

**VT Health Care Innovation Project
 Episodes of Care Subgroup Meeting Agenda
 Thursday, April 16, 2015 9:00 AM – 11:00 AM.
 Small Conference Rm, 312 Hurricane Lane, Williston, VT
 Call in option: 1-877-273-4202
 Conference Room: 2252454**

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	9:00-9:10	Welcome and Introductions; Approval of 02/12/15, 3/06/15, 3/26/15 EOC Sub-Group Meeting Minutes	Alicia Cooper	Y- Minutes Approval	Attachment 1a: 02/12/15 EOC Sub-Group Meeting Minutes Attachment 1b: 03/06/15 EOC Sub-Group Meeting Minutes Attachment 1c: 03/26/15 EOC Sub-Group Meeting Minutes
2	9:10- 10:50	Review Proposed Timeline, Outstanding Items, Draft Documents	Discussion	N	Attachment 2a: EOC Sub-Group Process Summary Attachment 2b: Specification of Work Attachment 2c: Memo: Proposed Activities
3	10:50- 11:00	Public Comment and Next Steps		N	Next Sub-Group Meeting: Thursday, May 7, 2015 9:00 PM – 12:00 PM Small Conference Room 312 Hurricane Lane, Williston, VT

Attachment 1a

**VT Health Care Innovation Project
 Episodes of Care Subgroup Meeting Agenda
 Thursday, February 12, 2015 9:00 AM – 11:00 AM.
 Small Conference Rm, 312 Hurricane Lane, Williston, VT
 Call in option: 1-877-273-4202
 Conference Room: 2252454**

Attendees: Cathy Fulton (VPQHC), Alicia Cooper (DVHA), Jim Westrich (DVHA), Amanda Ciecior (DVHA), Mike DelTrecco (VAHHS), Pat Jones (GMCB), Andrew Garland (MVP Health Care), Beth Tanzman (Blueprint for Health), Susan Aranoff (DAIL), Kelly Lange (BCBSVT), Amy Coonradt (DVHA), Sean Murphy (BCBSVT)

Topic	Notes	Next Steps
Welcome and Introductions	Alicia Cooper started the meeting at 9:05am. Those in attendance and on the phone introduced themselves, and for those unable to attend in person, a screen sharing option was available. Susan Aranoff moved to approve the minutes, Cathy Fulton seconded. The motion carried with one abstention.	
Updates and Follow Up	<p>Beth Tanzman gave an overview of the Blueprint for Health HSA-level Profile (attachment 2). The following were key points of from the discussion and questions from workgroup members.</p> <ul style="list-style-type: none"> • Reports are produced every 6 months; this is significantly faster than they were being produced at the start of this initiative. Currently, there are reports being done at both the HSA and practice level and for both adult and pediatric patients. Reports are also being distributed at an ACO level for internal analysis. • Beth noted that it is the long term goal of the Blueprint for profiles to be used to enhance collaboration among providers and ACOs and to improve clinical care and quality performance throughout the state. Results in these reports are normalized and the data does adjust for outliers, so it is easy to compare across HSAs throughout the State. • Susan Aranoff asked how inclusion in each HSA is determined. Beth responded that the HSA is made up of the residents that live there, not those who sought treatment in the HSA. This method allows for a better understanding of HSA residents and their particular patterns of care. 	

- Comparing Medicaid to Commercial data is challenging as Medicaid covers more social services than commercial payers do; most analyses included in the profiles exclude these Special Medicaid Services (SMS) to allow for more uniform comparison.
- Mike DelTrecco asked if the ‘cost’ is what is paid to providers. Beth responded that the cost is what is actually being paid by insurance based on VHCURES claims data. Additionally, he asked how these reports are being distributed and how they are being used for accountability purposes. Beth replied that all practices in the Blueprint and the Blueprint leadership team were receiving the reports. She believes this information is helping to hold people accountable, especially in the primary care networks as well as throughout the HSA. As these reports go beyond just primary care services, there is potential to expand the audience as providers and ACOs see fit.
- Cathy asked about the poorly performing Randolph HSA and whether the data can be used to drill down into what is occurring in the HSA to provide such poor results. Beth responded that Randolph is working to improve, and that they are starting to do this by looking more closely at their data. However, equally important to driving improvement is looking into what high-performing HSAs are doing so well.
- Pat Jones clarified that this analysis is based on beneficiaries attributed to Blueprint practices, or roughly 300,000 Vermonters, so it is not quite representative of the full state population.
- Currently, available data does not reach down to the patient level, but can tell practices where to start looking for cost savings. Mike shared VAHHS’ experience with sharing patient-level information with providers, noting that it can be more specifically actionable.
- Beth noted that the practice recipients are receptive to this information and find it to be actionable. The claims and clinical data sources and the analytics being done by the contractor tend to be credible
- Kelly Lange responded that presently, BCBSVT does not validate the data being used to generate the reports, and wondered if BCBSVT or other payers had done so previously. Beth responded that she was not sure – and would defer to other members of the Blueprint team for this information.

Alicia updated the sub-group on additional outstanding issues from the last

	<p>meeting. She reported that a request has been made to follow up on alignment between this initiative and the all payer waiver. Finally, the nursing home bundled payment program will be presented at the larger PMWG meeting, and staff is currently working on adding this to the next month's agenda.</p>	
<p>MVP Episodes Analytics Presentation</p>	<p>Andrew Garland presented on MVP's Episodes of Care program. The following are key points and comments on the presentation</p> <ul style="list-style-type: none"> • This data uses unique TINs to identify providers/practices. • Key terminology in this presentation: efficiency is in reference to resource use while effectiveness references quality • The vendor MVP selected has their own episode definitions, although there is some flexibility in how to define episodes. There are 527 episodes, while the top 15 account for majority of volume in costs. Episodes are often separated out by severity of illness, giving way to levels 1, 2 and 3 for most episodes. Severity level 3 is always removed from analysis as there is significant variation occurring around this level of illness. Other factors contributing to the assigned severity level is if it is an acute or chronic condition as well as the age of the patient. • The first set of MVP's reports was generated using 2012 data, and they are about to produce their 3rd annual installment of reports using data from 2014. Each episode analysis allows for a three month claims run-out, ensuring all services are included. MVP's vendor is already using ICD 10 coding. • Episodes exclude comorbidities, as it adds too much instability to fairly analyze and compare each case. In the end, about 50% of the available episodes are thrown out. • Episode assignment is achieved by preponderance of care on the provider side; to be assigned a patient the provider must bill for at least 20% of non-hospital charges. Often there will be multiple providers attributed to one patient which can be beneficial when trying to understand the care pattern of patients within a particular episode. • Mike asked about changing current attribution to the ACO attribution model, and if that would be possible with this vendor. Andrew responded 	

that yes, they could attribute to provider, and then attribute them to their respective ACOs.

