Health Care Payment Improvement

Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative

Episodes of Care

PRINCIPAL ACCOUNTABLE PROVIDER MANUAL

Program Overview

www.paymentinitiative.org

Arkansas Blue Cross and Blue Shield AHCPII Help Desk

APIICustomerSupport@arkbluecross.com | 888.800.3283

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Arkansas Blue Plans in this report refers to Arkansas Blue Cross and Blue Shield, Health Advantage and/or BlueAdvantage Administrators of Arkansas.

Arkansas BlueCross BlueShield

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Episode-Based Reimbursement Program

The Episode-Based Reimbursement Program was created in 2012 was part of the Arkansas Health Care Payment Improvement Initiative (AHCPII). The AHCPII was developed as a joint effort between Arkansas Medicaid, QualChoice and Arkansas Blue Cross and Blue Shield, its affiliates and subsidiaries (Arkansas Blue Cross). Click here: Episode_AHCPII Background and History for additional information on the program history and background.

How is an episode of care defined?

An episode of care is focused on all the care provided to treat a particular condition for a given length of time. Arkansas's approach is clinically based, contains efforts to affect reimbursement and effectiveness of care, and is transparent to patients and providers. Click here: Episode Selection Criteria for an explanation on the Episode Selection Criteria used by Arkansas Blue Cross.

Click here: Table of All Episodes for a table that describes the definition of each episode and identifies the payer involved in the episode. Detailed information for each episode used by Arkansas Blue Cross can be found within each Episode's specific section of this manual.

How does the episode of care payment model work?

For each of the Episodes of Care identified, a Principal Accountable Provider (PAP) will be designated. This PAP will be the provider with responsibility for the majority of care in a given episode. In some cases, the PAP will be a physician. In others, it will be a hospital or facility. The PAP will be eligible for gain and risk sharing based on the overall cost and quality of the care delivered to the patient during the episode period. Click here: Episode Thresholds Explained for an explanation of the cost thresholds in the episode of care model.

Click here: Table of All Episodes to see the PAPs designated for each of the episodes.

PAPs will submit claims as usual, as will non-PAPs involved in an episode of care as outlined. Both PAPs and non-PAPS will continue to receive fee-for-service payments throughout the transition period and once the new payment model is implemented.

How many episodes of care have been developed?

Click here: Table of All Episodes for a table that identifies all current episodes of care in the Arkansas Health Care Payment Improvement Initiative (AHCPII).

New Episodes and "Preparatory" Phases

As new episodes are launched, providers will have a three to six month "preparatory" phase. During this time, providers will have access to reports designed to help them understand their current practice patterns and the financial and quality outcomes they generate. The data for those reports will be pulled from existing claims data and from a limited set of data that providers will enter into a provider portal for some of the episodes. These reports are available on AHIN and should be reviewed as soon as possible by the PAPs. At the end of the transition period (not sooner than three months and not later than six), providers will be notified that the new payment methodology is being implemented. As noted previously, both PAPs and non-PAPs will continue to file claims and receive

reimbursement as usual. Payers will offer staff assistance through town hall-style meetings across the state, informational webinars and other educational resources both online and offline throughout the transition periods. No changes in reimbursement will occur during the transition period.

Reports for Principal Accountable Providers (PAPs)

Since the launch of the Episode-based Reimbursement Program, Arkansas Blue Cross and Blue Shield and its family of companies have published reports for principal accountable providers (PAPs) involved in the AHCPII projects. These reports are published to the AHIN portal following each quarter, and should be reviewed as soon as possible by the PAPs.

The AHCPII payment system now includes financial and quality targets for the individual metallic business sold through the Arkansas Marketplace (also known as Qualified Health Plans (QHP)). These services are reimbursed at different fee rates than usual commercial business, thus the need for separate financial targets. Due to the separation of this membership from the Commercial Business (non-Qualified Health Plan (non-QHP)), PAPs may have two reports within the same file on the portal. For the new QHP membership, PAPs have preparatory reporting available in 2016, with implementation effective January 1, 2017.

