Model ACO Contract Language

Contracting for Value through Accountable Care Organizations

June 2014

Disclaimer:
This Agreement is provided for information purposes only. Before Company makes any decisions as to whether to use this Agreement in whole or in part and to understand the legal implications of doing so, Company should consult with a qualified legal professional for specific legal advice tailored to its situation.
MODEL CONTRACT LANGUAGE FOR ACCOUNTABLE CARE ORGANIZATIONS

This Agreement is made and entered into this ___ day of __________, 2014, by and between [Accountable Care Organization name], hereinafter called “ACO,” OR [health plan name], hereinafter called “Administrator,” and [health care purchaser name], hereinafter called “Company.”

I. DEFINITIONS.

“Accountable Care Organization” or “ACO” is a provider organization that provides integrated care delivery in a manner that meets the criteria described in this Agreement.

“Administrator” provides third-party Plan administration services which are described in the Administrative Services Agreement entered into with the “Company” (if applicable) and contracts with a provider organization(s) representing a defined network for the purposes of this Agreement.

“Company” sponsors a group health plan with specified benefit coverage through “Administrator.”

“Participant” refers to Company’s employees, dependents, and retirees who are eligible to receive their health benefits under the Plan.

“Provider” refers to primary care and specialty physicians, hospitals, outpatient and ancillary facilities.

II. INTRODUCTION. This Agreement outlines the expectations of Company for improved care through system redesign, integration, cost control and value-based payment, including improvements to quality, efficiency, safety, patient-centeredness and experience, care coordination, and outcomes. Company seeks to align requirements among purchasers and accelerate the performance of providers through outcomes-oriented measures that improve care for Company enrollees as well as others seeking care from the ACO.

A. Primary Objectives. Company offers an ACO to achieve these primary objectives:
   1. Improve health outcomes and the quality of care for Participants and the population;
   2. Improve affordability and contain costs; and,
   3. Improve patient experience and health care delivery.

B. Principles and Requirements. To achieve these Primary Objectives, the ACO upholds and meets the following principles and requirements:
   1. Is a defined network of high-performance primary care and specialty providers, inpatient and outpatient facilities and ancillary providers;
   2. Is outcomes-focused and accountable for providing high quality care consistent with evidence-based medicine;
   3. Provides patient-centered care for Participants across the continuum of care they need, including intensive care coordination support for high risk individuals;
   4. Agrees to operate within a target budget, shared savings and value-oriented payment structure that achieves a x% savings for a defined, prospectively identified Participant population and maintains long-term trend below medical CPI;
Model Contract Language for Accountable Care Organizations

5. Agrees to promote value-based payment by increasing the portion of compensation tied to performance-based payments;
6. Maintains a health information technology and administrative infrastructure that supports regular reporting on quality outcomes and cost metrics;
7. Is transparent with respect to provision of claims and clinical information as required to support data reporting requirements of the Company; and,
8. Supports market competition through transparency on quality and cost performance.

III. COMPANY EXPECTATIONS. The following requirements outline Company’s expectations for ACO performance.

A. High-Performance Network. ACO [or Administrator] has a defined provider network that it selected based on its performance on quality, utilization and efficiency, using outcomes measures wherever available as well as patient experience measures. The ACO shall meet regulatory requirements for routine, urgent and emergent care access and geographic coverage for Participant population.

a. The ACO [or Administrator] shall maintain network contracts with the following types of health care providers to assure adequate access to a continuum of care including:
   a. Primary care;
   b. Specialty care;
   c. Behavioral health care;
   d. Ancillary services, including community and home-based services;
   e. Inpatient and outpatient facility care;
   f. Skilled nursing and rehabilitative care; and,
   g. Behavioral health.

b. The ACO will ensure adequate access by:
   a. Providing emergent care;
   b. Providing same-day appointments for routine and urgent services for both medical and behavioral health care;
   c. Providing non-urgent and urgent appointments outside of regular business hours;
   d. Providing alternative clinical encounters (e.g. telehealth); and,
   e. Identifying and acting on opportunities to improve access.