- MVP does not send providers these reports without having representatives there to explain what it all means. The information needs ‘socializing’ and therefore a group of experts who can effectively explain what the reports mean to providers accompany each release. Currently, MVP is only sending out reports to 10 of the 37 specialty types for which they produce episode analytics.
- There were a few questions within the group about how to cut costs while still being preventive and providing necessary services. Andrew responded that this is where an expert physician can be leveraged to speak to other providers in their field. The data suggests that efficiency and effectiveness can go hand in hand, and the best way for providers to learn how to drive down utilization and costs is to learn from their peers.
- When disseminating reports, MVP plans annual trips to practices to go over reports, choosing to focus on the highest utilizing practices first. Andrew reported that they do typically return back to the same practices every year. In addition, they have been adding roughly 3 specialty practices a year for report sharing and annual visits. There are currently 27 specialty types not receiving episode reports. Information is not shared with these specialty types due to a lack of resources and time; MVP does not want to provide reports without the accompanying effort to explain and socialize the information. Andrew reported that most have found this information very useful. In regard to concerns around reporting on so many types of episodes, it did not cost more to get analytic work done on all episodes versus just a few; and by running analytics on all episodes MVP could then prioritize and incrementally expand information sharing initiatives over time.
- Susan Aranoff expressed concern around how to assure patients are still satisfied with their care if physicians are actively trying to cut costs. Andrew said they are still a long way from being able to measure outcomes associated with each episode. However, there is a patient satisfaction measure for all physicians, and generally, patients are reporting they are satisfied with their providers and their care.

<p>Episode Selection</p>	<p>Alicia Cooper started the conversation around choosing which episodes to prioritize for Vermont’s planned episode analytics, and pros and cons were discussed around choosing a universe of episodes versus identifying specific episodes for analysis.</p> <ul style="list-style-type: none"> • Pat Jones said she was leaning towards a broader approach, and then prioritizing which episodes to share. She thinks the cost for a larger set of episodes will not change much, and is therefore worth it. • Cathy Fulton would like to know more about the process to follow after we collect this information, and how we would deliver the reports and what resources we would have to educate report recipients on the information gathered. She also supported a broader approach, but would like to further discuss how we will then manage the distribution of this information once it is available. • Alicia commented if the group feels a broader approach might be best, then we can -shift our focus in the near-term to discussion about a dissemination plan instead of episode-specific methodology considerations. • Susan commented that there should be as much overlap as possible between any new reports and what is already produced by the ACOs and BP. Pat Jones mentioned that it is important to keep in mind that BP and ACO measures are focused on primary care. Additionally, BP reports are focused on the PCMH population, and ACOs on their own populations, and that there may be a unique opportunity for Episodes information to be used population-wide. • Kelly also identified some potential challenges for future discussion: Presentation of the data presents a challenge with sustainability, particularly when the SIM grant ends. She also whether this initiative might want to require any actions or improvement by providers. • Alicia asked the payers if there may be an alternative to using VHCURES to provide claims to a vendor. Andrew responded that MVP would be able to provide files in a common format; Kelly agreed that it could be done. While it would take time to generate and share extracts on an ongoing basis, there is no immediate barrier to pursuing such an alternative option VHCURES proves unsuitable for this type of analysis. • Pat noted that the ACOs have a lot of specialists in their networks, and are continuing to develop their specialist participation. It will be important to 	<p>Feasibility of using VHCURES for future episode analytics work</p>
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	<p>leverage those networks when thinking about how to distribute this information to the appropriate people.</p> <ul style="list-style-type: none"> • It was noted that the Northern New England Accountable Care Collaborative (NNEACC) might have something currently available to OneCare around Episodes and we need to make sure we identify what is already being done before potentially duplicating efforts. • Blueprint has had conversations around bringing in a specialist focus through an Episode lens before, but no current work is occurring on this front. It would seem like a natural next step. • The question of a small sample size in Vermont arose. Andrew responded that MVP has meaningful data for roughly 25 specialty types in VT – should not be a concern in going forward. 	
Public Comment and Next Steps	<ul style="list-style-type: none"> • Next meeting will be focused on plans for disseminating analytics as well as long term sustainability beyond the life of the SIM grant. • Discussion of the group’s VHCURES flag “wish list” will be postponed until a later meeting. 	<p>Next Meeting: March 6th, 9am-11am, EXE 4th Floor Conference Room, Montpelier, VT</p>

Attachment 1b

**VT Health Care Innovation Project
 Episodes of Care Subgroup Meeting Agenda
 Friday, March 6, 2015 9:00 AM – 11:00 AM.
 109 State Street, Montpelier, EXE - 4th Floor Conf Room
 Call in option: 1-877-273-4202
 Conference Room: 2252454**

Cathy Fulton (VPHCQ), Andrew Garland (MVP), Pat Jones (GMCB), Kelly Lange (BCBSVT), Alicia Cooper (DVHA), Amy Coonradt (DVHA), Jim Westrich (DVHA), Mandy Ciecior (DVHA)

Topic	Notes	Follow up Items
Welcome and Introductions; Approval of 02/12/15 EOC Sub-Group Meeting Minutes	Alicia Cooper started the meeting at 9:15. A quorum was not present so the sub-group was unable to approve the minutes. Both the February 12th and March 6 th minutes will be approved at the next sub-group meeting.	
Arkansas Reports	<p>Alicia Cooper introduced two reports that the Arkansas SIM project is using to disseminate their Episodes of Care and PCMH analysis to providers and practices. The following were questions or comments on attachments 3a and 3b.</p> <ul style="list-style-type: none"> • For the Arkansas Episodes pilot, payments are still provided on a fee for service basis; however, they incorporate financial incentives (and penalties) based on retrospective comparison of providers to their peers. Providers can fall into the commendable, acceptable or unacceptable ranges – leading to additional payments or loses. Andrew Garland noted that Medicare is now using this approach as well for some of their episode-based initiatives. • Pat Jones asked for clarification around the term gain sharing. Gain sharing is the redistribution of any cost savings that is achieved by the commendable providers. In addition, Pat asked who provides this data to the practices. Alicia responded that it is presently a Medicaid and commercial initiative (Medicare has not yet agreed to participate). Both Medicaid and Commercial payers have agreed to use the same approach in their methodology and distribution but are not using the same vendor for analytics and report generation. Arkansas Blue Cross and Blue Shield has a strong analytics team so they are able to conduct this analysis internally. Arkansas Medicaid chose to contract with General Dynamics 	

Information Technology (GDIT) and reports coming from both payers are fairly comparable. So far, providers in Arkansas have not raised any issues with receiving two different reports.

