Acute Condition Episode,** involving a condition that requires a set of services with a defined beginning and end time (e.g., pregnancy and delivery), or is an acute exacerbation of a chronic condition (e.g., asthma attack)).

☐ Step 1.1: Analyze your data

There are many episodes-of-care to choose from and each health plan should conduct an analysis of its own data to identify which ones, if implemented, provide the plan with an opportunity to realize improvements in quality and cost. To do so, a health plan could:

1. conduct this analysis with its own internal tools and resources;
2. contract with an episode-of-care vendor or consultant to assist in this data analysis, or
3. submit data to the Health Care Incentives Improvement Institute (HCI3) which provides limited, but free analytics, among other offerings.

Regardless of which option you choose, you should seek to understand which episodes have:

- ❖ the greatest variation in costs among contracted providers;
- ❖ the highest complication rates;
- ❖ evidence-based guidelines that would significantly improve the quality of care, and
- ❖ sufficient volume to make the episode-of-care program worth building.

☐ Step 1.2: Define the episode

There are several publicly available episode-of-care definitions that can help you get started in identifying the costs and services that will be included within your episode of care and which represent a very good starting point for any plan. They are summarized in the following table.

Source	# of Episodes	Notes	Website or File
PROMETHEUS Payment	84	PROMETHEUS Payment has the most well-tested episode-of-care definitions; they include procedural, acute condition, chronic condition and system failure episodes.	http://www.hci3.org/content/ecrs-and-definitions
Integrated Healthcare Association	10	The ten episodes cover maternity and women's health, orthopedics, and cardiovascular care.	http://www.iha.org/episode-definitions.html
Arkansas	13	The 13 episodes are procedural only and are a derivative of the PROMETHEUS Payment model. Additional episodes are expected to be rolled-out in 2015.	
Ohio	6	The six episodes are procedural only and are a derivative of the PROMETHEUS Payment model. Additional episodes are expected to be rolled-out in 2015.	http://www.healthtransformation.ohio.gov/CurrentInitiatives/ImplementEpisodeBasedPayments.aspx
Tennessee	3	The three episodes are procedural only and are a derivative of the PROMETHEUS Payment model. Five additional episodes are expected to be rolled-out in 2015.	http://www.tn.gov/HCFA/strategic.shtml
Minnesota	7	The 2008 Minnesota Health Reform Law required that uniform definitions of "baskets of care" be developed. MN identified seven "baskets of care" that can be voluntarily used by plans and providers.	http://www.health.state.mn.us/healthreform/baskets/

A plan can choose to modify the publicly available definitions, or create its own. If you choose to modify or create your own definition, there are four key components of a definition to consider:

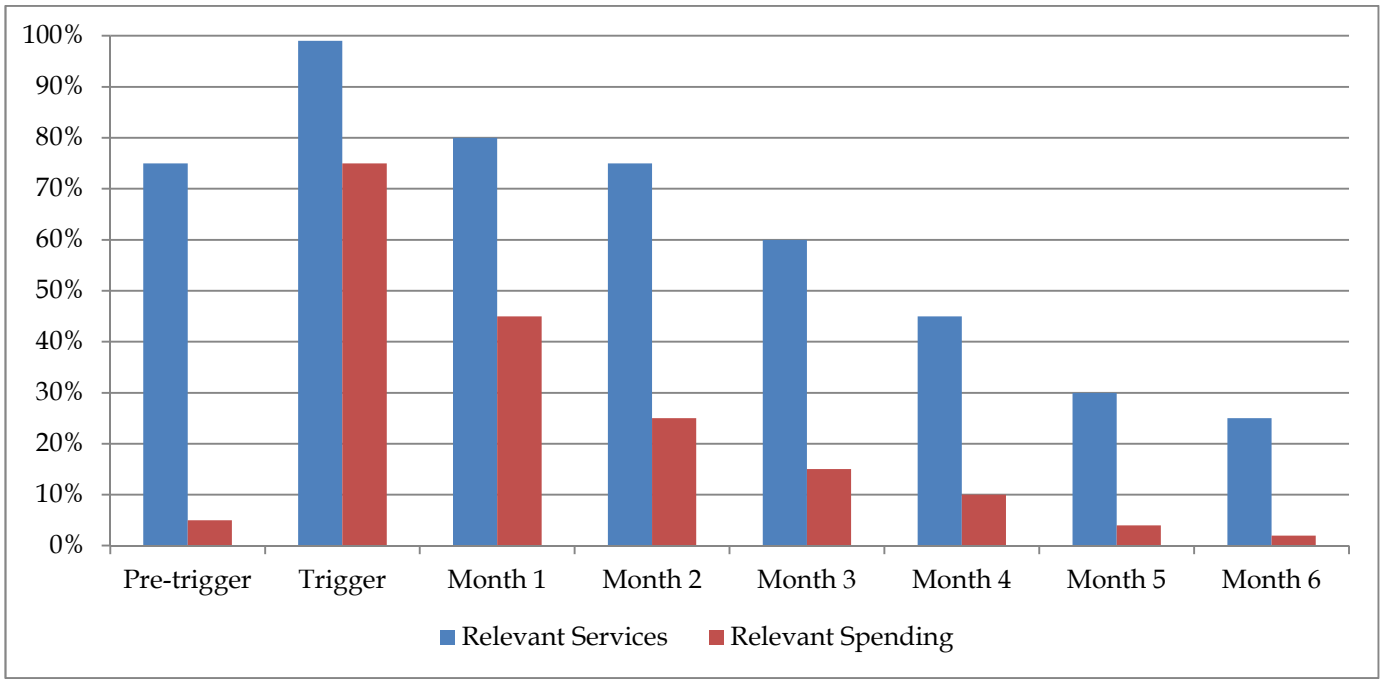
☐ What "triggers" the episode?