Click here: AHCPII PAP Report Glossary for the PAP Report Glossary.

Additional details on the initiative, the episodes, the reports and educational material/opportunities can be found at www.paymentinitiative.org or access it via links from a PAP's AHIN portal screen and click on the tabs for "Why Payment Improvement" and "How it Works". Located there is also a "Guide to Reading Your Report," which is designed to help with understanding all the sections of the report. For detailed questions about the **PAP reports** produced by Arkansas Blue Cross, please call 1-888-800-3283 or email APIICustomerSupport@arkbluecross.com.

To obtain access to AHIN, contact your site AHIN User Administrator (AUA) or AHIN Customer Support at 501-378-2336 or 855-822-2446.

Appeals

PAPs who wish to challenge their specific rating may do so through the following appeals process. Reward payments and refund request letters will be placed in line for review and decision. For PAPs who meet program targets for surplus sharing, reward payments will be issued to the "pay to" entity on record for the PAP by Arkansas Blue Cross and Blue Shield. Checks will be delivered to the PAPs with their final settlement report.

Level I is an informal process conducted by an informatics analyst or a regional medical director (RMD). Level II should be used only after a PAP is not satisfied with the outcome or ruling of the PAPs Level I review. PAPs may choose to pursue both the informal Level I review and the more formal Level II appeal, but it should be noted that all formal Level II appeal requests must be filed (in the manner further outlined below) within 45 days after Arkansas Blue Cross has distributed the quarterly reports to PAPs via the provider portal. If a proper written Level II appeal is not filed and received within 45 days after distribution of the specific performance reports, the data and ratings shall be deemed correct.

Level I Review

PAPs may seek informal review of the ratings indicated on the performance reports produced by Arkansas Blue Cross by contacting the AHCPII Provider Line at (information correct as of September 2012) 1-888-800-3283 or emailing APIICustomerSupport@arkbluecross.com. PAPs may also directly contact their respective Regional Medical Director (RMD). The RMD or the AHCPII Provider Line staff will provide the PAP with an explanation of the process and methodology for the quality and cost efficiency ratings, will review the data and ratings with the PAP, and will consider any additional information the PAP wishes to present.

A PAP who is dissatisfied with the results of this informal Level I review may seek Level II formal review of the challenged ratings by the process outlined below. Please note that mere pendency or pursuit of a Level I review shall not be sufficient to deem the PAP's cost and quality data and ratings as inaccurate and unusable (although the challenged ratings will not be used if Level I informal review determines that it is in error or otherwise invalid).

Level II Formal Review Process

Any PAP who is dissatisfied with the results of the informal Level I review and wishes to seek a formal reconsideration or formally challenge any utilization, efficiency, or quality ratings, may lodge a written appeal using the following procedures outlined below. This Level II process should only involve appeals that specifically challenge a PAP's utilization, efficiency or quality rating that is reflected on the PAPs performance reports.

A. Appeals must be sent in writing, via certified mail, addressed as follows:

AHCPII Arkansas Blue Cross Data Appeals
Enterprise Business Informatics 9UCC
P.O. Box 2181
Little Rock, AR 72201

B. All appeals must be postmarked within 45 days of the date that Arkansas Blue Cross distributed the PAP's performance report,

C. All appeals must include a statement from the appealing provider explaining all grounds upon which the appealing provider contends that the rating is erroneous; and

D. All appeals must include any supporting materials, documents or data that the appealing provider contends will demonstrate the error of the challenged rating.

Following receipt of a timely appeal that meets the standards outlined above, the AHCPII Arkansas Blue Cross Appeals Committee shall place the appeal in line for review and decision. The Appeals Committee may request additional data from the appealing provider, or may pose specific questions to the appealing provider. Failure of an appealing provider to respond promptly to any such requests shall be grounds for denial of the appeal. All appeals shall be processed in writing; personal appearances or hearings shall not be allowed except in rare circumstances solely at the request and discretion of the AHCPII Arkansas Blue Cross Appeals Committee. Following its review, the AHCPII Arkansas Blue Cross

Appeals Committee shall send written notification to the appealing provider of its decision. This decision will be considered final.