- The group discussed the gain sharing concept, and how some practices will lose money if they perform poorly. Arkansas reported coming out fairly even in terms of payments as some practices received bonuses and others had a financial penalty for suboptimal performance relative to peers.
- Kelly provided some more insight into the Arkansas SIM project as some Federal funding went to support the Arkansas BCBS website and provider portal. As it is a multi-payer initiative, the call center put in place has been fairly well utilized. Additionally, in Arkansas there is a lot more variability in performance of providers, which allows for more low hanging fruit. She also commented on the difficulty of getting the often necessary patient level information to providers to drive change. As the Episodes initiative was established as a requirement for most of the providers in the State, Arkansas made it a priority to include providers in program planning to ensure buy-in.
- Andrew Garland asked how many episodes Arkansas is working with. Around 15 episodes now, with more planned for release in future. Episodes are being added in 'waves'.
- Andrew spoke about the difference between using provider specific information for educational purposes versus accountability. It is possible that Arkansas can be more hands-off in socializing their information with providers because there is accountability (i.e. payment or penalty) tied to the information contained in the reports. MVP only uses their reports to inform providers and therefore must socialize the information to ensure it is being consumed. Andrew went on to explain that if Vermont plans to use this information for payment purposes in the future, early socialization of this information will be helpful. By going this route, we are also allowing providers some time to see where they can start achieving a cost savings before being held accountable. Alicia added that Arkansas reported quick behavior change by some practices after seeing their first reports, while others have been less inclined to use the information and make practice-level changes. Pat clarified that there are some practices and procedures that are easier to change in the short term than others. She also said that if the financial penalty isn't large, some practices might chose to take that small loss in order to avoid making substantial operational changes.

	<ul style="list-style-type: none"> Arkansas chose to focus on acute episodes as these are more sensitive to changes occurring over a shorter period of time. They felt that it is the goal of the PCMH initiative to focus on chronic care as primary care has the ability to achieve longer term health maintenance and improvement. 	
<p>Approach for Sharing Reports</p>	<p>The sub-group went on to discuss what they would like to see in the RFP and shared their thoughts on dissemination of the Provider Reports</p> <ul style="list-style-type: none"> The vendor’s ability to produce reports after their analysis is a characteristic the sub-group would like to see in an application. Andrew believes it is fairly usual for a vendor to be able to create a final report for providers. The sub-group agreed that the selected vendor should be able to create the reports, rather than relying on a separate group or organization for report generation. The group went on to discuss how to best use the developed reports as an educational tool and how to approach the dissemination process. Pat suggested that primary care should not be a focus of this project; instead we need to start looking at specialty care. So far there is a lot of information available to primary care providers, and they are the focus of many payment reform initiatives. Thus far there has been little effort directed at helping to cut costs in specialty areas. Pat also supported the idea of not just sending the reports, but walking providers through the information in targeted education sessions. Kelly Lange discussed the importance of creating a synergy among payers and creating a powerful front for providers to drive change. She also suggested focusing efforts on providers that are the worst performing as well as those that are the best performing in order to create opportunities for practices to learn from one another. In the absence of financial incentives or penalties, we need to clearly identify the areas of opportunity and improvement. Another issue relates to acute episodes occurring at the hospital; for information to be used effectively it would be important to approach the physicians delivering care and not the hospital administration. The group went on to discuss the potential for a regionally focused discussions or collaboratives for education and information sharing, especially in Southern Vermont where there are two large hospitals in the same region. Pat suggested that each practice or hospital receives their own report, blinded, to see how they perform relative to peers. Andrew responded by saying MVP benchmarks regionally (and that for their network Vermont is considered a single region), to show how a practice is performing against their peers. For a multi-payer initiative he would suggest splitting Vermont into two regions, North and South, for 	

benchmarking purposes.

Alicia asked the sub-group their thoughts on how frequently these reports should be provided. Arkansas provides them quarterly, Blueprint provides them bi-annually, while MVP provides reports annually. The limited availability of the SIM funding will also have to be taken into account.

- Andrew noted that when involving financial incentives or penalties, reports need to be more frequent. However, when they are just there to serve as an educational tool for providers, they can be more infrequent. Kelly agreed with this, and felt annually would be sufficient for this initiative at its onset.
- Cathy asked if there is a possibility of leveraging the provider portal through VITL. It could be beneficial to have a resource page for specialists with an option to see performance reports whenever they would like. The possibility of offering a learning session in addition to online reports would be a good complement. For those performing poorly, it would also make sense to have a 'friendly' visit, especially in the first round to facilitate learning. Kelly reported that it would be difficult to provide this online portal option with sufficiently data drill-down capabilities, and it would likely require a large change in the basic functions of VITL. This idea, and functionality of VITL should be further evaluated for future work.
- Pat felt there will likely be a significant requirement of time to create the impact we want to see using these reports. Alicia responded that Arkansas uses the approach of focusing on poorly performing practices and spending most of their time there. However, the group also saw a potential benefit in targeting the highest performing practices in order to spread best practices.
- Pat offered the idea of using multiple communication techniques while focusing on fewer specialties or episodes in order to test out a variety of dissemination and communication methods.
- Andrew reported that providers are not very likely to look at this information through an online portal. However, if the ACOs agree to participate there is a greater chance of them utilizing this information through an online portal and then discussing it with the providers delivering care.
- Andrew stated that there are four to six specialty types that account for the majority of episode-specific spending, making it easy to focus on a select number of episodes if that is what the group decides to do. He estimated that each

specialty has anywhere from 12-15 individual practices in the state, which would lead to ~60 practice visits per year if focusing on the most expensive six episodes. This number could be reduced by focusing on the most poorly performing practices. Alicia pointed out that we will need to identify the people who can do this level of dissemination work. It will be important research if there are already existing systems in place to utilize, and/or obvious candidates to do this work. Andrew described the MVP detailing team, it consist of 5 to 6 clinically trained people, with strong backgrounds in informatics as they bring the most credibility when speaking with providers.

