Attachment 1a - Payment Models WG Agenda Mtg 3 3 14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday March 3, 2014 2:00 PM – 4:30 PM.
EXE 4th Floor Conference Room, Pavilion Building, Montpelier
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	2:00 – 2:05	Welcome and Introductions Approve meeting minutes	Don George and Steve Rauh	Attachment 1a: Meeting Agenda Attachment 1b: Meeting Minutes
2	2:05 – 2:10	Update on ACO/SSP	Richard Slusky & Kara Suter	
3	2:10– 2:15	Updates from other WGs	Georgia Maheras	
4	2:15-2:35	Introduction of Analytics Consultants and Review of Draft Agenda for April Meeting	Kara Suter	Attachment 4a: Brandeis Team Bios Attachment 4b: Draft April Agenda
5	2:35 – 3:00	Case Study: Example EOC from Arkansas	Kara Suter	Attachment 5: Case Study: Example Presentation
6	3:00-4:00	Case Study: Example EOC from Rutland BPCI Program	Darren	Attachment 6: Rutland Presentation
7	4:00-4:15	Discussion and Next Steps April Meeting	Kara Suter	
7	4:15 – 4:20	Public Comment	Don George and Steve Rauh	
8	4:20 – 4:30	Next Steps and Action Items	Don George and Steve Rauh	Next Meeting: April 7, 1 – 3:30 pm. Montpelier

Attachment 1b - Payment Models Work Group Minutes 02.03.2014

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting: February 3, 2014 2pm to 4:30pm: DVHA Large Conference Room, 312 Hurricane Lane, Williston.
Call in: 877-273-4202 Passcode 2252454

Attendees: Steve Rauh, Don George, Co-Chairs; Sarah King, Rutland Area Visiting Nurse Assn; Paul Harrington VT Medical Society; , David Martini, Dept. of Financial Regulation; Abe Berman, Barbara Walters, and Lynn Guillett, One Care; Heather Bushey, Planned Parenthood of Northern NE; Michael Curtis, Washington County Mental Health Services; Mike Del Trecco, VT Assn of Hospitals and Health Systems; Marlys Waller, VT Council; Kelly Lange, Blue Cross of VT; Lori Real, Bi-State; Sandy McGuire, and Marie Zura, Howard Center; Julia Shaw, and Lila Richardson, Vermont Legal Aid; Tom Boyd; Michael Bailit, Bailit Health Purchasing; Julie Wasserman, AHS-Central; Nancy Hogue, Jenny Samuelson, and Kara Suter, AHS-DVHA; Con Hogan, Richard Slusky, Pat Jones, and Spenser Weppler, GMCB; Georgia Maheras, AOA; George Sales and Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome & Introductions; Approval of Minutes	Steve Rauh called the meeting to order at 2:03 pm. Mike Del Trecco moved to accept Minutes of January 6, 2014; Kelly Lange 2nd. Motion passed unanimously.	
2 Update on ACO/SSP	Richard Slusky reported that the 3 ACO's and 2 payers are close to an agreement. Once signed, the ACOs will send out to participation agreements to providers. The provider agreements are expected to go out next week and should be returned by end of March. Payers will begin attributing patients at that time. No solid enrollment numbers are available yet, and it could be weeks or months to determine attribution numbers. Small businesses making payments directly to payers/carriers are included since they are purchasing product through the Exchange. Both providers and ACOs are comfortable with calculating attributions of patients retroactively to	

