VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday, June 22, 2015 1:00 PM – 3:00 PM.
EXE-4th Floor Conference Room, Pavilion Building, Montpelier, VT
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Don George and Andrew Garland	Y – Approve minutes	Attachment 1: Meeting Minutes
2	1:10-1:20	Project Updates	Georgia Maheras	N	
3	1:20-2:00	VMSSP Yr 3 Total Cost of Care Presentation	Cecelia Wu	N	Attachment 3a: Presentation Attachment 3b: TCOC Comparison Grid
4	2:00-2:45	BPCI Presentation	Amanda Ciecior	N	Attachment 4: Presentation
5	2:45-2:50	Public Comment		N	
6	2:50-3:00	Next Steps and Action Items		N	Next Meeting: Monday, July 20, 2015 1:00 pm – 3:00 pm EXE-4th Floor Conference Room, Pavilion Building, Montpelier, VT

Attachment 1

Vermont Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, April 20, 2015, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Don George called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was not present. A quorum was present following the second agenda item. At this time, Bard Hill moved to approve the March 2015 meeting minutes. Abe Berman seconded. A roll-call vote was taken; the motion carried with 3 abstentions.	
2. Episodes of Care Presentation	Alicia Cooper provided an update on the work of the Episodes of Care (EOC) Sub-Group (Attachment 2b). • Bundled payments based on episodes were included in Vermont's original State Innovation Model (SIM) proposal to Centers for Medicare and Medicaid Innovation (CMMI); however, recognizing that bundled payments based on episodes were not a high priority for stakeholders, VHCIP is now pursuing EOC analytics to support delivery system transformation and other VHCIP activities. This work is being pursued by the EOC Sub-Group. Attachment 2b describes the charge of the Sub-Group. • Alicia gave a high-level definition of episodes of care and described how EOC analytics can support delivery system reform and broader VHCIP activities. • The EOC Sub-Group has now met five times. The Sub-Group has undertaken a review of preliminary Payment Models Work Group EOC analytics, existing EOC initiatives across the country and in Vermont (MVP), and discussed the potential for EOC analytics in Vermont. Thus far in Vermont, EOC analyses have been produced at the statewide and regional levels; the Sub-Group hopes to pursue practice-level analytics in the near-term, with the possible goal of including beneficiary-level detail in the future. • The Sub-Group has also discussed releasing an RFP seeking a vendor to provide EOC analytics to providers, and has developed a skeleton proposal describing what the Sub-Group would look for in a vendor (see Att. 2b, Slide 10). These proposed activities would likely provide practice-level EOC analyses. • The Sub-Group is seeking feedback from the Payment Models Work Group before deciding whether or not to pursue an RFP. • The EOC Sub-Group will meet again in early May to review feedback.	**Public Comment period is open through April 30, 2015. Please submit any written comment to Mandy Ciecior (amanda.ciecior@state.vt.us).**

Agenda Item	Discussion	Next Steps
	The group discussed the following: • Mike DelTrecco commented that he supports this effort, but it is important to clarify the intent and purpose of this work. How are the organizations doing payment reform going to use episode-based analytics if it won't be tied to payment? • Michael Bailit requested more information on how practice-level information could be useful for providers, and asked about the challenges that could prevent Vermont from pursuing beneficiary-level analyses. Alicia responded that data sources make this a challenge: one of the possible data sources, VHCURES (Vermont Health Care Uniform Reporting and Evaluation System), is de-identified but would be able to support practice-level analytics. The uniform claims extracts from participating payers are another possible data source, but the ability of payers to provider identified data varies, which would make it challenging to implement multi-payer episode analytics at the beneficiary level. Alicia noted that the Sub-Group has seen examples of MVP's episode analytics, all of which are practice-level. MVP reports that these reports have been very constructive for practices, and that beneficiary-level information could cause unnecessary focus on past care, especially outlier cases. • Larry Goetschius: From a practicing physician standpoint, this could support greater awareness of other ways of practicing. Alicia agrees – MVP and Arkansas EOC analytics also compare practices to their peers on various metrics, and have seen early success from this (ex/imaging in Arkansas). Mike DelTrecco agrees. • Mary Alice Bisbee: How will this impact beneficiaries? No beneficiaries are currently participating in the Sub-Group, but all decisions will go through the Payment Models Work Group. Don George noted that this is an inclusive process; Alicia will follow up with Mary Alice to see whether she is interested in joining the Sub-Group.	
3. Final Feedback on Blueprint Payment Methodology	Don George opened a discussion to provide final feedback on proposed changes to the Blueprint for Health Payment Methodology (Attachment 3). Kara Suter reminded Work Group members that there is ambiguity as to where Blueprint for Health oversight currently resides; this group decided against recommending changes to the Blueprint payment methodology that would go through VHCIP governance and instead will provide less formal feedback directly to the Blueprint Executive Committee for their consideration. Attachment 3 includes feedback developed based on Work Group discussion and written comment. This agenda item seeks to review and clarify this document to ensure it accurately captures previous discussions before it is submitted to the Blueprint Executive Committee. The group discussed the following: • Paul Harrington commented that an email he submitted that is included in Attachment 3 accurately represents his feedback. He noted, however, that recent reports suggest that the bill currently before the Legislature that provides increased funds to support the Blueprint is unlikely to pass. Paul suggests	