3. ACO shall promote consistent delivery of patient-centered care by providing:
   a. Practitioner education, practice redesign support and training of nurses and allied health professionals; and,
   b. Opportunities to be engaged in quality improvement teams and practice redesign.

B. Outcomes-Oriented Measurement. Company seeks to improve health outcomes through improved quality of care and patient experience. This Agreement links the ACO’s reimbursement to its ability to produce greater value – health care at lower cost and higher quality by establishing mutually agreed upon performance results that demonstrate meaningful evidence of its cost and quality improvements. The ACO shall report to Company on the following:

1. Quality, patient experience, cost, and utilization measures. The ACO shall report on the quality and efficiency measures listed in Appendix A at least quarterly or as mutually agreed upon, with no greater than a three-month lag time. While other measures may also be collected to monitor and evaluate performance, distribution of savings shall, at a minimum, be contingent upon meeting the agreed upon performance improvement
targets for the measures outlined in Appendix A. Measures will be reviewed and modified on an annual basis and attached as amendments to this agreement.

2. Baseline performance reporting. The ACO shall provide prior year performance reporting to compare performance to national and community standards, where available, and work with Company to identify areas of high variability for targeted improvement goals on an annual basis.

3. Participant engagement. The ACO shall report on Participants identified for care coordination, shared decision-making and other patient-centered services described in Sections III.C and III.D below at least quarterly or as mutually agreed upon, including:
   a. Percentage of population engaged and/or receiving specified services;
   b. Percentage of targeted Participants engaged and/or receiving specified services;
   and,
   c. Select quality and cost indicators for Participant population identified in Paragraph 3.a. and 3.b. above, and selected from the top 10 most prevalent acute and/or chronic conditions.

4. Company and ACO shall agree to performance improvement or maintenance targets relative to baseline results. Such targets will be used as performance threshold requirements prior to distribution of shared savings described in Section III.E., below.

C. Patient-Centered Care. Company seeks to assure that care is provided based on Participant preferences and needs. ACO shall monitor adherence to recommended patient support services and, as appropriate, create internal incentives for health care providers to adhere to specifications below and participate in shared decision making with their patients.
   a. Based on Participant risk profile, modifiable risk, utilization patterns, and/or adherence to recommended evidence-based care guidelines, the ACO shall coordinate with patient, family or caregiver to create an individual care plan that includes:
      a. Providing care planning and self-care support;
      b. Incorporating patient preferences and lifestyle goals;
      c. Jointly establishing individualized treatment goals;
      d. Addressing potential barriers to meeting goals and their possible solutions;
      e. Providing a written self-management plan; and,
      f. Providing 24/7 access to primary care services or a care coordinator.
   b. The ACO shall support shared-decision making among Participants through:
      a. Making available relevant support tools and information;
      b. Soliciting Participant preferences with respect to functional outcomes, recovery or rehabilitation expectations, and risk tolerance;
      c. Explaining treatment options as may be clinically recommended based on Participant risk profile and/or disease state progression; and,
      d. Monitoring claims and referral patterns to identify opportunities to support decision making around treatment options.
   c. The ACO shall support Participants in their preferred mode of communication wherever possible:
      a. Collecting information on preferred language; and,
      b. Supporting diverse platforms including secure e-mail, web visits and telehealth.

D. Care Coordination. The ACO shall coordinate care for its patient population. In particular, the ACO shall establish a systematic process for identifying and engaging patients who may benefit from care management.
Model Contract Language for Accountable Care Organizations

1. The ACO shall consider the risk factors including, but not limited to the following:
   a. Behavioral health condition;
   b. High cost/high utilization;
   c. Poorly controlled or complex conditions; and,
   d. Social determinants of health.

2. The ACO shall engage at-risk Participants identified through its process and criteria, including but not limited to the following:
   a. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver; and,
   b. Prospective identification of Participants and proactive outreach based on claims history and referral patterns, as available.