- Kelly said that BCBSVT does not have dedicated people for this work like MVP, but together, the quality and provider relations folks do this type of outreach.
- Pat suggested the staff look into SIM funding for specific practice facilitation dollars that could potentially be leveraged.
- Alicia asked the group if we need to look into funding practice facilitation or if it would be feasible to use the payers, ACOs (and potentially Blueprint) to help disseminate this information. Andrew will discuss this issue with his Director of Detailing – although he also thinks it will be important to include someone from Medicaid as they know the program intricacies. Pat suggests asking the DVHA medical directors for more insight into this issue. Kelly will also bring this to the BCBS Director for further discussion.
- Alicia summarized the decisions of the group, the list is more inclusive than will likely be possible:
 - the sub-group will propose vendor support for analytics and report generation,
 - initial Episodes analytics work will focus on a subset of provider specialties with the most potential for cost-savings
 - will advise face to face meetings at least for the lowest performing practices (and potentially all practices), using a detailing team comprised of ACO and payer representatives
 - propose a variety of strategies for information dissemination such as supplemental materials, online tools, ad hoc analyses (by request) and the establishment of regional meetings where higher performing practices will help to share their best practices.

<p>Quality Measures</p>	<ul style="list-style-type: none"> • Discussion took place around whether the sub-group will request input on quality measures identified by the vendor. The goal of seeking input and allowing for alternative measures would be to achieve alignment with ongoing State initiatives. Pat suggests looking at existing measure sets related to the specialties which are selected, this would lead to a broader alignment with what is occurring in healthcare, not necessarily just in Vermont. • Andrew noted that if we go outside the vendor scope, we will need a lot more clinical expertise involved in developing additional measures. In addition, he also reported that the specialty providers he works with rarely look at the quality measures (as the majority of measures being used by state and federal programs focus on primary care). • As there is no payment component in this initial run, it makes sense to use the measures that are available through the vendor. The subgroup can then adjust the measures after the first year if needed. • There will be opportunity for the Quality and Performance Measures work group to review the proposed measures for each episode once a vendor has been selected. 	
<p>Public Comment and Next Steps</p>	<ul style="list-style-type: none"> • Staff needs to be sure the funding request incorporates the new Steering Committee priorities. • The next meeting will be used to nail down the details of the funding request while the final meeting in April will focus on the RFP. • Cathy suggests revisiting the HCl3 RFP to ensure we get the correct outcomes with the new RFP. • Andrew suggests creating a 5 year roadmap to ensure what we are doing in the short term aligns with the ultimate goals of this project. 	<p>Next Meeting: March 26th, 9am-11am, AHS Training Room, 298 Hurricane Lane, Williston</p>

Attachment 1c

**VT Health Care Innovation Project
 Episodes of Care Subgroup Meeting Agenda
 Thursday, March 26, 2015 8:30 AM – 10:00 AM.
 Small Conference Rm, 312 Hurricane Lane, Williston, VT
 Call in option: 1-877-273-4202
 Conference Room: 2252454**

Pat Jones (GMCB), Mike DelTrecco (VAHHS), Luann Poirier (DVHA), Alicia Cooper (DVHA), Susan Aranoff (DAIL), Jim Westrich (DVHA), Amanda Ciecior (DVHA), Norman Ward (OCV), Cathy Fulton (VPQHC), Andrew Garland (MVP), Georgia Maheras (AoA)

Item #	Relevant Attachments	Next Steps
1	Alicia Cooper started the meeting at 8:33am. At that time, there was not a quorum present to vote on past meeting minutes.	
2	<p>The focus of this meeting was to help prepare the RFP and the Funding Request for presentation to the Payment Models Work Group. Alicia summarized some outstanding issues and discussed plans to socialize the information that comes from this Episodes Analysis once a vendor has been selected and data is available. At the last meeting sub-group discussed whether the payers would be able to help support this activity. Kelly Lange sent a response via email that stated Blue Cross Blue Shield of VT is supportive of this work, but will need to know the details of what is expected before they can commit to providing personnel to support the detailing activity. Those at Medicaid are also open to supplying personnel to help in the detailing activities. Andrew Garland noted that MVP would also be willing to leverage its detailing team to support this effort. Alicia also relayed to the sub-group that if additional support was deemed necessary, there are SIM funds that can be leveraged for this task.</p> <p>Mike DelTrecco asked if the payers will continue to help fund this project after the SIM grant has ended. Alicia was unable to comment on how such an initiative would be funded after a pilot launched under the SIM grant, noting that such a decision would likely not be made until the initiative is underway and its value is demonstrated. Mike noted two major questions: a) How will this work within the greater PMWG agenda? and b) How do we ensure this is sustainable in Vermont? He believes this is a sound idea, but would like more clarity around the logistics and how it works into the bigger VT picture. Susan Aranoff asked if this initiative can be seen as solely a research exercise with our SIM funding, and not a long term project. Mike suggested that if we ever want to implement any kind of episode-based payment model in future, it would be beneficial to clarify as many details as possible now.</p> <p>Alicia responded that this initiative is envisioned to be a ‘proof of concept’ using SIM funds, to better see if supplying episode-based analytics, information, and education to providers can improve quality</p>	

and reduce spending. Beyond being a tool for providers engaging in delivery system transformation, it is anticipated that this information will also provide value to payers and ACOs. Finally, this project is in line with what was outlined in Vermont's original SIM grant application, and in our most recent VHCIP Operational Plan. The SIM funding will end, but if stakeholders find this information valuable there is the potential to extend the initiative, and to have it be jointly supported by multiple parties. Mike marked a distinction between this information being valuable to providers versus actionable. Being able to drill down to the individual level and identify high-cost cases is the only way to be actionable (noting also that this would not be possible if the analysis relied on VHCURES, as the data can not be re-identified).