Agenda Item	Discussion	Next Steps
	this group wait until we know the final amount of revenue passed to support these changes. For this reason, he intends abstain from any vote on recommendations. • Don George noted that recommendations and feedback are different. Don agrees with Paul that a recommendation would be premature; however, this is not a recommendation but collected feedback from members. He suggests that we continue this discussion. • Kara Suter suggests that the word "recommendation" is removed from any document this group submits to the Blueprint Executive Committee. Kara also noted that if there is legislative action, it will be for the period starting July 1, 2015; not submitting feedback now means that the Work Group would have to put something together quickly if legislation does pass. Kara suggests any feedback to the Blueprint Executive Committee supports a sound methodology rather than absolute dollar amounts. • Don George feels comfortable with this feedback going through the VHCIP governance process, but notes that it isn't an action item so should not need to. • Bard Hill clarified that this is feedback to the Blueprint Executive Committee without a funding source. Kara Suter agreed. Don George noted that this group has had a number of presentations from Craig Jones, who has indicated that he welcomed feedback from this group. • Richard Slusky agreed that there are principals this group could reaffirm. Richard asserted that it is clear that primary care is essential and foundational to the health of our health care delivery system, and that we are trying to support primary care practices and practitioners through whatever means we can, whether through enhanced payments, focus on coordination and collaboration between practices, or other means. In the proposal the Blueprint has made, there are specific implications, including that primary care practices should be National Committee for Quality Assurance (NCQA) certified in order to receive enhanced payments (a base level of standards set for primary care practices eligible for enhanced payments); that enhanced payments should be based on a defined set of performance measures; and that we are interested in supporting enhanced payment to community health teams (CHTs) to support their efforts to coordinate and collaborate with other providers through Unified Community Collaboratives (UCCs) and other efforts. The amount of money and interaction with other payment models are yet to be determined, but Richard suggests these could be guiding principles. • Kara Suter asked – is NCQA recognition voluntary for practices? Pat Jones believes that in the current version of the proposal, NCQA recognition is required for providers to receive Blueprint payments (see Jenney Samuelson's 4/13 presentation to the Quality and Performance Measures Work Group). • Kara Suter suggested that the group discuss the relative amounts of base payment (based on NCQA recognition) and additional payments based on performance/quality. Kara has suggested that the relative amount of payment based on performance/quality increase over time, and the relative amount of payment based on NCQA recognition decrease over time. • Don George noted that the Work Group is not trying to reach consensus today and suggested that we identify commenters with each item of feedback in the document we submit to the Blueprint Executive Committee. Kara agreed with this suggestion and said that DVHA staff will ensure comments are	

Agenda Item	Discussion	Next Steps
	attributed following this meeting. • Richard Slusky suggested that his earlier comments (that NCQA recognition should be a prerequisite for enhanced base payments; that there should be additional payments to support and reward high performance; and that there should be additional payments to support CHTs) should be attributed to him and added to this document. • Kara Suter added that if UCC participation will be a requirement in the future, there will need to be rules that define this to help payers feel comfortable. Paul Harrington moved to forward this feedback, with additional attribution to be added by DVHA staff, to the Blueprint Executive Committee. Kara Suter seconded, with the recommendation that the final list of feedback is distributed to the Work Group via email for final review before it is sent on. • Larry Goetschius made a further recommendation that new funding allocated to CHTs be used based on recommendations by UCCs; this will support UCC leadership within each health service area. Kara agreed to add this to the document as well before it is distributed to Work Group members for review. A roll-call vote was taken and the motion carried with 3 abstentions.	

4. CMS Next Generation ACO Model Presentation	Kara Suter presented on the Next Generation Accountable Care Organization (ACO) Model, announced by the Centers for Medicare & Medicaid Services (CMS) in March.
	• The Next Generation Model attempts to address concerns about previous Medicare ACO models, including attribution and benchmarking. It also aligns with the CMS goal to quickly increase the percentage of Medicare payments that are value-based payments over the next few years.
	• Kara invited the ACOs to comment on their own experiences under previous Medicare ACO programs.
	  ○ Abe Berman from OneCare agreed that retrospective attribution was a challenge of the Medicare Shared Savings Program (MSSP) and Pioneer ACO programs.
	  ○ Kara noted that Vermont's Medicaid Shared Savings Program (VMSSP) and Commercial Shared Savings Program share many of these issues; Vermont will need to decide how to address them.
	  ○ Abe commented that one of the goals of the Next Generation Model is to provide additional flexibility for providers to pursue alternative payment methodologies and support additional providers taking on down-side risk and moving toward population-based payments.
	• *Key Changes:* Kara discussed key ways the Next Generation Model differs from previous Medicare ACO models. These include fixed benchmarks; four payment tracks that encourage ACOs to move toward capitation; higher levels of risk and reward; increased access to some service types as part of loosening of utilization management controls; payments to beneficiaries that reward staying in-network; increased communication between CMS and beneficiaries; and larger minimum beneficiary requirements. (Attachment 4b compares the Next Generation Model with Pioneer ACO, MSSP, VMSSP, Commercial SSP models.)
	• *Key ACO Qualifications and Program Timeline:* Abe Berman noted that in terms of participation in the	

Agenda Item	Discussion	Next Steps
	Next Generation program, CMS is seeking organizations that are experienced at and comfortable with taking downside risk; CMS only expects to approve 15-20 ACOs for this program. ACOs cannot participate in both MSSP and the Next Generation program. ACOs can begin participation in either 2016 or 2017; both tracks will end in 2020. Selection criteria are similar to the VMSSP and Commercial SSP programs, and could support Vermont in gathering lessons about ACO qualifications and selection criteria. • *Participating Providers:* Concept of participating providers has transformed since MSSP: the Next Generation model will include provider suppliers (attributing providers, consistent with MSSP), and new categories including preferred providers (provide benefit enhancements, ex/telehealth or home visits – not attributing), and Next Generation Affiliates (including Capitation Affiliates, who could participate in capitation arrangements, and Skilled Nursing Facility [SNF] Affiliates, which would circumvent SNF 3-Day Rule). • *Financial Benchmark:* The Next Generation Model is based on a prospective benchmark that takes into account a one-year historic spend, regional projected trend, risk adjustment, and a discount based on quality and both regional and national efficiency. (See Attachment 4a, Slide 11 and Appendix A.) • *Risk Arrangements and Payment Mechanisms:* Two possible risk arrangements; four possible payment mechanisms offers non-fee-for-service revenue options for interested providers. Capitation is an option beginning in 2017. (Note: In Option 2, Normal FFS + Monthly Infrastructure Payment, monthly infrastructure payments are included in total spend during year-end reconciliation of benchmark and actual spend; see Appendix B for additional information on payment mechanisms.) • *Beneficiaries:* Beneficiary eligibility is similar to the MSSP eligibility requirement. See Slide 15 for details. Richard Slusky notes that at least 50% of ACOs' patients (including Medicare, Medicaid, and commercially insured) must be covered under outcomes-based contracts by the end of the first performance year. Alignment (attribution) is claims-based, with some exceptions, and will include voluntary alignment (a new feature), which supersedes claims-based alignment. • *Benefit Enhancement:* The Next Generation Model offers incentive payments to beneficiaries for receiving services within the ACO's network. It also conditionally waives certain Medicare payment requirements. ○ Bard Hill observed that none of the Next Generation Model payment methodologies impact beneficiary cost-sharing; he also noted that CMS's ACO programs have been focused on incentivizing organizations rather than individuals and asked whether there was more movement in that direction planned. Kara replied that there not information available about CMS's plans beyond this new model. Bard also noted that people who enter a SNF or nursing home under Medicare sometimes stay and become eligible for Medicaid. Kara suggested that the benefit enhancements offered under the Next Generation Model, especially the waiver of the 3-Day SNF Rule, offer an incentive to do better in this area. Julie Wasserman noted that this is a potential cost shift. Abe Berman noted that the requirement that 50% of ACOs' patients are	