1. Analyze all of the codes that **trigger** a potential episode.
    a. For procedural episodes, the **trigger** is often the procedure itself.
    b. For chronic condition episodes, the **trigger** is often a diagnosis code or a code that identifies an acute exacerbation.
2. For chronic conditions, analyze all of the potential "contingent" codes that could suggest, given past history of the patient, that the patient is experiencing an acute exacerbation or "flare-up" of the condition (e.g., wheezing could be a code that identifies the start of an episode if the patient has a past history of asthma) or is experiencing the condition (e.g., a prescription drug claim for a diabetes medication or asthma inhaler).

☐ What time period does the episode cover?

1. Identify the "**look-back**" and "**look-forward**" time periods by assessing the time period in which the most relevant services and relevant spending occurs and for which the responsible provider has the most influence.
    a. Procedural and some acute conditions may have a **"look-back"** time period in which the costs for relevant services that occur prior to the trigger are included in the episode-of-care. Examples include the pre-operative time period before a joint replacement or in the case of pregnancy and delivery, the prenatal time period.
    b. Most conditions have a **"look-forward"** time period in which the costs for relevant services that occur beyond the trigger are included in the episode-of-care. Examples include the recovery time period after a procedure or a defined time period for a chronic condition.

Review this table of an **example procedure episode** in which the percent of episodes with relevant services is compared to the percent of relevant monthly spending before, during and after a "**trigger.**"



While relevant care continues to occur in months 3, 4 and 5, the vast majority of spending occurs at the "**trigger**" and during the first two months post "**trigger.**" In this example, the **"look-back"** time period should probably include the month before the trigger and the "**look-forward**" time period should probably include the first three months post "**trigger.**" **Consider creating a table like the one above in your own analysis.**

☐ Which members will be included?

1. Identify which members will have their services and costs included in an episode-of-care by considering:
    a. Which members are most likely to experience the episode-of-care and whether the service and care of the member differ by age, and
        a. If the services and care of the member differ significantly by age, you could consider limiting the bundle to certain age ranges or by creating two different bundles.

b. The stability of the patient's insurance status. If your plan has a high churn rate, you might consider limiting the episode-of-care to include only those members who had no gap in insurance enrollment during the episode time period. This may be particularly relevant for plans in states which require quarterly eligibility documentation for Medicaid recipients.
    a. If you limit the episode to exclude members with a short (i.e., 30 day) gap in enrollment, conduct an analysis to determine how many potential episodes-of-care will be "lost" so that you're aware of the impact those rules may have on the total volume of episodes.

☐ What criteria will you use to exclude certain events or services, that if occur, will make an episode-of-care invalid?

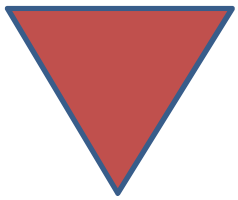
1. There are several reasons why a plan may consider excluding certain events or services from the episode-of-care program. They are:
    a. Patient exclusions, like:
        - ✓ Age
        - ✓ In-hospital death
        - ✓ Discharge status is AMA

    b. Claims exclusions, like:
        - ✓ Claims charges are missing or out of line with norms (e.g., <$10 or >$1,000,000)

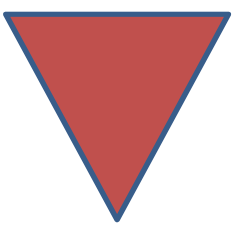
    c. Medical exclusions, like
        - ✓ Patient has HIV or active cancer

    d. Procedural exclusions, like
        - ✓ Patient had a transplant during the episode-of-care

Exclusions are optional! Model any exclusions you consider to determine the impact on volume and consider that risk adjustment can be used to account for differences in patient severity.



When implementing any risk-based payment methodology, providers and plans must be sure that there is a sufficient volume to limit the effect of random variation on patient outcomes and costs. The more patients involved, the less likely patients with costs significantly higher than normal will greatly impact the provider. When developing an episode-of-care program, be sure to model the impact exclusions have on the volume of episodes to ensure that providers will have enough volume to make the program viable.