Agenda Item	Discussion	Next Steps
	January 1.	
3 Update on Other Work Groups	Georgia offered a brief update on other Work Groups. The Core Team meets tomorrow and Health Information Technology meets on Wednesday. Care Models, and Core Team meet next week.	
4 Update on Analytics SOW	Kara Suter presented the analytics Statement of Work (SOW) ref: Att 3. Truven is performing similar work nationally, is already under contract with GMCB, and will perform the work described. The structure of an existing GMCB contract with Truven has capacity and placeholders for this additional work. Truven will facilitate defining the universe of episodes, creating criteria for each episode, and the supporting evidence to help narrow the Work Group's focus. Don opened the floor for discussion. Truven will begin its work on in-patient episodes of care (EOC), and may include a mix of outpatient EOCs.	
5 Update on EOC Work Stream Process: Advisory Groups and Other WG's	Kara asked the Work Group to consider forming 2 advisory committees to address multiple work streams each with a different focus; a clinical advisory committee, and an operational committee. The first steps include: how to form the groups, identify clinical and coding experts as potential resources, seek volunteers or nominations, specify the mission and expected output. Kara suggests leveraging the expertise of other Work Groups creating a dynamic collaboration among participants.	
6 Review Agenda's for March & April	Looking ahead, Kara proposed draft agendas for the next 2 Work Group meetings. In March, a case study example from Arkansas will be presented, and Rutland BPCI will present on its experience with EOC pilots. Truven is expected to deliver its scope of work in 8 weeks, and in April, a presentation of findings and recommendations is planned.	
7 Public Comment	Don opened the Public Comment section of the meeting acknowledging the substantive discussions and questions during today's meeting. The Staff supporting this Work Group have been sensitive about not getting ahead of the members, and the rigid timelines of the grant are being balanced with momentum of the Work Group as stakeholder participation is very important to process. Don invited public comment: Lori Real asked about the possibility of sharing information on a web based medium. Georgia advises that the VHCIP Website will launch Website next week. A comprehensive webpage is dedicated to each Work Group. Mike Del Trecco offered that, in his opinion, the momentum is in the right direction. Understanding that the answers will be divined as EOC payment reform is developed, Mike placed	

Agenda Item	Discussion	Next Steps
	emphasis on the importance of understanding how EOC payments will fit with the larger payment reform methodology. Mike then asked what is Truven's responsibility to Medicaid and Commercial payers, and what are overlaps with GMCB? Kara responded that while the contract will be paid by GMCB, Truven will be responsive to the Payment Models WG. Don endorsed the contract amendment with Truven as an appropriate move forward. Understanding the need to move forward, Abe Berman expressed concern about how to ensure that separate payment reform initiatives work together rather than interfere with one another. Kara responded that getting the right experts on the clinical and operational advisory committees and focusing on putting resources where we get significant results are key. For example, not all providers are participating in an ACO – so there will be a balance to get everyone in the payment reform door. Richard added that the overall mission for our ACO and EOC work is about improving the delivery of care and achieving some savings. Paul Harrington thanked Kara for proposing the clinical and operational advisory groups, and commented that serving on one takes a lot of work. Paul suggested using one of the existing advisory groups instead of reinventing one. Lori Real expressed concern that participants are fully engaged in the many demos being proposed. Don's closing comments are that EOC is aligned with entire payment reform initiative, and it is pertinent that we hear from participants about disparate views and issues. Meeting ended at 3:16pm	
8 Next Steps & Action Items	Next meeting: March 3, 2014, Pavilion Building 4th Floor Executive Conference Room	

Attachment 4a - Analytics Consultant Bios

Truven/Brandeis Team Bios

Christopher Tompkins, Ph.D. directs the Institute on Healthcare Systems at Brandeis University. He has pioneered payment and incentive systems for healthcare reform, including development of the Medicare shared savings system implemented in the Physician Group Practice demonstration, the MSSP, and Accountable Care Organizations (ACOs). He led the design of hospital value-based purchasing for Medicare. Since the fall of 2010, he has been directing a project to develop an episode-of-care system for Medicare, which is being used for individual feedback to physicians, and will be used for the physician value-based payment modifier in 2015.

Dr. Tompkins led analytic support for nearly 100 hospitals considering participation in the Medicare Bundled Payment for Care Improvement demonstration. Also, he directed support of the Office of the National Coordinator's Beacon Communities in relation to claims-based performance measures based on Medicare data.