3. The ACO provides additional patient and caregiver support, including but not limited to the following:
   a. Educational materials and resources to patients;
   b. Self-management and self-monitoring tools; and,
   c. Structured health education programs.

4. The ACO reports at least quarterly on the following:
   a. Total membership engaged in care management programs;
   b. Total membership by type of intervention; and,
   c. Total membership graduated and/or disenrolled from care management programs, including tracking of reason for disenrollment.

E. Value-oriented Payment. The ACO shall implement reimbursement and contracting strategies that promote value through paying for quality, not quantity, such as described below and in Appendix B.

1. The ACO agrees to set a goal of at least 20%* of provider compensation flowing through value-oriented payment methods, including but not limited to the following:
   a. Alignment with Medicare value-based purchasing and the Medicare Physician Quality Reporting System, which includes incentives related to performance on measures of healthcare-acquired conditions, readmissions, and mortality outcomes, as well as non-payment for “never events” and inappropriate use.
   b. Payment linked to achieving other quality improvement or performance-based metrics.

2. The ACO agrees to hold Company and Participant harmless for the cost of “never events.”

3. The ACO shall adopt specific methods that may include risk adjustment, episode-based payment or bundling, and case rates.

4. If the ACO receives capitation as a risk-bearing entity or payment as a medical services organization,
   a. The ACO shall undertake efforts to promote performance-based rewards and pass through quality incentives to individual providers with which it contracts.
   b. The ACO shall structure payment to support primary care availability.
   c. The ACO shall structure payment to support evidence-based care, reduce waste, and avoid medically unnecessary care.

F. Cost Measurement and Savings Determination. ACO shall reduce overall spending and moderate trend to target CPI or less. For purposes of assessing cost savings, the Company will apply a prospective patient attribution model. Subject to mutual agreement, the parties
may identify a designated patient population based on a specific geographic catchment area, claims incurred prior to the period of the attribution analysis, or open enrollment benefit plan selection. The ACO will have a defined patient population for purposes of cost and quality measurement, as well as to target care coordination strategies. Such attribution or designation will be updated quarterly.

1. The ACO agrees to evaluate utilization, cost trend and savings. The ACO shall provide Company with evaluation results on a quarterly basis with an annual reconciliation to track progress on achieving the Company’s overall expectations outlined in Section III. Specifically, ACO (and if applicable, Administrator) shall report on the following information specific to the Company:
   a. Total membership;
   b. Cost, utilization and quality indicators defined in Appendix A;
   c. Total spend, PMPM, per admission, and per episode for the condition categories below and any other top 10 service by cost not reflected in this list;
      i. Musculoskeletal
      ii. Cancer care
      iii. Cardiovascular
      iv. Maternity care
      v. Other Women’s health and reproduction
      vi. Gastrointestinal
      vii. Preventive services
      viii. Respiratory
      ix. Behavioral health
      x. Endocrine
   d. Overall change in total spend compared to prior year (total savings);
   e. Average reduction in PMPM spending compared to prior year (when applicable);
   f. Break down of total payment distribution of savings;
   g. If Company membership attributed to the ACO exceeds 2,499 covered lives, ACO shall report the above outlined utilization and cost data for the engaged Participants and at a Company-population level; and,
   h. If Company membership attributed to the ACO is below 2,500 covered lives, ACO shall provide responses for engaged Participants, at a Company-population level, as well as in aggregate for Administrator’s engaged and non-engaged population overall.