Agenda Item	Discussion	Next Steps
	under outcome-based contracts will hopefully prompt providers to be more conscious of spending and utilization across all payers, not just Medicare. ○ Bard suggested that home health is also a key player here, and wonders how this will fit in. Kara suggested that the post-discharge house visits support increased access to home health and similar services. CMS is also encouraging ACOs to develop relationships with providers like home health. Larry Goetschius suggests that there could have been bigger opportunities for home care/home visits for people with chronic illnesses who are not acutely ill and will otherwise not be eligible for home-based services. Kara notes that a capitated affiliate with a Next Generation ACO could receive reimbursement for this if the ACO chooses to put money toward this. ○ Mike Hall asked whether this could involve a waiver of the 60-day episode for home-based services. Kara noted that this would not apply until an agency entered into a capitated arrangement with a Next Generation ACO. • *Quality and Performance:* Measures are similar to MSSP, minus one measure. The major change is that CMS is moving away from current scoring methodologies to a "discount" approach. • Appendices offer details on the discount methodology, payment mechanisms, savings and loss calculation, and claims-based alignment. The group discussed the following: • Larry Goetschius asked whether any Vermont ACOs were planning on applying. Abe Berman responded that OneCare will be filing a Letter of Intent, but may choose not to apply. Joyce Gallimore responded that Community Health Accountable Care (CHAC) will not apply.	
6. Public Comment, Next Steps, and Action Items	Public Comment: • Richard Slusky commented that there have been questions about how the Next Generation Model could dovetail with the potential All-Payer Model. Richard noted that they are different tracks, but have similar intents: both support an all-payer movement toward value-based payment. Don George asked whether this means that an All-Payer Model would ask Vermont providers to step up to the challenging requirements of the Next Generation Model. Richard responded that this would likely be the case, with potentially some additional flexibility. • Mary Alice Bisbee asked a question about how co-insurance as a Medicare beneficiary would interact with membership in an ACO. Kara Suter responded that it would not. Next steps: • DVHA team will update the Blueprint feedback and share with members via email before submitting to the Blueprint Executive Committee. **Next Meeting:** Monday, May 18, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Attachment 3a

TCOC Expansion in VMSSP

Year Three Discussion

Payment Models Workgroup

June 22nd, 2015

Vermont Health Care Innovation Project

What is Total Cost of Care (TCOC)?

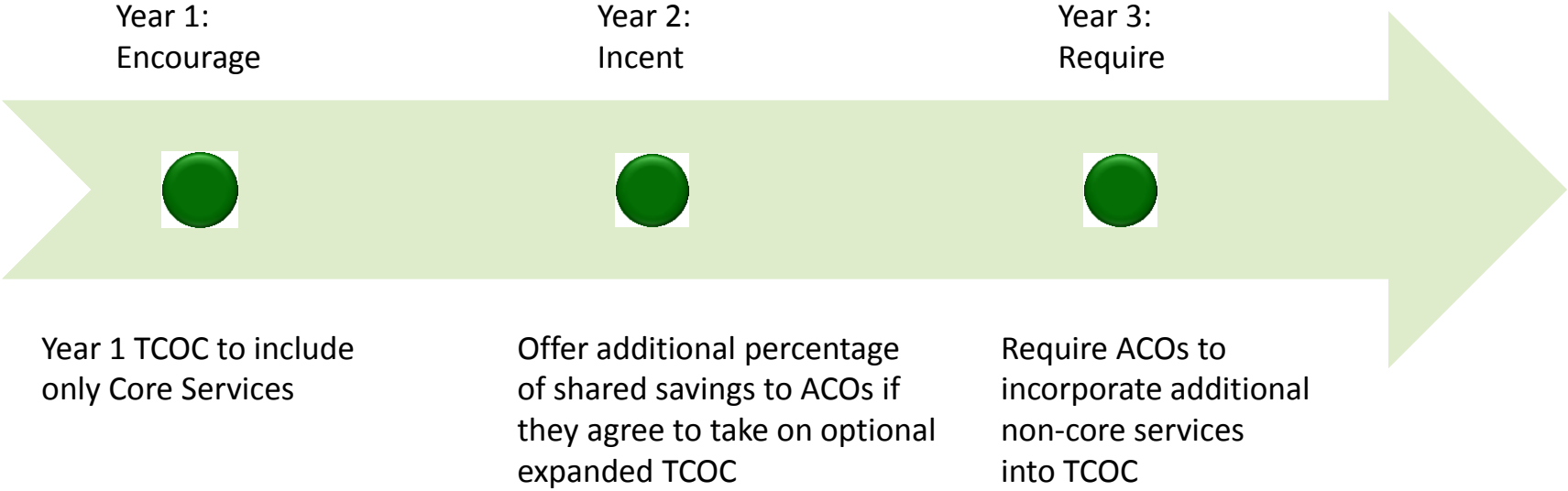
- The Total Cost of Care (TCOC) includes spend for specified categories of services for which the ACO will be held accountable during a performance year.

- The TCOC for Year 1 of the Shared Savings Program includes only **core services:** inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.

- The TCOC for Years 2 and 3 of the program may include additional **non-core services**, such as: personal care, pharmacy, dental, non-emergency transportation, services administered by the VT Department of Mental Health through Designated Agencies and Specialized Service Agencies, services administered by the VT Division of Alcohol and Drug Abuse Programs, services administered by the VT Department of Disabilities, Aging and Independent Living, services administered by the VT Department for Children and Families and services administered by the Vermont Department of Education.