The choices you make on these basic building blocks can make an episode-of-care more or less complicated. It's important to model your intended program based on your decisions. Doing so will allow you to identify any potential problems with episode volume, the number of providers that could engage in the program and costs to administer the program.

Step 2: Calculate the Budget

The second step in implementing an episode-of-care program is to identify how you will calculate the budget for each provider and episode.

☐ Step 2.1: Determine the basis of the budget

When beginning to calculate a budget, plans must consider the locus of the budget (the provider group level or individual physician level) and what basis it will use to determine the budget. Generally, there are two ways to determine the basis of an episode budget:

1. Calculating the historical averages of:
   a. an individual physician;
   b. a provider group;
   c. an institution (e.g., hospital, SNF);
   d. many providers or groups, including IPAs or ACOs, or
   e. a geographic area or marketplace.

2. Identifying all expected services within an episode and using payer rates to build the episode budget.

Experience shows us that setting budgets at the provider group level is more efficient for health plans when implementing non-institution based episodes.

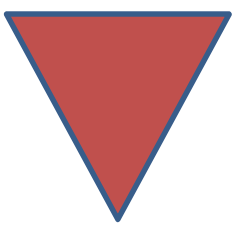
☐ Step 2.2: Determine whether to calculate a risk-adjusted or flat-fee budget

When building the budget, the plan must decide whether a risk-adjustment will be applied to the budget or whether each individual episode (within an episode type, e.g., pregnancy and delivery) will have the same budget.

1. Risk-adjusted budgets can be desirable when:
   a. patient severity is a major contributor to variation of episode costs, or
   b. when episode definitions are broad.

2. Flat-fee budgets can be desirable when:
   a. patient severity is not a major contributor to variation of episode costs;
   b. major contributors to patient severity are excluded from the definition, or
   c. care processes for episodes may be well engineered.

Research shows that some candidates for flat-fee budgets may include asthma, CHF and hypertension, and a candidate for risk-adjusted budgets may be pregnancy and delivery.[2]



If considering a risk-adjusted budget, plans may want to use the same risk-adjustment methodology as the state employs in plan rate setting, so that there is alignment between the state's approach to identifying risks for plan members and the plan's approach to identifying risks of providers' patients.

☐ Step 2.3: Consider including other budgetary factors

There are several budgetary factors around which plans and providers can negotiate. Each is considered below.

☐ How will complications be included in the budget?

Complications are usually preventable, but not always, and include care like readmission, post-surgical infection and a preventable disease-related condition.

1. If you decide in **Step 2.2** to base your budget on historical averages, the budget will inherently include the costs of complications. For example, a pregnancy and delivery episode based on historical averages will account for all of the C-sections, including those that were not medical necessary.

[2] O'Brien et al. "Evaluating ACO efficiency: risk adjustment within episodes." Society of Actuaries, December 2013. See http://www.soa.org/research-2013-eval-aco-risk-report.pdf.

2. If you choose to use the PROMETHEUS Payment model, complications (also termed "**Potentially Avoidable Complications"** ("**PAC**")) are itemized within the budget and a plan can choose to include all or any percentage of the "**PAC**" line item into the final budget.

Experience shows that most plans using the PROMETHEUS Payment designs include a significant (i.e., 50% or more) amount of PAC into their budgets to a) account for the fact that not all complications are preventable and b) that providers cannot necessarily improve on their complication rate overnight.

☐ Will you give providers a margin?

A margin is an addition to the budget that may be used to engage providers. It could be a small percentage increase to the budget (e.g., 2 or 3%) that might work well, especially when continuous improvement and continued savings are difficult to achieve or for Medicaid providers who are reimbursed at low rates.

☐ Will you add a fee that can help protect for the underuse of services?

You can protect the patient and the health plan from a provider "gaming" the episode-of-care program or "skimping on care" by identifying the core services that should be delivered during an episode of care (e.g., the recommended number of prenatal visits for a pregnancy). Then, if those services were not performed by the provider, the cost of those services could be added to the final budget, therefore discouraging the provider from "skimping on care."

☐ Will you include a stop-loss provision?

Limiting a provider's exposure to outliers can help protect providers from both random variation and risk variation and could be considered as part of the budget of an episode. If you choose to include a stop-loss provision, there are a few ways to do so:

1. By applying it at an episode level, in aggregate, or both,

2. By setting the limit based on a dollar amount or a multiplier of the budget.

Step 3: Determine the Risk Model

The third step in implementing an episode-of-care program is determining what risk model will be applied to the program.

☐ Step 3.1: Identify the Risk Model

In payment arrangements that represent an alternative to traditional fee-for-service, the provider is being financially incentivized to provide high-quality care by either accepting some financial risk in the payment model, and/or through sharing a portion of any generated savings. The following text describes four different risk models and how they can be applied to an episode-of-care program.