2. If the ACO is contracted with the Administrator under a fee-for-service payment model, the ACO shall implement a shared-risk payment arrangement designed to align provider incentives and reduce overall costs that includes the following characteristics:
   a. An aggregate minimum savings rate of X% must be achieved before any savings are distributed.
   b. Company and ACO shall agree upon a clearly defined measure of the ACO’s cost savings prior to the start of this contract. The ACO will be able to share up to 50% of the savings above the minimum saving rate, if it meets 100% of the quality standards described in Appendix A. Savings shall be capped at not more than 15%* of the medical cost target for that given year. ACO or Administrator may elect to apply a withhold on fee-for-service payments to fund the shared savings arrangement.
   c. If the ACO does not reach cost targets outlined in Paragraph 2a above, the ACO will be responsible for up to 50% of losses on a schedule to be mutually agreed upon.
Model Contract Language for Accountable Care Organizations

d. Medical cost will be case-mix adjusted.
e. Geographically out-of-area claims will be excluded provided ACO has made best efforts to repatriate the Participant in its provider network as clinically appropriate.

3. If the ACO is contracted with the Administrator under a capitation and/or existing shared-risk payment arrangement, benchmarks shall be created each performance year based on both historical claims data and prospective trending.
   a. A minimum savings rate of X% must be achieved before any savings are distributed.
   b. Company and ACO shall agree upon a clearly defined measure of the ACO’s cost savings prior to the start of this contract. The ACO will be able to share up to 50%* of the savings above the minimum saving rate, if it meets 100% of the quality standards described in Appendix A. Savings shall be capped at not more than 15%* of the benchmark of that given year.
   c. If the ACO does not reach cost targets outlined in Paragraph 3a above, the ACO will be responsible for 50%* of losses. Losses will be capped with a sliding rate, starting at a minimum of 5% percent of the ACO’s medical cost benchmark in year one, ramping up to 10% by year three.*
   d. Medical cost will be case-mix adjusted.
e. Geographically out-of-area claims will be excluded provided the ACO has made best efforts to repatriate the Participant in its provider network as clinically appropriate.

4. Company and ACO agree to a timely reconciliation period. Cost savings will be measured after the initial year of operation, based on a 90-day claims lag. The claims reporting and analysis period will be completed by 180 days after the close of the operating year.

5. Wherever possible, ACO agrees to use best efforts to implement value-oriented payments for its providers as described in Appendix B.

G. Transparency. ACO acknowledges that transparency on quality and costs are critical for Company, patient participants, and participating providers within the ACO. Thus, the ACO agrees to:
   1. Providing information to Participants on:
      a. The quality of care at the individual provider level, including but not limited to hospital acquired conditions, post discharge complications, errors;
      b. The cost of care at the provider and/or episode of care-level reflective of plan design impacts; and,
      c. The cost of pharmacy including prescriptions PMPY and generic prescribing rate by each physician.
   2. Providing claims data, financial performance and quality information to Company on:
      a. Patient claims data within 30 days of processing;
      b. Quality outcomes, patient experience, claims and utilization data delineated in Appendix A;
      c. Overall spending;
      d. Portion of spending linked to performance-based payments as described in Appendix B;
      e. Savings amount, if any; and,
      f. Methodology for savings distribution to providers within the ACO.
   3. Providing feedback and benchmarking information to Providers on:
      a. Measures definitions and performance targets for performance-based payment arrangements; and,
b. Performance of individual providers within the ACO to guide referral patterns to highest value providers.

H. **Health Information Technology and Administrative Infrastructure.** The ACO will support meaningful use of health information technology. ACO shall utilize an advanced IT infrastructure that enables it to manage the health of its population.

1. The ACO shall maintain the following functionalities to optimize data management:
   a. Real-time patient data capture across providers and care settings;
   b. Timely data-sharing for use in care management and treatment across providers and care settings;
   c. Real-time access to all patient information across providers and care settings;
   d. Participant access to self-monitoring information (e.g., lab results) and condition status with self-reported updates; and,
   e. Portability of clinical information should a Participant leave a provider practice or employment.

2. The ACO shall maintain the following functionalities to optimize care management:
   a. Registries designed to track patient health status and recommended evidence-based preventive screenings and chronic care management;
   b. Automated tools for care management;
   c. Electronic prescribing;
   d. Online patient education and care guidance/engagement;
   e. Patient portals with secure Web-based access; and,
   f. Telehealth/home monitoring services.