Approach to TCOC Expansion

- The State has adopted an incremental approach to the inclusion of services in the Total Cost of Care spend across the three performance years.
- In Year 1, **only** core services are included in the TCOC.
- In Year 2, ACOs **may elect** to include additional non-core services in their TCOC, as selected by the State and will be offered an increased sharing rate (from 50% to 60%) for doing so.
- In Year 3, ACOs **may be required** to include additional non-core services into their TCOC, if additional services are selected by the State. The State will notify the ACO of selected non-core services by **October 1, 2015**.



Process for Determining Year 3 TCOC

1. DVHA SIM team conducts research and speaks with various departments throughout AHS
2. DVHA SIM team shares findings with stakeholders
3. Stakeholders have the opportunity to provide public comment and feedback
4. DVHA team decides Year 3 TCOC categories for DVHA leadership approval
5. DVHA team notifies ACOs and workgroups

Presentation Goals

- Share findings from research and internal DVHA discussions
- Solicit workgroup feedback
  - Amanda.ciecior@state.vt.us by July 13th

A quick thank you…

- DVHA SIM staff would like to extend their appreciation and gratitude to the various state personnel who took the time to share their program expertise during the course of researching Year 3 TCOC services.

Categories Under Consideration

- Year Three
  - Pharmacy
  - Dental
  - Non-emergency Transportation (NEMT)
  - Medically-necessary personal care services
  - Mental and Behavioral Health
  - Alcohol and Drug Abuse Services

Research Parameters

- Can this program's claims be cleanly isolated and linked to attributing VMSSP providers?
- What is the Actual Annual Spend ($)?
- Can the ACOs and attributing providers reduce overall spend of this program?
- Can the ACO improve the quality of services currently being provided?
- What other States are including this service?
- Is this program Medicaid specific? Does it cross all payer populations? (Is it included in benefit package of ACO attributees?)
- Is there alignment in this program across payers? (Is there interest in bringing this service under TCOC?)

Year Three Expansion of TCOC

ADDITIONAL SERVICES UNDER CONSIDERATION

Dental

Advantages

- Incents more active coordination between medical and dental providers
- Annual dental visits is currently a M&E measure

Challenges

- Other SSPs not including dental
- ACOs uncertain about their ability to control these costs
- Significant lag time between claims and supplemental payments

Non-emergency Transportation (NEMT)

Advantages

- Incents more active coordination and cost-effective use of NEMT benefit

Challenges

- Not all SSPs including NEMT
- ACOs uncertain about their ability to control these costs and/or whether using more NEMT may help reduce spending for other services
- NEMT costs could rise in short term without immediate decrease in acute service use (i.e., ED or hospitalization avoidance)

Mental/ Behavioral Health Services

NOTE: Mental and Behavioral services under contemplation are those currently not already included in TCOC.

Advantages

- More accurately accounts for costs of services to support beneficiaries
- Inclusion of additional services could encourage better integration/coordination between mental/physical health providers, e.g., through increased referrals

Challenges

- Will require an update to the methodology described in the contracts, current standards and SPA
- Management of programs in multiple state agencies and multiple programs

Personal Care Services (PCS)

NOTE: PCS services under contemplation are those paid via DVHA medical benefit; those PCS services paid through other specialized programs (like CFC) would continue to be excluded

Advantages

- Incents more active coordination and cost-effective use of personal care services
- May improve transitions of care and help avoid the need for otherwise avoidable downstream acute or LTSS services

Challenges

- ACOs uncertain about their ability to control these costs and/or whether using more PCS may help reduce spending for other services
- Some spending for these type of services are not under the medical benefit
- A number of PCS are bundled into other services which we would not be able to parse out

Alcohol and Drug Abuse Programs

Advantages

- More accurately accounts for costs of services to support beneficiaries

Challenges

- Will require an update to the methodology described in the contracts, current standards and SPA
- Limited ability to share data because of federal Substance Abuse Confidentiality Regulations (42 CFR Part 2)