Financial Settlements in the Episodes of Care Model

To be included in the Episodes of Care financial settlement process, a PAP needs at least five (5) episodes to qualify. Eligibility in gain-sharing may also require a passing quality component. Refer to the specific episode's algorithm chart for details.

The AHCPII payment system now includes financial and quality targets for the individual metallic business sold through the Arkansas Marketplace (also known as Qualified Health Plans (QHP)). These services are reimbursed at different fee rates than usual commercial business, thus the need for **separate** financial targets. Due to the separation of this membership from the Commercial Business (non-Qualified Health Plan (non-QHP)), PAPs must have at least five (5) episodes within a single line of business to be eligible. For example, a PAP must have five (5) episodes for members in the individual metallic business (QHP) to be eligible for gain or risk-sharing for that population. A PAP will four (4) episodes within the individual metallic business (QHP) and two (2) episodes in the commercial business (non-QHP) would not be eligible to participate in the financial settlement process.

Following each designated performance period, the payer involved will reconcile the results of the episodes completed during that period against previously established and communicated cost thresholds and quality metrics. Calculations are risk-adjusted and consider factors impacting performance such as outliers, disease severity, co-morbidities, patient population, etc. If the PAP meets or exceeds these target metrics, additional incentive will be paid. If performance falls short of the targets, risk amounts will be withheld from future claims payments. Click here: Episode Thresholds Explained for an explanation of the cost thresholds in the episode of care model.

This will be determined based on an annual basis, closing at the end of each calendar year (e.g. December 31, 2016) using the episodes that ended within that respective year. The settlement process will begin in the second quarter of the following year (e.g. April - June 2017). If cost sharing is indicated, Arkansas Blue Cross and PAP will split the costs 50/50 and only 50% of the PAPs total cost overage will be recouped. Arkansas Blue Cross and PAP will also split the total surplus. A PAP's total cost sharing amount will never be more than 10% of the total amount of allowed dollars on claims for Covered Services to the PAP by Arkansas Blue Cross and Blue Shield's commercial business.

For PAPs qualifying to share in the savings with Arkansas Blue Cross per the terms of the Program, an additional payment will be made to PAPs within 180 days after the close of the Reporting Period. Normally, the reporting period will end on December 31st and gain sharing payments, usually one check per line of business will be made in the following year's second quarter.

Legislation effecting Settlements

In order to meet the requirements of existing laws and regulations impacting episodes, while maintaining the positive impacts created by AHCPII, Arkansas Blue Cross has implemented a process to remove the impact of hospital costs that would reduce a PAP's gain sharing amount or increase a PAP's risk sharing amount. These processes vary for the

fully-insured and self-insured groups. See below for details on how these adjustments will be performed.

Fully-Insured Settlements

Starting with the 2015 AHCPII Settlement Process, and in accordance with Arkansas Act 902 of 2015, Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation will, for *fully-insured members only,* make appropriate adjustments to the cost of inpatient facility services that are outside the control of the Principal Accountable Provider, in those circumstances where including such unadjusted costs would reduce a PAP's gain-sharing amount or increase a PAP's risk-sharing amount. The same process will be used for the 2016 performance period.

Starting with the 2018 settlement activities for 2017 dates of service, the hospital will be responsible for the hospital episode costs in excess of the threshold amounts as well as costs that would reduce a PAP's gain sharing amount. This will be the process for 2017 dates of service and beyond.