☐ Shared Savings

A shared savings model allows for the provider to share in a portion of savings when costs are below the negotiated episode rate. In this case, the provider bears no responsibility for costs that occur above and beyond the episode price. It is common for payers to share 50% of the savings with providers. This approach is particularly good for providers that have limited experience with risk-based contracting by giving the provider experience in managing to a budget.

☐ Shared Risk

Stop-loss provisions are often used with this model.

A shared risk model allows for the provider to share in a portion of savings when costs are below the negotiated episode rate, but the provider also bears some responsibility for a negotiated percentage of costs above the negotiated episode rate. This approach is desirable when the provider has some experience with risk-based contracting and is operationally and financially ready to assume some portion of risk.

☐ Discount Arrangement

Stop-loss provisions are often used with this model.

A discount arrangement allows the payer to have guaranteed savings by automatically retaining a small percentage of the budget. In return, the provider is often able to retain all of the savings beyond the discounted budget. While this approach does guarantee the plan savings, the savings are often small, especially if the episode-of-care program is small or there are only a limited number of episodes.

☐ Full Risk

Stop-loss provisions are often used with this model.

A full risk model allows the provider to retain all of the savings below the negotiated episode rate in exchange for the provider bearing total responsibility for all of the costs above the episode payment rate. This approach is for sophisticated plans and providers who have experience in risk-based contracting. The plan needs to ensure it is not passing on insurance risk to the provider and the provider must be operationally and financially ready to accept greater risk. This model might work best with ACO provider.

Step 4: Incorporate Quality

The fourth step in implementing an episode-of-care program is to determine how quality will be incorporated into the payment model and how it will be measured.

Incorporating quality measures into episode-of-care program is an important way of ensuring that providers are focusing on the outcomes of the individual patient, not just on the cost of care. It can also reduce the risk of providers withholding services from the patient in order to keep the full price of the episode-of-care. Lastly, some consumers distrust payer arrangements that appear to solely reward cost reduction.

☐ Step 4.1: Identify how quality will be incorporated

There are two ways in which quality can be incorporated into an episode-of-care program and each are described below. These two ways, and the sub options are **not mutually exclusive**.

☐ Integrate quality directly into the financial risk arrangement

Provider performance on quality measures can be incorporated directly into the financial risk arrangement by using that performance in the following ways:

1. Determine whether a provider is eligible to share in savings by setting a particular quality threshold which a provider must meet. See **Step 4.3** for a more detailed discussion on establishing a quality threshold.

2. Determine what percentage of savings is to be distributed by tying varying levels of performance to savings percentages. For example, a provider that meets the highest level quality threshold could share in 50% of the earned savings and a provider that meets the lowest level quality threshold might only be eligible to share in 25% of the earned savings.

This approach allows plans to clearly indicate that quality is an important part of its episode-of-care program. However, neither the plan nor the provider know the financial value of the quality program because it is tied to savings earned by the provider.

☐ Use quality performance independently of the financial model

Provider performance on quality measures does not have to be incorporated directly into the financial model. It can also be used in the following ways:

1. By only contracting with providers that have *or have not* achieved a predetermined quality threshold. A plan might consider contracting only with those providers who have the highest quality performance as a means for piloting the episode-of-care program with a trusted, high-quality partner. On the other hand, a plan might only contract with those providers who have the greatest opportunities for improvement in quality performance. This approach may work for plans that want to simplify their episode-of-care program, but providers and consumers may view the program to be too focused on cost outcomes.

2. By creating separate bonus pool where:
    a. The provider is eligible for a budgeted amount based on quality performance, or
    b. The payer sets aside a set amount of money that is guaranteed to be distributed to providers based on quality performance.
        i. In this case, the entire pool is distributed to providers that achieve pre-established thresholds in actual performance or improvement and the percentage of the pool that each provider receives depends on the number of providers that achieved the pre-established threshold.
        ii. This approach allows plans to budget the available bonus dollars and gives providers a sense of the reward for improved quality.

3. By determining the impact of the episode-of-care program more broadly for program evaluation, member education and/or quality assurance purposes. This option would best work in combination with any of the quality inclusion options discussed above.

☐ Weighting measures in your quality program

Regardless of how you incorporate quality measures into your episode-of-care program, you could consider weighting the measures differently to bring focus and attention to the measures and activities that are most important to the health plan. For example, if you incorporate quality into your financial model by requiring a certain threshold to be reached to receive a shared-savings payment, you could require that a provider must meet one or two select measures thresholds, but only require a statistically significant improvement in other measures. However you decide to design the quality program, it

is important to balance the plan's desires for a certain level of performance with an easy-to-understand episode-of-care payment methodology.

☐ Step 4.2: Identify relevant quality measures

Incorporating quality into the episode-of-care program is only a successful strategy if the right measures are used to assess performance. There are three ways to identify which measures are the most meaningful to include in your program, none of which are mutually exclusive.