Pharmacy

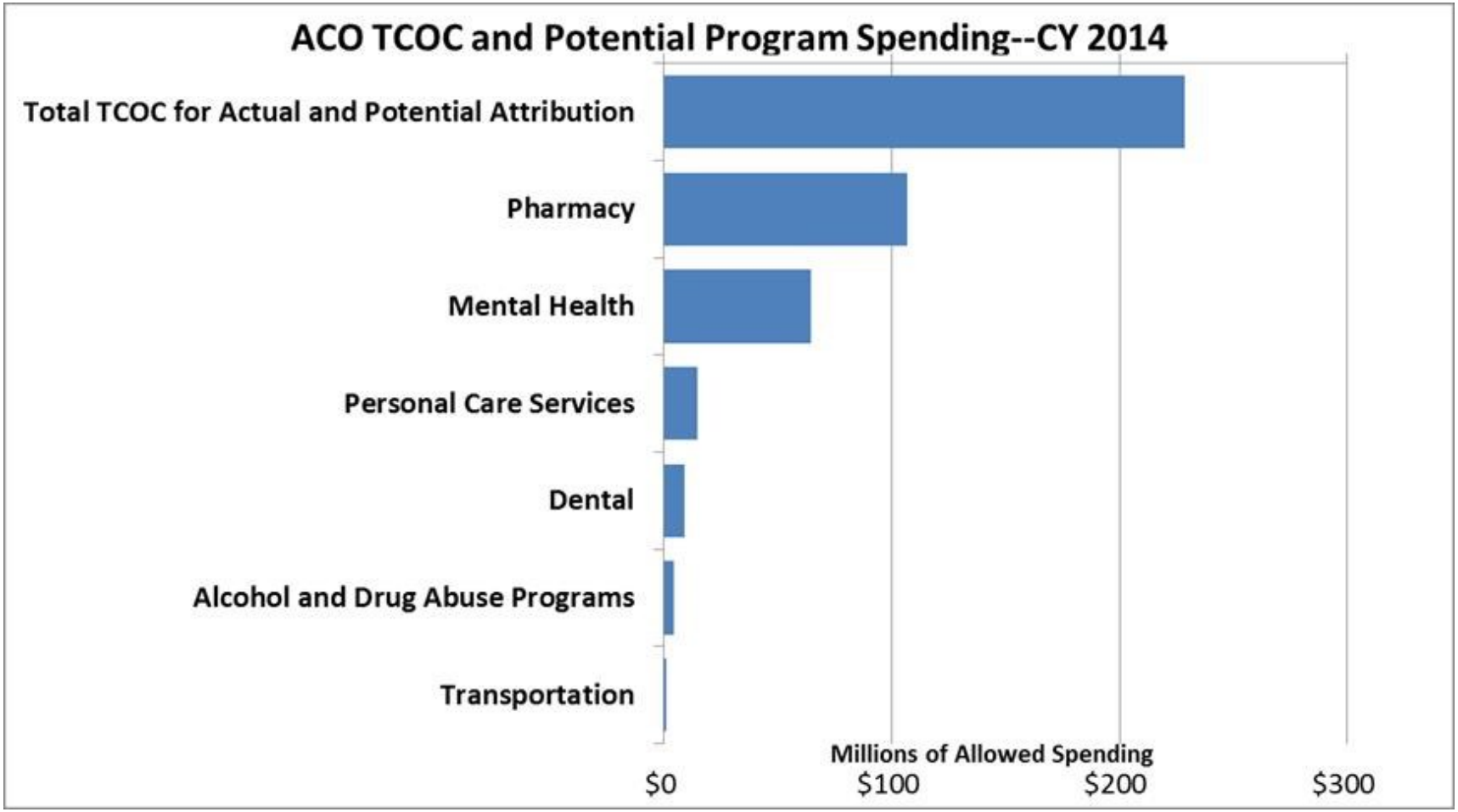
Advantages

- Pharmacy costs are a large and increasing component of total spend
- Using prescription drugs more cost effectively could drive savings and improve outcomes

Challenges

- Other SSPs not yet including pharmacy
- ACOs uncertain about their ability to control these costs as benefit administered under a PBM

Category Spend at a Glance



Vermont Health Care Innovation Project

TCOC Comparison Grid

Program	Can this program's claims be cleanly isolated and linked to attributing VMSSP providers	Actual Annual Spend ($)	Can the ACOs and attributing providers reduce overall spend of this program?	Can the ACO improve the quality of services currently being provided?	What other States are including this service?	Is this program included in the benefit package of the payer?	Is there alignment in this program across payers? (Is there interest in bringing this service under TCOC?)
Dental	Regular Dental claims are paid through MMIS and claims are available to ACOs. There is a significant lag between supplemental payments and claims payments paid. FQHC supplemental payments can be 25-40% of total payment. Other provider supplemental payments (for dentists with large Medicaid volume) can be 5-15% of total payment.	Regular Claims are $27 M (annually for all DVHA) $1.5 M FQHC supplemental payments ~$1M Other Supplemental payments $0.8M General assistance/Emergency Dental More direct service provision from DH	Yes. By better educating patients about their options for dental care and be push for more preventive care than reactive	Maybe - by referring more patients who seek dental care	Oregon	Medicare: Not included Medicaid: Included Commercial: Included	Medicaid has expressed interest in including this in TCOC
Transportation	Yes but not in regular claims. Payments are in Special Payments universe and are tied to specific recipients.	$11M for 2014 $5.5M first half of 2015	Maybe. By improving or streamlining this service there is the potential to reduce those being admitted to the ER or using an Ambulance	Maybe.	None	Medicare: Not included Medicaid: Included Commercial: Not included	This is a Medicaid-specific program
Mental (Behavioral?) Health	Funding from many depts in SOV; interdepartmental grants, FFS and bundled rates	$196M in DAIL Fund Souce (HCBS waiver) $158M in DMH Fund Source $26M in regular claims (not excluded) Many, many direct programs from DMH	Maybe - savings possible in the long run	Maybe. By providing more referrals, or developing a better level of care coordination	Oregon, Maine, Minnesota	Medicare: Not included Medicaid: Some programs included Commercial: Not included	Payers have interest, but operationally may not be feasible
Personal Care Services	There are specific PCS services that are identifiable. A number of PCS are bundled into other services; cannot parse out.	$123 M in allowed claims $13M in paid claims Personal Care Services are bundled with many other long-term care services and other DAIL programs	No	Maybe. By providing more referrals, or developing a better level of care coordination	Maine - "optional" category for PYs 2 and 3	Medicare: Not included Medicaid: Included Commercial: Not included	This is a Medicaid-specific program
Alcohol and Drug Abuse Programs	There are claims available for ADAP services in MMIS, including spending with DH/OADAP funding source. DH/OADAP provides further direct programs.	$3.2M in Regular Claim $18M in DH/OADAP funding source	Yes	Maybe. By providing more referrals, or developing a better level of care coordination	None	Medicare: Not included Medicaid: Some programs included Commercial: Not included	No--limitations on data sharing for these serviecs make this category difficult to include in TCOC
Pharmacy	Yes. Pharmacy data is available in regular claims and details are available in Drug Claims universe (one variable useful for identifying generic drugs is missing in 2015).	Small Amount in TCOC now (pharmacy in outpatient or physician office) $380M overall in regular claims	Yes, by purchasing through the 340B program.	Maybe. By providing better medication management and communication between providers	Minnesota	Medicare: Not included Medicaid: Included Commercial: Included	Medicare Part D not included in TCOC; interest among Mediciad and BCBSVT.

Next Steps

- Workgroup input is requested on the following:
  - Which services, if included, would most benefit Vermont residents?
  - Which services, if included, would be the biggest challenge for ACOs?
  - Which services have the greatest opportunity for cost savings and quality improvement?
- Input to be sent to amanda.ciecior@state.vt.us by Monday, July 13th 2015.
- Comments to be shared at July meeting
- Internal DVHA Discussions
- DVHA to notify ACOs of selected services by October 1, 2015.