Self-Insured Settlements

Beginning January 1, 2017, the hospital will be financially responsible for overage amounts directly related to its higher costs while non-hospital PAPs will continue to be responsible for all other episode results. In mid-year 2017 settlement activities for episodes ending in 2016, we will hold higher cost hospitals accountable for PAP's overage amounts due to a hospital's cost component for our self-insured bloc of business. This will be the process for episodes ending in 2016 and beyond for the self-insured bloc of business. However, unlike the fully-insured process, adjustments will *not* be made in the scenario of a hospital's cost impacting the gain share amount. The requirements of Act 902 are preempted by the self-insured group's ERISA rights with respect to such plans.

Refunds

For PAPs whose final results fall into the cost sharing levels, a refund request letter will accompany the PAPs final settlement report which identifies the amount of cost share applicable to the episode and PAP. In addition to the request letter, an extra letter copy and prepaid envelope will be enclosed to facilitate the refund process. The PAP will have a maximum of sixty (60) days to refund the applicable cost share amount.

Offsets

After sixty (60) days, if the cost share portion has not been returned to Arkansas Blue Cross, an offset against current and future (if needed) Arkansas Blue Cross commercial claims payments will be initiated. The offset transaction will remain open until the total cost share amount has been recouped. Arkansas Blue Cross will also perform the cost share recoupment process for BlueAdvantage Administrators and Health Advantage.

Episode-Based Reimbursement Program

As the health care industry faces increasingly stringent demands to control rising costs, both from the private and public sectors, payment transformation has become part of the national conversation. Effective payment transformation should address both the cost and quality of care by aligning incentives across stakeholders to reduce unwarranted variation in quality and increase cost efficient processes and practices. Physicians and hospitals should be rewarded for improved care coordination and improved outcomes. The Arkansas Health Care Payment Improvement Initiative (AHCPII) is an effort on the part of health care payers in Arkansas to transform the provider payment system in the state to reward high quality, cost efficient providers.

The AHCPII is a collaboration between Arkansas Medicaid, Arkansas Blue Cross and Blue Shield (and its affiliated companies Health Advantage and BlueAdvantage Administrators of Arkansas), and QualChoice. It was formed to replace our current payment model, which often rewards activity regardless of value, with a model that rewards health care providers for providing necessary, high quality and cost-effective care. There will be no immediate change to reimbursement. Following this introductory period, reimbursement methodology changes will be implemented by Arkansas Blue Cross and its affiliated companies.

This Initiative was developed with input from hundreds of individuals and organizations including physician associations, hospital executives, clinicians, patients, advocacy groups and the Center for Medicare & Medicaid Services (CMS). Unrelated to the federal health care reform legislation passed in 2010, the AHCPII puts Arkansas on the leading edge of national efforts to improve health care quality and cost efficiency.

While the private payers (Arkansas Blue Cross and QualChoice) have joined with the public agencies (CMS and Arkansas Medicaid) to work on developing a common approach to assessing, tracking and promoting quality and cost efficiency, each private payer will separately and independently determine its own specific reimbursement changes and policies that may result from the broader, government-sponsored initiative. In addition, the implementation for each measure will be phased-in on a payer-by-payer basis.

Health care costs are unsustainable. As a nation, as a state and as individuals, we are all paying the price of an uncoordinated delivery system based on misaligned incentives. It is essential that we as stakeholders in health care delivery and financing take the lead in building a new model that will serve our country, our state and our patients and provide the kind of high-quality, affordable care that is our mutual goal.

More information may be found within this manual or at www.paymentinitiative.org.

Empowering Consumers

Conditions & procedures with opportunities to include patients and family caregivers' through the use of decision aids support for shared decision-making; goal setting and support identifying high-value providers.

High Volume, High Cost

Conditions & procedures for which high cost is due to non-clinical factors such as inappropriate service utilization and poor care coordination that correlate with avoidable complications, hospital readmissions and poor patient outcomes.

Unexplained Variation

Conditions & procedures for which there is high variation in the care that patients receive, despite the existence evidenced based "best" practices.

Care Trajectory

Conditions & procedures for which there is a well-established care trajectory, which would facilitate defining the episode start, length and bundle of services to be included.