☐ Review current status of performance to identify areas for improvement

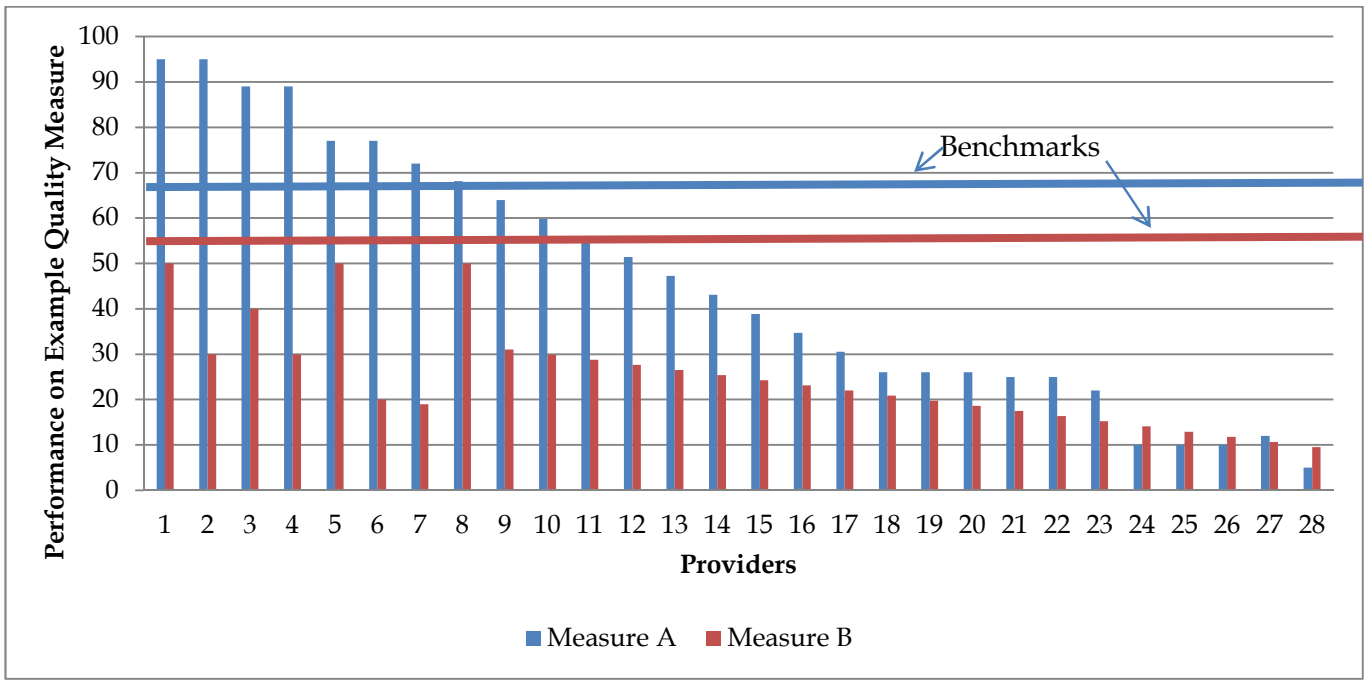
It's important to understand what the baseline performance is at the episode level and how that performance may or may not vary by provider, or compare to benchmark.

1. First, use data to which you already have access and which is relevant to the episode of interest to assess the variation in provider performance. Consider doing so by creating a table that may look similar to the example provided below. Consider including quality metrics in your program where there is:
    a. significant variation between the highest performing providers and the lowest performing providers, or
    b. consistently poor performance across all providers.

2. Secondly, identify benchmarks to which you will compare provider performance. Some example benchmark sources include:
    a. Medicaid-specific performance on HEDIS measures found in NCQA's Quality Compass;
    b. state-specific rates of health risks and behaviors found in the CDC's Behavioral Risk Factor Surveillance System;
    c. benchmarks of FQHC performance recorded by HRSA's National Program Grantee Data, and
    d. goals set by the CDC on a variety of health objectives in its Healthy People 2020 goals.

Review this table of an **example analysis of provider performance** in which the performance on two quality measures is compared across all providers and to benchmarks. The performance on Measure A shows wide **variation between the highest performing providers and the lowest**

performing providers. Performance on Measure B shows **consistently poor performance across all providers. Consider creating a table like the one below in your own analysis.**



☐ Engage providers in the process of choosing quality measures

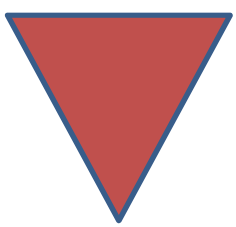
Providers may have strong opinions about what measures to use, because of the level of burden that collecting data and reporting that data may have on the providers, as well as their perception of the relevancy of the measure and their level of influence over the phenomenon it assesses. A plan could consider using a tool, like the Buying Value How to Build a Measure Set, with a committee of interested physicians.

☐ Consider measures that are already collected, reported or publicly available

Providers are often subjected to many different quality measures as part of federal, state and payer requirements. Review those measures which are already being collected and reported upon in your state (whether or not they are publicly available) or by your plan and consider integrating those which are relevant into your episode-of-care program.