Attachment 3b

Program	Can this program's claims be cleanly isolated and linked to attributing VMSSP providers	Actual Annual Spend ($)	Can the ACOs and attributing providers reduce overall spend of this program?	Can the ACO improve the quality of services currently being provided?	What other States are including this service?	Is this program included in the benefit package of the payer?	Is there alignment in this program across payers? (Is there interest in bringing this service under TCOC?)
Dental	Regular Dental claims are paid through MMIS and claims are available to ACOs. There is a significant lag between supplemental payments and claims payments paid. FQHC supplemental payments can be 25-40% of total payment. Other provider supplemental payments (for dentists with large Medicaid volume) can be 5-15% of total payment.	Regular Claims are $27 M (annually for all DVHA) $1.5 M FQHC supplemental payments ~$1M Other Supplemental payments $0.8M General assistance/Emergency Dental More direct service provision from DH	Yes. By better educating patients about their options for dental care and be push for more preventive care than reactive	Maybe - by referring more patients who seek dental care	Oregon	Medicare: Not included Medicaid: Included Commercial: Included	Medicaid has expressed interest in including this in TCOC
Transportation	Yes but not in regular claims. Payments are in Special Payments universe and are tied to specific recipients.	$11M for 2014 $5.5M first half of 2015	Maybe. By improving or streamlining this service there is the potential to reduce those being admitted to the ER or using an Ambulance	Maybe.	None	Medicare: Not included Medicaid: Included Commercial: Not included	This is a Medicaid-specific program
Mental/Behavioral Health	Funding from many depts in SOV; interdepartmental grants, FFS and bundled rates	$196M in DAIL Fund Souce (HCBS waiver) $158M in DMH Fund Source $26M in regular claims (not excluded) Many, many direct programs from DMH	Maybe - savings possible in the long run	Maybe. By providing more referrals, or developing a better level of care coordination	Oregon, Maine, Minnesota	Medicare: Not included Medicaid: Some programs included Commercial: Not included	Payers have interest, but operationally may not be feasible
Personal Care Services	There are specific PCS services that are identifiable. A number of PCS are bundled into other services; cannot parse out.	$123 M in allowed claims $13M in paid claims Personal Care Services are bundled with many other long-term care services and other DAIL programs	No	Maybe. By providing more referrals, or developing a better level of care coordination	Maine - "optional" category for PYs 2 and 3	Medicare: Not included Medicaid: Included Commercial: Not included	This is a Medicaid-specific program
Alcohol and Drug Abuse Programs	There are claims available for ADAP services in MMIS, including spending with DH/OADAP funding source. DH/OADAP provides further direct programs.	$3.2M in Regular Claim $18M in DH/OADAP funding source	Yes	Maybe. By providing more referrals, or developing a better level of care coordination	None	Medicare: Not included Medicaid: Some programs included Commercial: Not included	No--limitations on data sharing for these serviecs make this category difficult to include in TCOC
Pharmacy	Yes. Pharmacy data is available in regular claims and details are available in Drug Claims universe (one variable useful for identifying generic drugs is missing in 2015).	Small Amount in TCOC now (pharmacy in outpatient or physician office) $380M overall in regular claims	Yes, by purchasing through the 340B program.	Maybe. By providing better medication management and communication between providers	Minnesota	Medicare: Not included Medicaid: Included Commercial: Included	Medicare Part D not included in TCOC; interest among Mediciad and BCBSVT.

Attachment 4

Bundled Payments for Care Improvement (BPCI) Initiative

VHCIP Payment Models Work Group

June 22, 2015

Vermont Health Care Innovation Project

BPCI

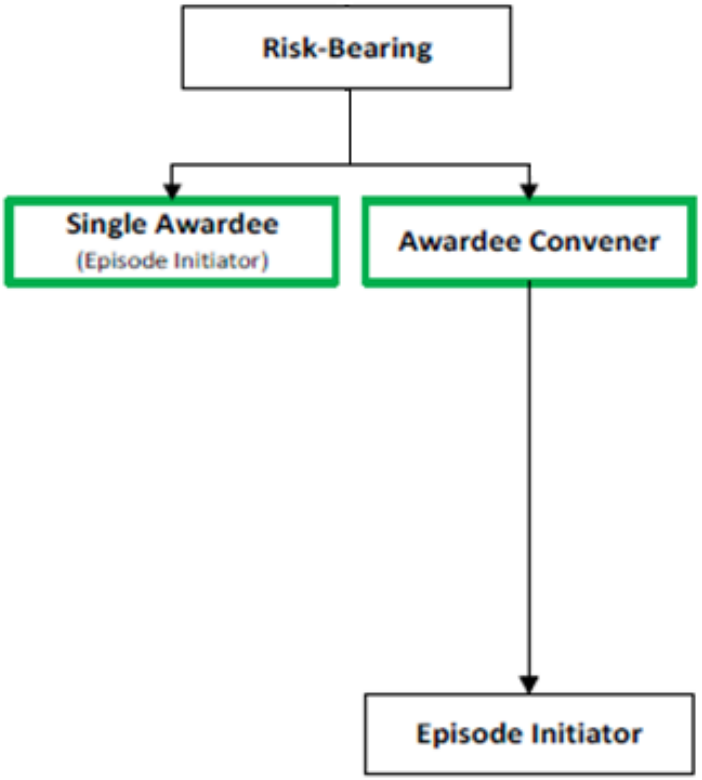
- CMMI initiative
  - Medicare fee-for-service
- Three year payment reform pilot
- Includes 4 model options
- Initial pilots began in January 2013
- Goals include:
  - Improve care transitions
  - Improve coordination of care
  - Collaboration on best practices
  - Improve efficiency and seamlessness of care across care continuum

Key Phrases

- **Skilled nursing facilities -** SNFs
- **Inpatient rehabilitation facilities -** IRFs
- **Long-term care hospitals -** LTCHs
- **Home health agencies -** HHAs
- **Diagnosis Related Group -** DRG
- **Prospective payment bundling** – pre-determined payment made for the bundle of services to be provided
- **Retrospective payment bundling** – payments are made at the usual fee-for-service rates (actual cost) then aggregated and compared to the target price

Key Roles

- **Episode Initiator –** Program participants that begin the actual care of the patient
  - An episode initiator can be a physician group practice, an acute care hospital or a SNF, IRF, LTCH, HHA
- **Convener –** Helps facilitate participation in the program by providing services such as data analytics and CMS compliance.
- **Awardees** – Medicare providers that bear risk for episodes they initiate