Availability of Quality Measures

Conditions & procedures with availability of performance measures that providers must meet in order to share savings which will eliminate the potential to incentivize reductions in appropriate levels of care.

HCP LAN
Health Care Payment Learning & Action Network

Episode	Definition/Scope	Principal Accountable Provider (PAP)	Payer(s)	Launch Date	Implementation Date
Hip/Knee Replacements	Surgical procedure plus all related claims from 30 days prior to procedure to 90 days after	Surgeon; hospital may also be considered as a Co-PAP	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicare*	July 2012	January 2013
Perinatal	Pregnancy-related claims for mothers from 40 weeks before to 60 days after delivery; excludes neonatal care	Physician who delivered the baby	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicaid	July 2012	January 2013
Ambulatory URI	21-day window beginning with initial consultation and including URI-related outpatient and pharmacy costs; excludes inpatient costs and surgical procedures	Initial treating physician*	• Medicaid and • Medicare*	July 2012	January 2013
Acute/Post-acute Congestive Heart Failure (CHF)	Hospital admission plus care within 30 days of discharge	Hospital	• Arkansas Blue Cross and its affiliated companies**, • QualChoice, • Medicaid, and • Medicare*	July 2012	January 2013
Attention Deficit Hyperactivity Disorder (ADHD)	12-month episode including all ADHD services and pharmacy costs with exception of initial assessment	Treating physician or licensed clinical psychologist	• Medicaid	July 2012	January 2013
Oppositional Defiant Disorder (ODD)	12-month episode including all ODD services and pharmacy costs with exception of initial assessment	Primary ODD treating provider	• Medicaid	July 2012	January 2013
Colonoscopy	Procedure plus all related claims from 30 days prior to procedure to 30 days after	Performing Physician	• Arkansas Blue Cross and its affiliated companies • QualChoice, and • Medicaid	July 2013	January 2014

Tonsillectomy/ Adenoidectomy	Surgical procedure plus all related claims from 90 days prior to procedure to 30 days after	Performing Physician	• Arkansas Blue Cross and its affiliated companies • QualChoice, and • Medicaid	July 2013	January 2014
Cholecystectomy	Surgical procedure plus all related claims through 90 days after	Primary Surgeon	• Arkansas Blue Cross and its affiliated companies • Medicaid	July 2013	January 2014
Coronary artery bypass graft (CABG)	Surgical procedure plus all related claims through 30 days after	Cardiothoracic Surgeon	• Arkansas Blue Cross and its affiliated companies • Medicaid	July 2014	January 2015
Percutaneous coronary intervention (PCI)	Procedure plus all related claims from 30 days prior to procedure to 30 days after OR If no diagnostic angiogram, procedure to 30 days after Discharges included for both, even if readmission discharge is after 30 day period.	Interventional Cardiologist or Interventional Radiologist	• Arkansas Blue Cross and its affiliated companies • Medicaid (in development) •QualChoice	July 2014	January 2015
Chronic obstructive pulmonary disease (COPD)	Hospital admission plus care within 30 days of discharge	Hospital	• Arkansas Blue Cross and its affiliated companies • Medicaid	July 2014	January 2015
Asthma	Hospital admission plus care within 30 days of discharge	Hospital	• Arkansas Blue Cross and its affiliated companies • Medicaid	July 2014	January 2015
Pneumonia	Emergency room diagnosis of Pneumonia plus all related claims through 30 days after discharge from facility	Hospital	• Arkansas Blue Cross and its affiliated companies • Medicaid (in development) • QualChoice	January 2017	January 2018

Hysterectomy	Procedure plus all related claims from 60 days prior to procedure to 60 days after discharge from facility	Surgeon	• Arkansas Blue Cross and its affiliated companies • Medicaid (in development) • QualChoice	January 2017	January 2018
Lumbar Spinal Fusion	Procedure plus all related claims from 30 days prior to procedure to 90 days after	Surgeon	• Arkansas Blue Cross and its affiliated companies • Medicaid (in development) • QualChoice	January 2017	January 2018

**on hold