3. The ACO shall maintain Performance Analytic systems and reporting tools that:
   a. Make clinical data actionable at the point of care, generate follow-up alerts to patients, and support care management;
   b. Measure organizational and individual provider performance; and,
   c. Monitor and generate reports on utilization and financial performance.

4. Subject to mutual agreement and execution of appropriate health information privacy and security agreements, the ACO shall exchange relevant Participant information with such vendors as designated by Company, including but not limited to Centers of Excellence, health and wellness, disability and/or behavioral health and prescription drug carve-out suppliers.

I. **Maintaining Market Competition.** ACO and its contracted Providers shall not engage in the following actions:

   1. Withholding quality and cost data from statewide or regional public performance reporting initiatives;
   2. Requiring exclusive contracts with physician groups, hospitals and ambulatory surgery centers (ASC) such that they are precluded from entering into contracts with other ACOs or commercial payers;
   3. Instituting non-disclosure provisions that prohibit ACOs or commercial payers from disclosing quality, utilization, price and cost data and information to its Participants, Company, or commercial payers; and,
   4. Instituting non-disclosure provisions that prohibit its claims from use in a multi- or all-payer claims database that is a designated Centers for Medicare and Medicaid Services (CMS) Qualified Entity.

*Please note, these percentages are provided for illustration purposes only.*
APPENDIX A: QUALITY, PATIENT EXPERIENCE, COST AND UTILIZATION MEASURES

Company and [ACO [or Administrator]] will mutually agree upon a benchmark for comparing results such as NCQA national performance percentiles, or publicly reported statewide plan or provider organization performance percentiles. Targets will reflect an improvement relative to prior year experience based on the following schedule:

<table>
<thead>
<tr>
<th>If current performance is at:</th>
<th>Target improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>90th percentile</td>
<td>Maintenance</td>
</tr>
<tr>
<td>75th percentile</td>
<td>2%</td>
</tr>
<tr>
<td>50th percentile</td>
<td>4%</td>
</tr>
<tr>
<td>25th percentile or less</td>
<td>10%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Name</th>
<th>Description</th>
<th>Endorsement</th>
<th>Target</th>
<th>Frequency*</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Risk Population – Diabetes</td>
<td>HbA1c control</td>
<td>Percentage of patients with HbA1C levels in control (8 and &gt;9)</td>
<td>NQF #729</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Blood pressure control</td>
<td>Percentage of patients with blood pressure &lt;140/90</td>
<td>NQF #729</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Lipid control</td>
<td>Percentage of patients with LDL-C&lt;100 mg/DL</td>
<td>NQF #729</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Optional</td>
<td>Optimal Diabetes Care - Process - Outcomes</td>
<td>To the extent that there are data gaps in clinical outcomes measures, the parties may elect to use the composite measure that captures the percentage of diabetes patients who meet ALL individual process (testing) measures. If performance in the three measures listed above is satisfactory, the parties may elect to use the composite outcomes measure that includes these measures, non-smoking status and daily aspirin use.</td>
<td>NQF #729</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD): Lipid Control</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result &lt;100 mg/dL OR patients who have a LDL-C result &gt;=100 mg/dL and have a documented plan of care to achieve LDL-C &lt;100mg/dL, including at a minimum the prescription of a statin.</td>
<td>NQF #74</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) &lt; 40% who were prescribed ACE inhibitor or ARB therapy</td>
<td>NQF #66</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>At Risk Population – Behavioral Health</td>
<td>Depression Remission at Six Months</td>
<td>Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score &gt; 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.</td>
<td>NQF #711 MN Community Measurement</td>
<td></td>
<td>Annual</td>
</tr>
<tr>
<td>Domain</td>
<td>Measure Name</td>
<td>Description</td>
<td>Endorsement</td>
<td>Target</td>
<td>Frequency*</td>
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</tr>
<tr>
<td>Functional &amp; Health Status: Behavioral Health</td>
<td>Depression screening</td>
<td>Percentage of patients screened for depression/behavioral health issues</td>
<td>PHQ-9</td>
<td></td>
<td>Quarterly- % completion rate</td>
</tr>
<tr>
<td>Other Clinical Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At Risk Population</td>
<td>Controlling High Blood Pressure</td>
<td>Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year.</td>
<td>NQF #18</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Cesarean Section</td>
<td>Assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.</td>
<td>NQF#471</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Adherence</td>
<td>Drug Possession Rate</td>
<td>Assesses the percentage of patients 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement period. Beta blockers Diabetes medications (biguanides, DPP-IV inhibitors, sulfonylureas, thiazolidinediones) Calcium channel blockers ACE/ARBs</td>
<td>Pharmacy Quality Alliance</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Hospital-Wide All-Cause Unplanned Readmission</td>
<td>Estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.</td>
<td>NQF#1789</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions</td>
<td>Low Birth Weight Hypertension Adult asthma Pediatric asthma Uncontrolled diabetes Urinary tract infection Pain control</td>
<td>AHRQ (PQI)</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Follow-up</td>
<td>Follow-up after Emergency Department visit</td>
<td>Percentage of ED discharges for patients with an OP visit within: 72 hours 7 days</td>
<td>NA</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Follow-up</td>
<td>Follow-up after hospitalization</td>
<td>Percentage of discharges for patients who had an OP visit. The percent of members who received follow-up within: 24 hours of discharge 30 days of discharge</td>
<td>NA</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Patient Experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/ Caregiver Experience</td>
<td>Patient Experience Measures- CAHPS</td>
<td>Patients’ Rating of the Provider (or Doctor) Getting Timely Appointments, Care, and Information How Well Providers (or Doctors) Communicate with Patients</td>
<td>NQF#5</td>
<td></td>
<td>Annual or semi-annual cohort-based</td>
</tr>
<tr>
<td>Functional &amp; Health Status</td>
<td>Health status survey</td>
<td>Assesses the patient’s health status.</td>
<td>SF-2</td>
<td></td>
<td>Quarterly- % completion rate Annual-% change</td>
</tr>
</tbody>
</table>
Model Contract Language for Accountable Care Organizations