Pat Jones observed that aggregate information has the potential to be helpful to providers, especially specialty providers. One of the benefits of the SIM grant is the ability to help build capacity to report, understand, and use new types of information. This is a good opportunity to develop a means of reporting episode-based information to the providers and stakeholders. If there appear to be improvements, and the EOC information provides new opportunities for system transformation, we will then have enough information to determine whether and how to continue such work. Sub-group members expressed concern that if providers see they are performing poorly, they will not believe the results, particularly if they are unable to refer back to the original claims. Susan asked if practices can validate their own data. In theory yes, but there might be a lot of variability in each practice's system to do this successfully.

Mike expressed concern about VHCURES as a potential data source and its ability to yield accurate reports. He would like the data to be thoroughly validated so he can assure providers the information they are seeing is correct.

Pat suggested that it would still be worth moving forward with the proposed plan, despite not knowing what will happen after the SIM grant is over or how the information will impact providers. Mike agreed, but believed that more detail was needed before going forward. Having seen the value in the work MVP and Blueprint have presented, he would like to make sure the approach that the sub-group recommends will be similarly impactful.

Norman Ward expressed concern around how complicated that information will be and the need for a detailing team to socialize the information. Pat reported that the ACOs and Blueprint are collaborating around regional utilization and quality performance through the UCCs, noting that we could follow a similar model for the Episodes analytics initiative. Mike responded that we need to make sure we are not duplicating efforts, but complementing ongoing initiatives.

Cathy Fulton said that she would like to see one single data warehouse in Vermont; conflict begins when we start seeing several versions of the same data set. Alicia suggested that we are still years from having that capability, and that for the purposes of the episodes analytics initiative, we would be limited

to using VHCURES or unified claims extracts from the payers. Acknowledging advantages and disadvantages of each, Alicia asked the group which option they would prefer.

Pat felt that because we are not developing a payment model based on the episodes analytics, VHCURES would be a viable option as it is continually improving. If it can drill down to the practice level, for a 'proof of concept' functionality, it can be useful.

Mike noted that, despite his extensive work with VHCURES, he is not sure if VHCURES will be beneficial or problematic when using it for EOC purposes. He would agree with Pat that we should go forward with VHCURES and validate it as a data source. However, he suggested that the sub-group still needs to figure out how to answer the providers' questions around data validity if they arise.

Andrew said that MVP does not include beneficiary-level detail in their episode reports, noting that they instead choose to focus on overall practice trends. However, Andrew did feel that having the *ability* to drill down to the patient level in the source data is beneficial when specific questions arise.

Georgia Maheras reported that being able to identify individuals has been very helpful to the Arkansas SIM team, as it engenders both payer and provider trust in the information being used. She noted reservations about using VHCURES for our episode analytics work. Mike suggested that if there was a way to establish a re-identification process the database would be much more useful.

Susan suggested moving forward with plans for the episode analytics work without definitively selecting a data source, so as not to slow progress. Pat suggested including both in the RFP, allowing bidders to prepare proposals for using both an all payer database and uniform claims extracts. Georgia suggested that using uniform claims extracts will likely cost more. Alicia noted her preference for providing a sub-group preference when presenting the proposal to the PMWG. Based on prior experience working with and manipulating VHCURES data, Mike expressed willingness to share information with the selected vendor.

Georgia noted that Arkansas was unable to establish an all payers claims database, which has been good for payment reform efforts as it is identifiable data. With VHCURES, Medicaid data can be re-identified, whereas commercial cannot. Mike suggests using VHCURES, as we have this tool and it goes mostly unused.

Georgia spoke on sustainability plans for this work, noting that a comprehensive sustainability assessment will be completed for VHCIP in the summer. In the meantime, questions of sustainability should not preclude the development of new initiatives that are in line with our overall SIM goals. The State will find a way to keep things around that prove to be beneficial.

Norm asked about the beneficiary level cost summaries listed in the RFP. Alicia clarified that the RFP was created to be more inclusive than exclusive, so that bidders could respond to all potential activities.

	<p>He also sought clarification regarding the RFP and whether it suggests having the vendor do the information dissemination and socialization. Unless the sub-group makes an alternate recommendation, the current proposal would be for the vendor to complete the analytic work and generate reports, and a stakeholder-based detailing team as needed. There also exists the ability to leverage other state structures (e.g. ACOs, Blueprint, regional collaboratives, etc.) to help deliver this information.</p> <p>Once we have selected a vendor and know which episodes they can analyze, we will be able to better identify how many episodes we want to focus on, how many specialty types to target, and how many people we will need on a detailing team. Andrew commented that the top 4 specialty types constituted about 50% of the service volume, and that moving to 7 specialties covered about 65% of the volume.</p> <p>There was a brief conversation around estimated costs for vendor support, and what channels already exist to disseminate information to providers to keep additional non-analytic costs down.</p> <p>Pat made a number of suggestions regarding the draft RFP. In particular, she suggested including in the scope a vendor’s capacity to answer questions from local dissemination efforts (i.e. a ‘help desk’, or something similar). She also suggested stronger language regarding methodological transparency.</p> <p>Susan requested an episode focus on beneficiaries with complex conditions.</p> <p>The sub-group will continue to discuss details of the RFP and funding request at the next meeting.</p>	
3	Next Meeting: April 16 th , 9am-11am, Small Conference Room, 312 Hurricane Lane, Williston, VT	

Attachment 2a

Episodes of Care Sub-Group 2015 Work Summary & Charter

Members:

Aranoff, Susan	Department of Disabilities, Aging, and Independent Living
Cooper, Alicia	Department of Vermont Health Access
Del Trecco, Mike	Vermont Association of Hospitals and Health Systems
Fullem, Leah	OneCare Vermont
Fulton, Catherine	Vermont Program for Quality in Health Care
Garland, Andrew	MVP Health Care
Harrington, Paul	Vermont Medical Society
Jones, Craig	Vermont Blueprint for Health
Jones, Pat	Green Mountain Care Board
Lange, Kelly	Blue Cross Blue Shield of Vermont
Murphy, Sean	Blue Cross Blue Shield of Vermont
Simpatico, Tom	Department of Vermont Health Access
Tanzman, Beth	Vermont Blueprint for Health
Ward, Norman	OneCare Vermont