There are many sources of evidence-based and tested quality performance measures. The table below contains a few of the most popular websites, including the websites for existing Medicaid episode-of-care programs.

Source	Notes	Website
National Quality Measures Clearinghouse	A public resource for evidence-based quality measures and measure sets.	http://www.qualitymeasures.ahrq.gov
National Quality Forum	An organization that endorses consensus standards for performance measurement.	http://www.qualityforum.org
HEDIS	A tool used by more than 90 percent of health plans to measure performance.	http://www.ncqa.org/HEDISQualityMeasurement.aspx
CMS Physician Quality Reporting System	A CMS incentive program for providers to report certain quality measures for their Medicare patients.	http://www.cms.gov/PQRS
Hospital Compare	A CMS program in which hospital quality of care data are reported publically.	http://www.medicare.gov/hospitalcompare/search.html
Buying Value	A suite of tools to assist in creating quality measure sets.	http://www.buyingvalue.org/resources/toolkit/
Arkansas Medicaid Episode-of-Care Program	Measures that Arkansas has incorporated into its episode-of-care program.	http://paymentinitiative.org/episodesofcare/pages/default.aspx
Ohio Medicaid Episode-of-Care Program	Measures that Ohio has incorporated into its episode-of-care program.	http://www.healthtransformation.ohio.gov/CurrentInitiatives/ImplementEpisodeBasedPayments.aspx
Tennessee Medicaid Episode-of-Care Program	Measures that Tennessee has incorporated into its episode-of-care program.	http://www.tn.gov/hcfa/strategic.shtml



When identifying quality measures of interest, you may discover gaps in what data are currently available to you. Consider adding a reporting requirement for measures for which you would like to establish a baseline, monitor performance, or potentially incorporate into your episode-of-care program at a future date.

☐ Step 4.3: Determine performance on quality

There are three general ways to determine provider performance on quality measures, which can be used in combination with one another. See page 21 for an example of how these approaches can be employed together.

☐ Absolute performance

You could choose to develop a threshold which must be achieved in order for a provider to receive a payment adjustment, or episode-of-care contract the following year. The threshold could be based on a benchmark or average.

- The downside to this approach is that the providers may improve in a statistically significant way, yet not reach the established threshold, and therefore not be rewarded for their improvement.

☐ Relative performance to other providers

You could choose a "tournament style" approach where distribution of payment is determined relative to the performance of other providers.

- The payer could budget the amount of dollars that will be allocated to providers in a performance pool. The pool could be funded with dollars that providers do not earn back in savings.
- The downside to this approach is that the providers do not know how much they are eligible for, since it's based on the performance of others.

☐ Relative to past performance

You could require that providers achieve a certain increase in performance over baseline, or the prior year, in order to receive an adjustment to payment or an episode-of-care-based contract for the following year.

An example from Oregon's 2014 Coordinated Care Organization Incentive (Bonus) Pool:

1. A provider is eligible to receive up to 3% of the total payment based on performance of 17 measures and benchmarks (some of which are based on **absolute performance** and others which are **relative to past performance**).

2. All funds not distributed (due to poor performance) will be allocated to providers who perform well on "challenge" or "stretch" measures that are considered to be more transformative than the measures used in the first step (e.g., diabetes blood sugar control and use of SBIRT).

Step 5: Contract with Providers

The fifth step in implementing an episode-of-care program is to contract with providers.

☐ Step 5.1: Selecting providers

☐ Identify providers that might be amenable to contracting on an episode-of-care basis.

There are several factors that make providers good contracting partners, none of which are mutually exclusive. Consider approaching providers with:

1. a high volume of episodes of interest;
2. whom you have a good working relationship;
3. high (or low) quality scores in areas that related to the episodes of interest;
4. strong internal management systems and effective leadership well-poised to make any necessary changes to clinical operations;
5. wide variation in episode costs, or variation from health plan benchmarks for best practice, and/or
6. engagement in another episode-of-care program, such as CMS's Bundled Payment for Care Improvement Program.

☐ Share data with providers for the purposes of engagement

Before contracting with providers, plans should engage interested providers by sharing data on variation in episode-of-care costs, complication rates and quality to help providers understand why episode-of-care payment is a potential solution. A plan could share data specific to interested providers contrasted with blinded data from other similar providers or plan-wide information. The plan should also consider sharing modeling analyses that show the potential opportunity for gain available to the provider.

☐ Conduct a readiness assessment

After you've identified providers that are willing to engage in an episode-of-care program, it is prudent to conduct a readiness assessment that identifies whether the provider is financially stable enough to take risk and has engaged leadership willing to change clinical and business operations, as necessary, to be successful. When conducting a readiness assessment of interested providers, consider examining the following:

1. whether the provider's practice has the clinical operations necessary to be successful, or the willingness to change or invest in clinical operations;
    a. For a provider to be successful in an episode-of-care program, it's critical for the provider to standardize high quality and evidence-based care practices that may be different from current practice.