Vermont Health Care Innovation Project

BPCI - Four Models

BPCI MODELS

	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients, all DRGs	Selected DRGs, hospital plus post-acute period	Selected DRGs, post-acute period only	Selected DRGs, hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions. Up to 48 episodes.	All non-hospice Part A and B services during the post-acute period and readmissions. Up to 48 episodes.	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective
Phase 1 participants		-364 participants -47 conveners -2,038 providers	-240 participants -33 conveners -4,646 providers	-7 participants -1 convener -8 providers
Phase 2 participants	-1 convener -12 providers	-60 awardees -18 conveners -142 providers	-20 awardees -8 conveners -81 providers	-8 awardees -1 convener -8 providers
Total providers	12	2,180	4,727	17
Episode length		30, 60, or 90 days	Services must begin within 30 days of discharge and end 30, 60, or 90 days after the initiation of the episode	Covers inpatient stay and related readmissions for 30 days after the hospital discharge
Episode initiators		-acute care hospitals (ACH) -physician group practices (PGPs)	-skilled nursing facilities (SNFs) -long-term care hospitals (LTCHs) -inpatient rehab facilities (IRFs) -home health agencies (HHAs) -physician group practices (PGPs)	-acute care hospitals (ACH) paid under the Inpatient Prospective Payment System (IPPS)

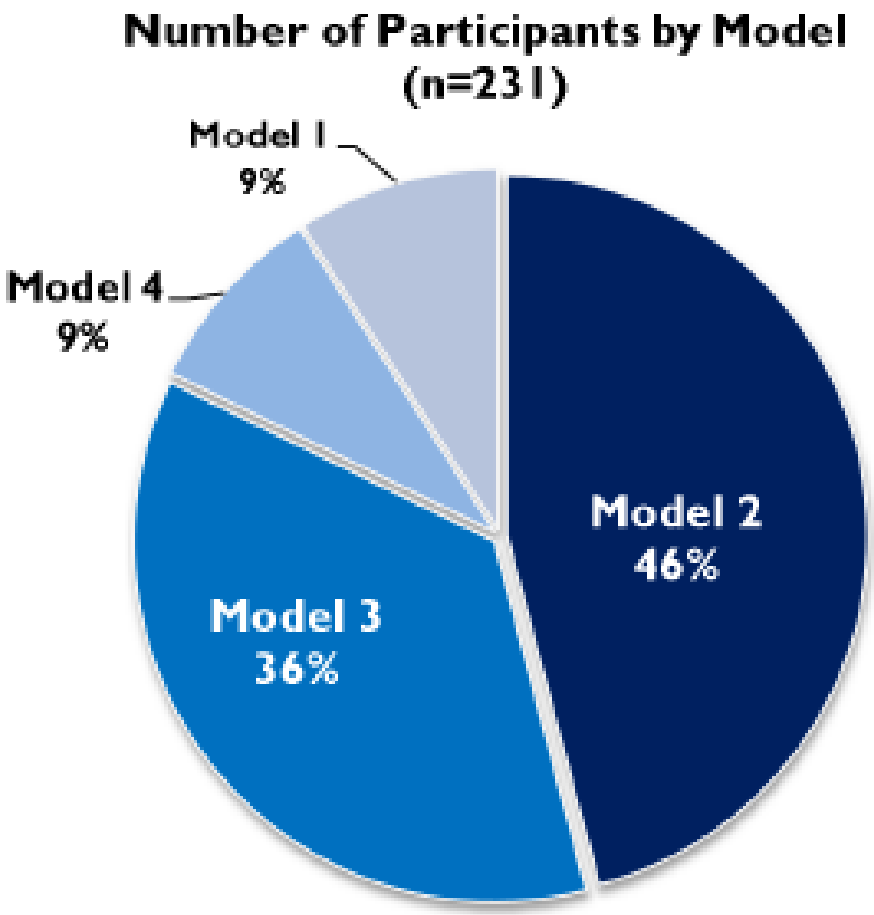
http://www.paccr.org/wp-content/uploads/2015/04/BPCI_Overview.pdf

Vermont Health Care Innovation Project

Phases in BPCI Models (2,3 and 4)

- Phase I
  - "Preparation" period as CMS and participants prepare for implementation and assumption of financial risk
  - Exploratory for participants
  - Emphasis on data analysis
  - No risk
- Phase II
  - "Risk-bearing" period
  - Optional for participants based on findings from Phase I

Percentage of Phase II Participants



*As of March of 2014

http://www.dgapartners.com/wp-content/uploads/2014/10/DGA-Medicare-Bundled-Payment-Whats-It-Worth-2014-HFMA-NJ-Annual-Institute.pdf

BPCI in VT: Models 2 and 3

Model 2

- Episode begins with an inpatient admission at a participating hospital for a DRG designated by the participant
- Length 30, 60, 90 days
- Participant proposes minimum discount dependent on episode length (2-3%)

Model 3

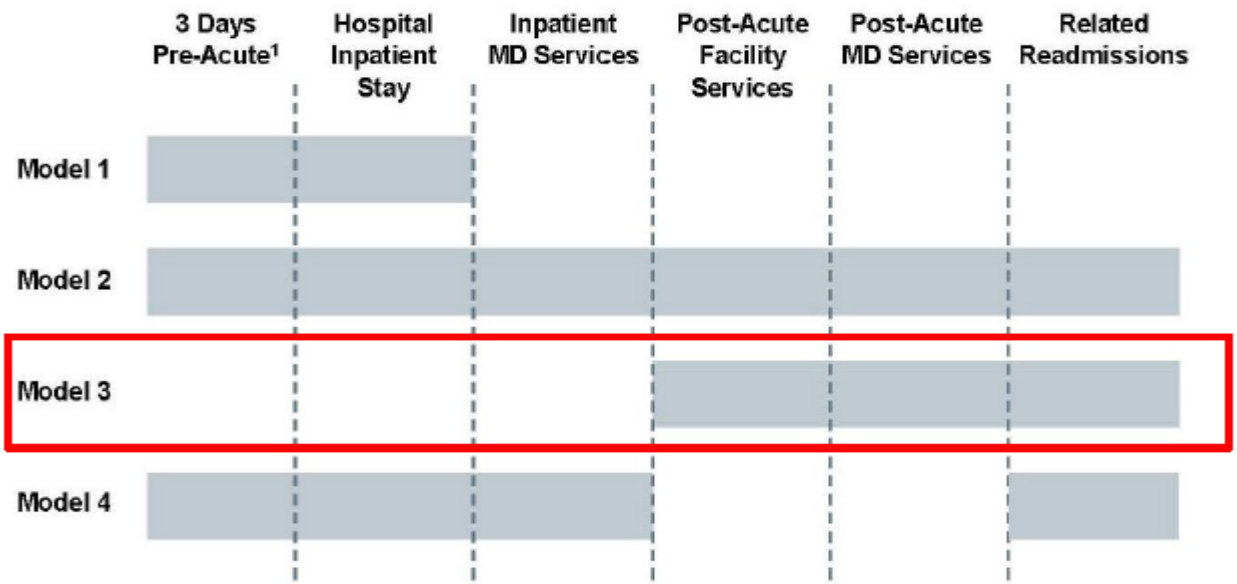
- Episode begins with initiation of care at a SNF, IRF, LTCH or HHA that occurs within 30 days of discharge from a hospital
  - Services provided in the initial hospital stay are not included
  - Services after the hospital discharge but prior to the episode start are not included in the bundle
- 3% discount rate
- Length 30, 60, 90 days
- Readmissions are included