Episodes of Care Sub-Group Meeting Schedule:

Phase 1 – Sub-Group Develops Proposal

- *January 29 Sub-group Meeting*
- *February 12 Sub-group Meeting*
- *March 6 Sub-group Meeting*
- *March 26 Sub-group Meeting*
- *April 16 Sub-group Meeting*
- *May 7 Sub-group Meeting*

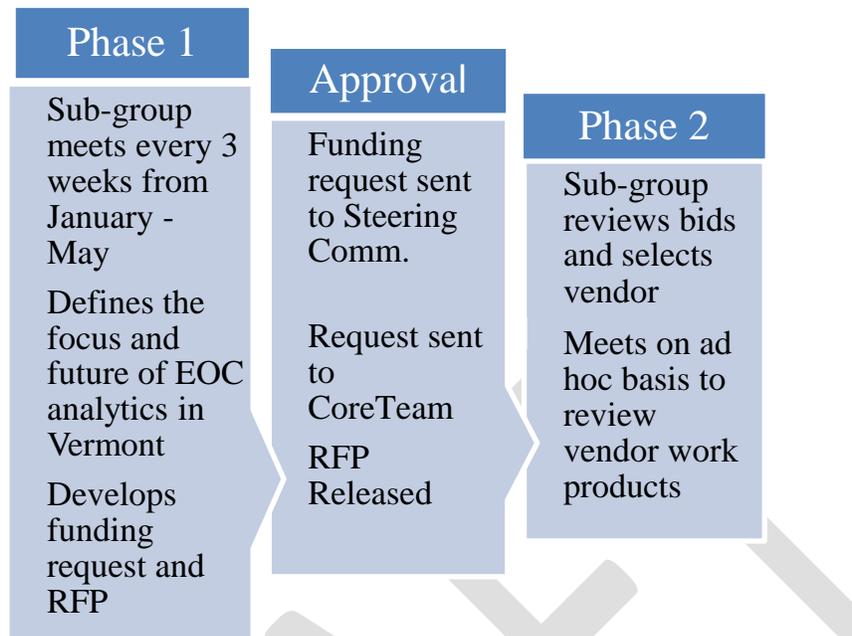
Materials can be found: <http://healthcareinnovation.vermont.gov/node/842>

Planned Next Steps

- Monday, May 18: Funding Request to **PMWG**
- Wednesday, May 27: Funding Request to **Steering Committee**
- Monday, June 1: Funding Request to **Core Team**

Phase 2 – Sub-Group Oversees Project Launch

- Reviewing bids and vendor selection
- Ad hoc meetings after contract execution to review reports and coordinate dissemination



Phase 1 Meeting Topics:

January 29: Introduction, Priority-Setting

- Sub-group discussed the overall focus for Episode analytic work and reports to be distributed to providers and stakeholders
 - Discussion around alignment between Episodes work and other State initiatives
 - Discussion of CMS' goals toward more value-based programming
 - Clarified the distinction between using EOC analysis for payment reform and as an informative tool
- Review current programs
 - Reviewed current initiatives to ensure no similar initiatives were in place in the state
 - Conducted a brief review of prior Episodes analytics by HCl3
 - Andrew Garland briefly discussed MVP's EOC initiative
- Future of Episodes in Vermont
 - Discussed alignment with other initiatives, ensuring providers are not overwhelmed with reports
 - Discussed pros and cons of a large analysis (>10 episodes) or a smaller, more focused analysis (5-10 episodes)

February 12: Reviewing Current Reports

- Beth Tanzman provided the sub-group with a presentation on the Blueprint for Health Practice and HSA Profiles

- Andrew Garland gave the sub-group an overview of the Episodes Reports that come from MVP's vendor
- Sub-group expressed a preference to use a similar approach and request analyses on a 'universe of episodes' rather than a small number of episodes
- Discussed data source options for future analytics work (e.g. VHCURES; individual payer claims)

March 6: Provider Reports and Dissemination

- Reviewed Arkansas' SIM EOC reports and discussed the benefits and limitations of that approach
- Discussed expectations of a potential analytics vendor
- Discussed preferred frequency of reports and possible activities for provider engagement and education

March 26: Developing an RFP for Vendor Support

- Discussed the question of sustainability after SIM funding ends and the benefits that aggregate EOC data can provide to stakeholders
- Continued to discuss data source options
- Discussed estimated costs, and the ability to leverage existing structures within the State to disseminate reports and engage providers

April 16: Additional Discussion of Outstanding Items

- **[ADD WHEN AVAILABLE]**

May 7: Finalization of Proposal Materials

- Finalization of Funding Request and RFP, incorporating changes suggested by PMWG members

Episodes of Care Sub-Group Work Charter

I. Purpose

The Episodes of Care sub-group will play a key role in developing and defining the future of Episodes data use in Vermont. The sub-group will recommend a number of episodes for further exploration using already established selection criteria. The sub-group will also aid in the development of a Request for Proposals (RFP) to elicit bids from potential vendors to produce user-friendly data reports related to selected episodes in the State. Sub-group members will be asked to provide recommendations regarding:

- selection and definition of episodes
- methodological considerations
- identification of appropriate quality measures
- report development and dissemination for delivery system transformation including identification of the need for additional provider supports to enhance the use of data and analytics
- bid review and vendor selection

II. Membership

The Episodes of Care sub-group will consist of a variety of healthcare experts from across the State. Membership will include an array of individuals to include those such as: health care providers, health plan representatives, ACO representatives, advocates and State employees with a range of expertise including clinical practice, data analytics, and quality improvement.

III. Sub-group Expectations

- Membership of this sub-group will require members to attend approximately one meeting every three weeks during the first four months, and on an ad-hoc basis thereafter; members should be able to make attending these meetings a priority in their schedule.
- Members will demonstrate a good understanding of Episodes of Care and the ability to think critically about issues that arise in meetings. Information may be distributed to the Sub-group in advance of meetings to ensure all members are prepared to contribute.
- Members will be expected to represent the perspective(s) of their stakeholder groups in all discussions and decisions.
- Members are to keep the statewide goal of the triple aim in mind during discussions and decision-making.
- Members will aid in establishing clear guidelines and expectations for the funding request for vendor support to further develop Episodes of Care data utilization in Vermont.
- Members should understand that the process will seek but not mandate consensus. Members should support the goals of the process, but members are free to disagree on specific decisions within the process. If consensus cannot be reached on specific topics, divergent views will be reflected in the minutes

IV. Meeting Format

Meetings will be 120 minutes in length and held in Williston or Montpelier. A call-in or webinar option will be provided for members who are unable to attend in person. All sub-group meetings and activities will be subject to provisions of the Vermont Open Meeting Law.