2. whether the provider's practice has the business operations necessary to be successful, or the willingness to change or invest in business operations;
    a. Providers must be comfortable using data to manage patients' episodes of care through electronic health records and the use of health plan-provided claims and/or analytic data.

3. whether the provider's practice has the necessary financial reserves to take on risk, and
    a. While a plan can implement an episode-of-care program with a provider on shared-savings basis where the provider does not accept financial risk, eventually, most programs shift some amount of risk to the provider. The plan should consider conducting an actuarial analysis to ensure the provider could accept some financial risk now, or in the future.

4. whether the provider's practice has engaged and stable leadership, and is willing to invest the necessary time and resources.
    a. Implementing any payment reform program takes commitment on behalf of all levels of the organization and strong, committed leadership is essential to be successful.

☐ Step 5.2: Determining the contracting entity

Generally speaking, there are three different contracting approaches that can be used in an episode-of-care program. Depending on the specific episode, the covered services and the participating providers, a plan might choose different contracting entities.

☐ Plan contracts with one "Principal Accountable Provider" (PAP)

The simplest option to contracting for an episode-of-care program is a contract with one provider who will assume total responsibility for the entire episode, despite not directly controlling all elements of the episode.

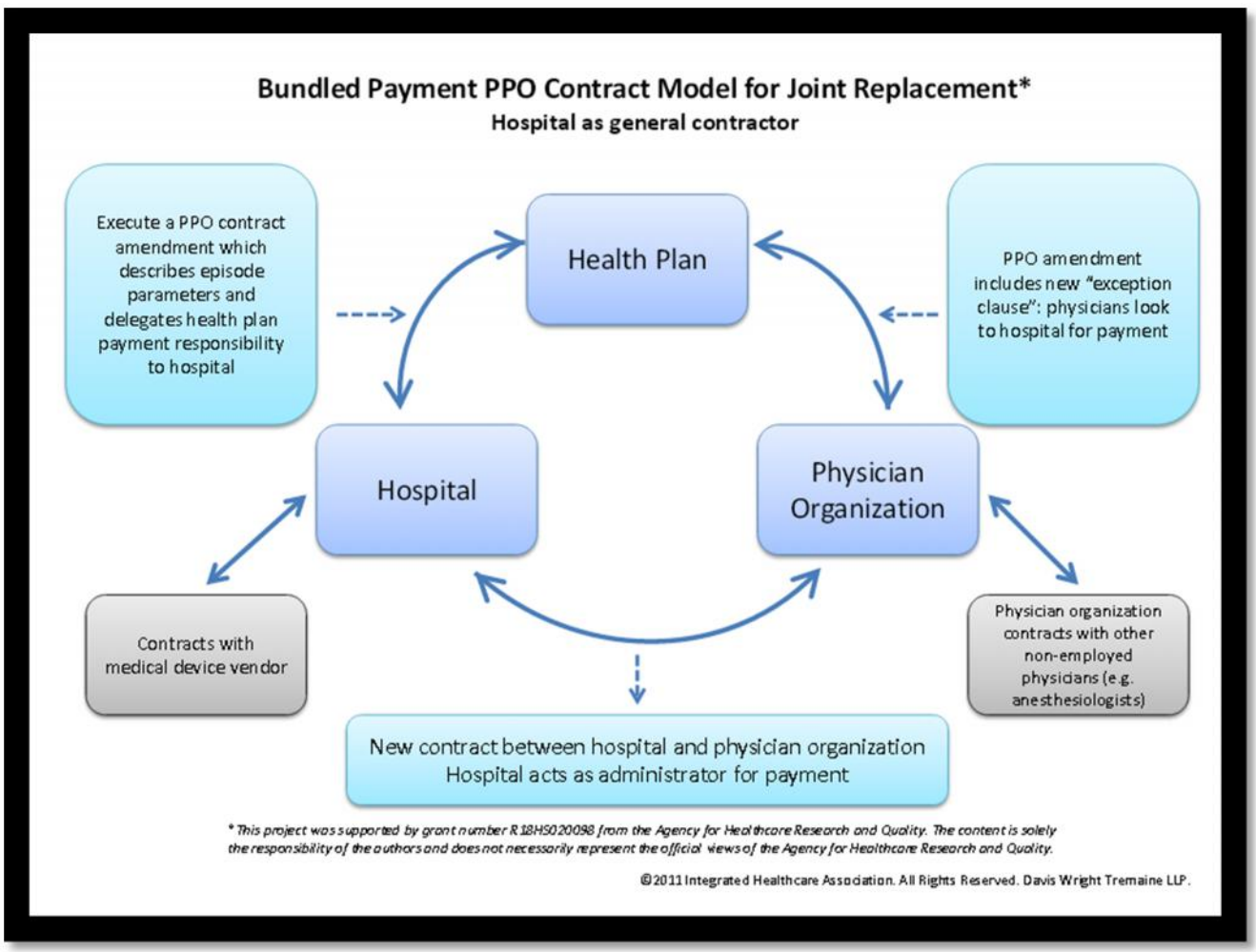
- **PAP**s are typically determined based on episode definition and a retrospective analysis of claims.
- **PAPs** are the only providers eligible to share in savings (or in risk).
- This approach is used by the Arkansas, Ohio and Tennessee Medicaid programs.