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Name</th>
<th>Description</th>
<th>Endorsement</th>
<th>Target</th>
<th>Frequency*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost/Utilization</td>
<td>Admissions Hospital readmission rate</td>
<td>All-cause inpatient readmission rate</td>
<td>NQF#1789</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Emergency Department visits Emergency Department</td>
<td>Emergency Department Visit Rate, including after hours and Monday-Friday daytime hours (9:00 am – 5:00 pm)</td>
<td>NA</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Cost of Care</td>
<td>Total Cost of Care</td>
<td>This measure is used to assess the total cost of care population-based per member per month (PMPM) index.</td>
<td>NQF #1604</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Appropriateness of Care</td>
<td>Use of Imaging Studies: Low Back Pain</td>
<td>The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.</td>
<td>NQF#0052</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Operational (optional or as mutually agreed upon)</td>
<td>Member Engagement Volume and percentage of targeted members engaged in health coaching, health management or case management programs, as mutually agreed upon.</td>
<td>Quarterly</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Member Engagement Volume of members accessing electronic health record, member portal, telehealth, or other Web-based communications, as mutually agreed upon</td>
<td>Quarterly</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Member Engagement Volume and percentage of targeted members using self-care and self-monitoring tools</td>
<td>Quarterly</td>
<td></td>
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<tr>
<td></td>
<td>Reporting Timeliness of data and performance reporting</td>
<td>Quarterly</td>
<td></td>
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</tbody>
</table>

*Quarterly reporting assumes rolling calendar year with availability of baseline data.
APPENDIX B. VALUE-ORIENTED PAYMENT*

ACO shall use best efforts to implement payment strategies that tie payment to value and reduce waste. Such strategies include, but are not limited to the following:

1. **Pay Providers differentially according to performance.** ACO shall evaluate and implement successful programs to differentiate Providers who meet or exceed national standards for quality and efficiency. Compensation paid to effective and efficient Providers should reflect their performance and result in market efficiencies and savings to purchasers and payers. ACO shall align commercial payments to hospitals with the approach being taken by Medicare, in which an increasing proportion of reimbursements is tied to performance, including performance on value-based measures, which include, but are not limited to:
   a. Hospital-Acquired Conditions;
   b. Readmissions;
   c. Mortality outcomes measures; and,
   d. The other measures in Center for Medicare and Medicaid Services’ Hospital Value-Based Purchasing program.