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Attachment 2b

1. ATTACHMENT A SPECIFICATION OF WORK TO BE PERFORMED

1.1. Overview

The Department of Vermont Health Access (DVHA) is soliciting proposals from qualified vendors to consult on statewide Episodes of Care Analyses.

On February 21, 2013, Vermont was notified of award of a \$45 million SIM grant from the federal government. This grant will fund activities inside and outside of state government over the next four years to:

1. Increase both organizational coordination and financial alignment between Blueprint advanced primary care practices and specialty care;
2. Implement and evaluate the impact of value-based payment models;
3. Coordinate with those payment models a financing and delivery model for enhanced care management and new service options for dual-eligibles; and,
4. Accelerate development of a Learning Health System infrastructure designed to meet the needs of providers engaged in delivery system reform and the state's needs for ongoing evaluation of the impact of reforms.

Specifically, the grant will support:

- a) Rapid diffusion of three alternatives to fee-for-service payment:
 - o Shared savings accountable care payments, under which a single network of providers takes responsibility for managing the costs and quality of care/services for a group of Vermonters;
 - o Episodes of care, which provide a single reimbursement amount to a group of providers for treatment of a patient's acute or chronic care episode; and
 - o Pay-for-performance models, which incorporate the total costs and quality of services in provider compensation
- b) Expansion of electronic health records (EHRs) to primary care, mental health and long term service providers;
- c) Accelerated development of interfaces between EHRs and the state's Health Information Exchange;
- d) Improved data transmission, integration and use across providers;
- e) Coordination and possibly expansion of the measurement of consumer experience;
- f) Improved capacity to measure and address provider workforce needs;
- g) Improved data analytics and predictive modeling to support monitoring system costs and quality; and
- h) Development of stronger links between the Blueprint for Health (Vermont's program to support development of advanced primary care practices) and specialty care, including mental health.

1.2. Scope of Work and Contractor Responsibilities:

The contractor will use Episode grouper programs or software to organize claims data into predetermined episodes to conduct quarterly, statewide analyses of healthcare costs and utilization across multiple payer populations.

The contractor will work collaboratively with State staff, State contractors, and public and private stakeholders as needed to customize and conduct analyses and to develop an ongoing process for report generation and distribution.

1. Episode Analytics

The Contractor will be required to have Episode grouper programs or software to incorporate data from either a) Vermont's all payer claims database (VHCURES) or b) uniform claims extracts from participating payers in the state to conduct analyses on all episodes available. The Contractor is expected to bring an array of analytic tools to this project, and the ability to add to, enhance, or refine the episode analyses as dictated by DVHA to best align with industry standards and/or State needs. The following are expected analytic capabilities of the Contractor:

- a) Ability to conduct analyses on a large array of episodes (both acute and non-acute) in Vermont on a quarterly basis.
- b) Ability to conduct analysis using a person-level risk adjustment.
- c) Ability to conduct an evaluation of cost and quality (efficiency and effectiveness) by provider type or location of services.
- d) Ability to provide a cost breakdown by spending category (i.e. inpatient, outpatient, professional, pharmacy) as well as frequency of components of care for each episode (e.g. E&M visits, procedures, drugs, testing, others) while highlighting areas of variability across providers and any differences between practice patterns and clinical guidelines .
- e) Ability to conduct analyses of episode-specific physician-to-physician referral patterns (taking into consideration the effect of practice size on referrals).
- f) Ability to rank providers' quality and overall cost relative to peers within the same specialty.
- g) Ability to modify episode definitions as requested by DVHA.

2. Software/Program Detail

The Contractor shall provide detailed documentation about how each episode is constructed using the grouper program or software, and shall include relevant definitions on reports distributed to providers and stakeholders. For each episode, such detail must include:

- a) The trigger event(s) and information within the claims data that define whether an episode took place

- b) The definition of the attributing provider(s) , defined as the provider(s) in the best position to influence the cost and quality of an episode
- c) The episode time window, defined as the start and stop points that encompass the episode (including a pre-trigger window, a trigger window, and a post-trigger window as applicable)
- d) Codes and information from claims used for inclusion in and exclusion from the episode
- e) Episode-specific quality and utilization metrics (and detailed specifications)
- f) Patient-level and provider-level risk adjustment factors
- g) Patient exclusion criteria

3. Data Hosting and Access

When the data intake and cleaning phases are complete, the data may be housed or hosted in a central location. Hosting tasks will include providing a data storage space that:

- a) Is protected from physical damage;
- b) Maintain a secure and encrypted database environment;
- c) Maintain secure, encrypted file transfer and data communications at all times;
- d) Maintain an acceptable emergency back-up plan for database; and
- e) Can be securely connected to the VCHURES infrastructure or other internal data centers
- f) Is prohibited from use except as directed within this RFP and as directed by DVHA to address the stated objectives of the Vermont Health Care Innovation Project. Any unauthorized use of data obtained through the contract expected to result from this RFP shall be grounds for contract termination.

4. Provider Reports

The Contractor shall develop reports to aid providers and practices in their care transformation efforts. While the Contractor may have a standard report format for client use, they must be able to incorporate recommendations and customizations from DVHA and other stakeholders. At a minimum, the Contractor's episode reports must include the following:

- a) Practice and Health Service Area level analyses
- b) Detailed information on how the episode was constructed, along with detail about exclusions and any risk-adjustment applied
- c) Episode-specific quality measures, with a comparison of each provider or practice to their peers
- d) Episode costs (i.e. average cost per episode, total vs. expected in care category, greatest cost of care drivers, etc.), with a comparison of each provider or practice to their peers
- e) A cost breakdown by spending category (i.e. inpatient, outpatient, professional, pharmacy)
- f) Beneficiary-level cost summaries for each practice

5. Additional Potential Activities

In addition to the responsibilities above, the Contractor may be asked to do the following activities:

- a) Perform a re-pricing of historic Medicaid and Medicare claims for years 2013 and 2014 to current payment polices and rates.
- b) Deliver interactive webinars for providers, ACOs and other interested parties to answer questions about their reports.
- c) Coordinate with the State and other stakeholders in developing a sustainability plan for ongoing episode analytics.
- d) Maintain the capacity to answer questions about reports via a phone-based or online 'help desk'.
- e) Conduct a comparison of two data sources using 3-6 months of claims to assess consistency in results.