☐ Plan contracts with one provider, who in turn has multiple subcontractors

A slightly more complicated contracting approach would be for plans to contract with one provider, who will in turn subcontract with other providers that are part of the episode arrangement. In this case, the plan would then amend its existing contracts with those subcontracted providers.

- In this approach, the lead provider is responsible for collecting the **episode-of-care payment** and is responsible for paying subcontracted providers. Therefore, the plan would need to build a prospectively paid episode-of-care program.
- This approach gives providers accepting the **episode-of-care payment** more control over other providers via their own contractual agreements. However, the plan could consider including guaranteed savings distributions that the lead provider would need share with subcontracted providers.
- This approach is best for sophisticated and large providers with the means to pay subcontracted providers.

Review this illustration from the Integrated Healthcare Association of an **example contracting scenario** where the plan contracts with one lead provider and amends its existing contracts with other providers that are subcontracted by the lead provider.



☐ Plan contracts with each partnering provider

When multiple providers are involved in one episode, the plan could contract separately with each provider who cares for the patient. For example, in a joint replacement bundle, the plan could contract with the hospital where the surgery and

aftercare is performed, the surgeon who operates on the patient and the anesthesiologist who cares for the patient during surgery. If the episode-of-care is:

- prospectively paid, you and the providers will need to agree on what percentage of the payment is delivered to each provider;
- retrospectively paid, you and the providers will need to agree on what percentage of the *budget* is assigned to each provider, which will likely correlate with what percentage of savings or risk is assigned to each provider.

☐ Step 5.3: Developing the contract details

The last step in contracting with providers is to develop contract language, ensuring that all of the important components of your episode-of-care program are included in the contract. Below are five categories of contract details that should be included in a contract.

☐ Episode definition

- The scope of services, including any services or care that will be excluded. Be as specific as possible by using DRG, CPT and/or ICD-9/10 codes
- Episode time period, including the **look-back** and **look-forward** time periods. Be specific in how those times will be defined (e.g., "24 hours" vs. "one day")
- Member eligibility
- Quality measurement procedures, including which entity will collect which data, and how the results will be calculated

☐ Terms of payment

- Whether providers will be paid a bundled prospective **episode-of-care payment** or fee-for-service with a retrospective reconciliation to a budget.
    - If you choose to do a retrospective reconciliation to a budget, include the expected timing of the reconciliation.
- What the financial risk arrangement will be, including how any shared savings will be calculated and what adjustments may be made based upon quality performance.
- What the schedule for payment will be, including any penalties that the plan will incur for late payment or late reconciliation.
- Include any requirement you may have for contracting entities to distribute any portion of realized savings to individual physicians or subcontracted entities.
- See the "Provider Responsibility" section for provider's responsibility with respect to terms of payment.

☐ Appeals process

- Include how and whether provider can appeal the inclusion or exclusion of entire episodes, or claims within an episode. The more specific you are in other sections of the contract (e.g., the episode definition and scope of services), the fewer appeals you may have.

☐ Provider responsibility

- Be sure to include details on when and how to submit claims, data required for quality measurement and, if required, notification of the plan at the start of an eligible episode.

☐ Payer responsibility

- Plans should articulate within the contract what reports will be provided and the timing of those reports. Having access to plan data is critical for providers to be able to understand individual episodes. Below is a suggested list of data items that providers will likely want from plans:
  - episode count, plus notification of eligible episodes and the budget for each episode;
  - routine claims level data for relevant episode costs and if the claim didn't occur at the contracted provider's facility, summary information about the claim;
  - categorization of claim history into expected claims and potentially avoidable claims (especially if using the PROMETHEUS model), and
  - a routine comparison of the episode costs of care to the budget.

- Payers may also commit to give providers the opportunity to review and comment on any publicly reported quality data, or quality data that will be used to adjust payment.

Review these two model episode-of-care contracts between plans and providers and consider using them as a template for your program.

Glossary of Terms

Episode-of-care payment: A fixed dollar amount to cover a set of services over a defined period of time.

Look-back time period: The time period for which a provider is responsible for costs prior to the trigger of an episode.

Look-forward time period: The time period for which a provider is responsible for costs after the trigger of an episode.

Potentially Avoidable Complications (PAC): A widely accepted and tested measure of complications that include ambulatory-care sensitive admissions, hospital-acquired conditions and inpatient-based patient safety failures.

Principal Accountable Provider (PAP): A physician practice, hospital or other provider that coordinates all aspects of an episode "team" of providers and takes on total responsibility for the performance of each episode.

Triggers: Lists of codes, in combination with a date, that identify the "start" of the bundle.