2. **Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.** ACO shall evaluate and implement successful approaches to payment that are designed to cut waste while not diminishing quality. Examples include, but are not limited to Choosing Wisely recommendations from medical specialty societies on services and procedures that are not medically indicated.

3. **Payments designed to encourage adherence to clinical guidelines.** ACO shall evaluate and implement approaches to payment that successfully encourage adherence to clinical guidelines in the delivery of health care.
   a. Examples include, but are not limited to Maternity Care Payment that provides financial incentives to reduce inappropriate or unnecessary medical interventions in labor and delivery such as early inductions and elective C-sections.
   b. If ACO determines that the linkage between payment and adherence to clinical guidelines results in meaningful improvement in value and clinical outcomes, Administrator shall report to Company 1) plans to expand initiatives in the short term (1 year) and longer term (3-5 years); and, 2) other clinical areas where current payment approaches create financial incentives to provide care that is not evidence-based and where a change in payment methodology could instead provide incentives for evidence-based care.

4. **Payment strategies to reduce unwarranted price variation.** ACO shall undertake payment strategies including, but not limited to:
   a. **Analyze prices.** ACO shall conduct an analysis of price variation among its network Providers and share information with Company indicating those procedures, regions or other market segments with the widest variation and greatest cost savings opportunities through a reference or value pricing scheme or adjustments to the referral practice patterns of the ACO providers.
   b. **Pilot value pricing programs.** [ACO or Administrator] shall develop value pricing pilots for procedures or services amenable to a reference, value, or bundled pricing arrangement with potential savings for Company. For the purposes of this section, reference pricing is defined as
an approach to pricing that establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that Participants pay any allowed charges beyond this amount. Value pricing builds on reference pricing by adding a threshold of quality performance to the identification of Providers of a procedure, service or bundle of services that are able or willing to provide care at the reference price. Bundled pricing is defined as an approach that combines professional and facility services into a standard price. ACO shall work closely with Company to define and implement pilot(s) and to determine the basis upon which the success of pilot(s) will be evaluated. As results become available, ACO will share those results with Company. For any procedures for which ACO implements reference, value, or bundled pricing, ACO shall investigate introducing bundled payments to providers so that patient members can better estimate their out-of-pocket costs. ACO will explore the use of warranties on discharges for patients who undergo procedures.

c. **Encourage consumer value-based purchasing.** In support of such pilots, ACO shall help Company to consider benefit designs and/or incentive and communication strategies that engage Participants to be active shoppers while also helping them to identify the highest-value Providers and limit out-of-pocket exposure. ACO shall manage and maintain and/or make available to Company data and tools for Participants to enable price and quality comparisons among Providers.

d. **Center of excellence pricing.** ACO shall explore development of a value pricing program for episodes of care utilizing and based on its existing or new centers of excellence.

e. **Rebalance payment between primary and specialty care.** ACO shall develop, pilot and implement successful strategies to improve payment for primary care services, including strategies to reduce payment discrepancies between primary and specialty care. Such strategies may include, but are not limited to, performance-based incentive programs, fee schedule adjustments, and health care delivery system programs such as Medical Homes. Irrespective of reimbursement method, delivery system programs should be structured to focus on improving the quality of care while also reducing overall health care costs.

*Adapted from Catalyst for Payment Reform 2014 MODEL HEALTH PLAN CONTRACT LANGUAGE ON PAYMENT REFORM.*