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Attachment 2c

To: VHCIP Payment Models Work Group
From: VHCIP Episodes of Care Sub-Group
Date: April 20, 2015
Re: Proposed Activities -- Episodes of Care Analytics

Background

The Vermont Health Care Innovation Project (VHCIP) submitted its Year 2 Operational Plan to CMMI in November 2014, outlining objectives and planned activities for the 2015 testing year. In the Operational Plan, it was noted that although establishing a payment model based on bundled payments was not a top priority for stakeholders, there may still be great potential to use Episodes of Care analytics to support delivery system transformation in Vermont. As a result, proposed activities for the 2015 testing year included: 1) facilitating multi-stakeholder development of analytics to support regional care delivery activities including Blueprint and ACO collaborations and learning collaboratives; and 2) providing SIM resources to support development of provider-level and regional analytics of priority Episodes of Care.

To support these planned activities, an Episodes of Care sub-group of the VHCIP Payment Models Work Group was established in January 2015. This sub-group was charged with establishing a proposal for statewide Episode analytics and report dissemination activities. Between January and April 2015, the sub-group has convened five times; discussing stakeholder interests and concerns, learning about Episodes of Care analytics successes and challenges in other settings, and considering programs and structures already in place that could be leveraged in support of this future work.

Proposed Activities

The Episodes of Care sub-group proposes the following activities:

1. Contracting for vendor support to conduct Episodes of Care analytics and to develop reports for dissemination to providers, ACOs, and communities engaging in collaborative quality improvement activities.
 - a. DVHA would hold the contract with the vendor.
 - b. The vendor would be asked to use [DATA SOURCE] and to conduct analyses by payer population [COMMERCIAL, MEDICIAD, MEDICARE?] on a quarterly basis.
 - c. The vendor would be asked to conduct analyses on all episodes included in their grouper programs, but to prepare reports on only a sub-set of episodes initially.
2. Developing and disseminating reports specific to a select number of specialty types, in order to more fully engage specialists in VHCIP activities, and to complement the

ongoing work and engagement of primary care providers in Vermont's payment reform activities.

- a. Specialty types accounting for the largest volume of service delivery and cost would be targeted initially.
 - b. Proposed specialty types for initial engagement include [**CARDIOLOGY, ORTHOPEDICS, GASTROENTEROLOGY, OBSTETRICS & GYNECOLOGY**].
 - c. Reports would include analyses on one or more episodes specific to the specialty type of the recipient, and would feature detailed episode-specific information about spending and quality performance for the recipient relative to their peers. The reports would also include detailed descriptions of how each episode is constructed using claims data.
3. Leveraging structures and programs already in place to disseminate Episodes analytics reports and to educate practices and providers about how to interpret results.
- a. Detailing teams would be established, comprised of representatives from each participating payer organization, from ACOs affiliated with each recipient practice, and from the Blueprint for Health.
 - b. Detailing activities would include visiting each participating practice after the distribution of the first, third, and fifth rounds of reports (see below for timeline) and describing the analyses, results, and practice-specific opportunities for improvement.
 - c. At intervals during the program period, partner organizations would collaborate to hold webinar-based learning sessions for each specialty type. These sessions would provide participating practices opportunities to ask questions about their reports, and to discuss challenges and successes. Highly efficient and/or effective practices would be invited to present their "best practices" to other participants.
 - d. Similarly, at intervals during the program period, partner organizations would collaborate to host regional, in-person learning sessions. These sessions would bring together participating practices of all targeted specialty types with other regional partners, allowing for interaction and collaborative learning. Again, highly efficient and/or effective practices would be invited to present their "best practices" to other participants from the community.
4. Evaluating the utility of the activities carried out during the program period. Such evaluation will be critical when considering whether or not to extend (and potentially expand) the program beyond the life of the SIM grant.
- a. Having a series of practice-specific reports as vendor deliverables will allow for the quantitative assessment of change in efficiency and effectiveness over time.
 - b. Participants will be surveyed about their experience with the program, the utility of the reports provided and learning sessions organized, and their interest in having activities continue.

Proposed Timeline

Work on this project is expected to begin in August 2015 and would extend through December 2016, with the possibility of programmatic extension and expansion (supported by some combination of stakeholder partners) after the conclusion of the State Innovation Model grant period. Episode-based analytics would result in a series of reports that would be disseminated on a quarterly basis. It is anticipated that five rounds reports will be released throughout the duration of this program:

Anticipated Report Release Date	December 2015	March 2016	June 2016	September 2016	December 2016
Anticipated Data Quarters Included	Q1-Q4 2014; Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1-Q4 2015; Q1 2016
Anticipated Supporting Activities	Practice visits by detailing team	Learning sessions	Practice visits by detailing team	Learning sessions	Practice visits by detailing team

Anticipated Benefits

The proposed activities have been developed based on successful programs that have been implemented elsewhere, and have been designed to complement ongoing programs and health care reform efforts in Vermont. It is expected that individual providers receiving Episodes analytics reports will find value in the information presented as it will highlight opportunities to improve their own efficiency and effectiveness, and will allow them to track their progress over time. Payers and ACOs will also derive benefit from this information by gaining a better understanding of practice trends and referral patterns across their networks of providers. The proposed opportunities for collaborative learning will further extend the potential benefit to other providers and regional partners that are engaged in ongoing, regional quality improvement activities.

Next Steps

The Episodes of Care Sub-Group is seeking feedback on the proposed activities, and is opening a *period of public comment* through the close of business on **April 30, 2015** (comments may be directed to Mandy Ciecior at Amanda.Ciecior@state.vt.us). The Sub-Group will reconvene in early May to review feedback received and to finalize the proposal and budget. A request for funding to support these activities will be prepared for Payment Models Work Group consideration during the May 18, 2015 meeting.