Model 2 – Acute Care + Post-Acute Care

- Presentation from Darren Childs at Rutland Regional Medical Center in March, 2014
- Model 2 Participant: Retrospective Acute Care Hospital Stay plus Post-Acute Care
- Focus on Congestive Heart Failure
- Early Results:
  - Target readmission rate of 18.5% or less by end of FY13.
  - 2013 Results: below 15%

Model 3 – Post-Acute Care

- 48 Clinical Episodes based on 179 DRGs
- 17 facilities in Vermont participated in Phase I



http://www.advisory.com/research/health-care-advisory-board/blogs/toward-accountable-payment/2013/01/a-breakdown-of-the-four-bundling-models

Model 3, Phase I – VT Facilities

Berlin Health & Rehabilitation Center	Barre
Rowan Court Health & Rehabilitation	Barre
Bennington Health & Rehabilitation	Bennington
Pine Heights At Brattleboro Center For Nursing & Rehabilitation	Brattleboro
Burlington Health & Rehabilitation	Burlington
Bel-Aire Center	Newport
Thirty Five Bel-Aire Drive SNF Operations LLC	Newport
Forty Six Nichols Street Operations LLC	Rutland
Mountain View Center	Rutland
Nine Haywood Avenue Operations LLC	Rutland
Rutland Healthcare & Rehabilitation Center	Rutland
The Pines At Rutland Center For Nursing & Rehabilitation	Rutland
Five Ninety Six Sheldon Road Operations LLC	Saint Albans
Saint Albans Healthcare & Rehabilitation Center	Saint Albans
St Johnsbury Health & Rehabilitation	Saint Johnsbury
Springfield Health & Rehabilitation	Springfield
Redstone Villa	St Albans

Model 3 - Optional Bundled Services

FORTY-EIGHT CLINICAL EPISODES REPRESENT ABOUT 70 PERCENT OF SPENDING ON EPISODES OF CARE

Acute myocardial infarction	AICD generator or lead	Amputation	Atherosclerosis	Back & neck except spinal fusion	CABG	Cardiac arrhythmia	Cardiac defibrillator
Cardiac valve	Cellulitis	Cervical spinal fusion	Chest pain	Combined anterior posterior spinal fusion	Complex non-cervical spinal fusion	Congestive heart failure	COPD, bronchitis, asthma
Diabetes	Double joint replacement of the lower extremity	Esophagitis, gastroenteritis and other digestive disorders	Fractures femur and hip/pelvis	Gastrointestinal hemorrhage	GI obstruction	Hip & femur procedures except major joint	Lower extremity and humerus procedure except hip, foot, femur
Major bowel	Major cardiovascular procedure	Major joint replacement of the lower extremity	Major joint upper extremity	Medical non-infectious orthopedic	Medical peripheral vascular disorders	Nutritional and metabolic disorders	Other knee procedures
Other respiratory	Other vascular surgery	Pacemaker	Pacemaker device replacement or revision	Percutaneous coronary intervention	Red blood cell disorders	Removal of orthopedic devices	Renal failure
Revision of the hip or knee	Sepsis	Simple pneumonia and respiratory infections	Spinal fusion (non-cervical)	Stroke	Syncope & collapse	Transient ischemia	Urinary tract infection

http://www.aha.org/content/14/140924webinar.pdf

Convening Organizations

- **Awardee Conveners** may work with BPCI facilities across all 50 States
- In Phase I, conveners:
  - Assist participants with analysis of baseline data for all possible episodes
  - Help participants decide whether to transition to Phase II for any episodes
- In Phase II, conveners:
  - Are eligible to share in savings, and also assume a share of the risk
  - Serve as a "General Contractor" to support Episode Initiators
  - Assist Episode Initiators with administrative work (meeting reporting requirements, etc.)
  - Assist Episode Initiators with patient identification using admission and discharge data
    - SNFs generally do not receive DRG information
    - ICD 9 → DRG predictor
  - Provide resources for post-discharge care coordination (call centers, web-based provider & patient portals, etc.)
- An **Awardee Convener**, *Remedy Partners,* worked with 13/17 VT facilities on Phase I activities

Timeline – Models 2-4

- In January 2015, new Awardees and Episode Initiators may enter **Phase II** by transitioning to risk-bearing for *at least one* clinical episode
- All Awardees and each Episode Initiator must enter *at least one* BPCI clinical episode into **Phase II** by April 2015
- Awardees and EIs may transition *additional* clinical episodes from **Phase I** to **Phase II** in July 2015 and October 2015
- **Phase I** will end in October 2015, so all episodes for all EIs must be transitioned to **Phase II** by that time

Model 3: Phase II

- Few choosing to move onto Phase II
  - All models (3.5%), Model 3 (1.7%)
  - No Vermont facilities have transitioned to Phase II
- Conditions that were most commonly selected and the percentage of organizations that selected that condition
  - Congestive heart failure (66%)
  - Major joint replacement of the lower extremity (53%)
  - Simple Pneumonia and Respiratory Infections (34%)
  - Chronic obstructive pulmonary disease, bronchitis, asthma (32%)
- Average number of episodes per facility in Phase II is 11

Few Transitioning from Phase I to Phase II

- Why not?
  - Administrative burden can be significant if not working with a convening organization
  - Results of baseline data analyses may suggest that assuming risk is not a viable option
- Bundles are being priced against the state average
  - Already high-performing facilities doing are better positioned to assume risk than average- or poor-performing facilities