Dr. Tompkins has led many applied research studies, and has taught program evaluation, healthcare financing, and research methods. He chaired the Brandeis University IRB for eight years.

Cindy Parks Thomas, Ph.D., is Associate Research Professor at the Brandeis University Schneider Institutes for Health Policy, and leads the Brandeis team for the Truven/Brandeis analytic services contract in support of Vermont health reform. Dr. Thomas has over 20 years' experience in research and evaluation related to health policy and financing, medical and prescription drug coverage and benefit design, and Medicare and Medicaid coverage and spending. She has led numerous economic and policy analyses of state and Federal health programs, using both large claims databases and qualitative analyses, in general health services and addiction treatment. Recent or ongoing work includes design of health care cost trends reports for the state of Massachusetts, assessing the impact of the Medicare drug benefit on dually eligible beneficiaries and on Medicaid programs, evaluating state health information system initiatives for linking state prescription monitoring data with electronic health records, and designing and evaluating electronic prescribing practices. Dr. Thomas holds a Ph.D. in Health Policy from Brandeis University Heller Graduate School and a Master's Degree in Health Policy and Management from the Harvard School of Public Health. She is a Physician's Assistant, in the past specializing in internal medicine, trauma and emergency care in both Kaiser Health Plan Colorado, and rural private practice settings.

Attachment 4b - Draft Payment Models WG Agenda Mtg 4 7 14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday April 7, 2014 1:00 PM – 3:30 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00 – 1:05	Welcome and Introductions Approve meeting minutes	Don George and Steve Rauh	Attachment X: Meeting Minutes
2	1:05 – 1:10	Update on ACO/SSP	Richard Slusky & Kara Suter	
3	1:10– 1:15	Update on Other Work Groups	Georgia Maheras	
4	1:15 – 1:25	Introduction of Contractors and Work Plan for Meeting	Don George and Steve Rauh	
5	1:25 – 1:55	EOC Objectives	Cindy Thomas, Brandies (TBD)	Attachment X: Draft EOC Objectives and/or Presentation
5	1:55-2:35	EOC Universe	Cindy Thomas, Brandies (TBD)	Attachment X: Draft EOC Universe and/or Presentation
6	2:35-3:15	EOC Criteria for Selection	Cindy Thomas, Brandies (TBD)	Attachment X: Draft EOC Criteria for Selection and/or Presentation
7	3:15 – 3:20	Public Comment	Don George and Steve Rauh	
8	3:20 – 3:30	Next Steps and Action Items	Don George and Steve Rauh	Advisory Group Meetings Scheduled Next Meeting: May 12th, 2 – 4:30 pm. Montpelier

Attachment 5 - Example from Arkansas ADHD Webinar Presentation 11.14.12

Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative (APII)

Attention Deficit/Hyperactivity Disorder (ADHD)

Statewide Webinar

November 14, 2012

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

- Angela Littrell, Medicaid Health Innovation Unit Infrastructure Development and Implementation Manager - **Overview of the Healthcare Payment Improvement Initiative**

- Shelley Tounzen, Medicaid Health Innovation Unit Public Information Coordinator – **Initiative Update**
- Dr. William Golden, Medicaid Medical Director – **ADHD Providers , Patients & Quality**
- Wanda Colclough and Paula Miller – HP Enterprises Technical Consultant and HP APII Analyst - **Episode Descriptions & Reports**
- Patricia Gann – ValueOptions, Program Director - **Portal & Certifications**

Today, we face major health care challenges in Arkansas

- **The health status of Arkansans is poor**, the state is ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes
- **The health care system is hard for patients to navigate**, and it does not reward providers who work as a team to coordinate care for patients
- **Health care spending is growing unsustainably:**
  - Insurance premiums doubled for employers and families in past 10 years (adding to uninsured population)
  - Large projected budget shortfalls for Medicaid

Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system…

Focus today

Objectives

For patients

- Improve the health of the population
- Enhance the patient experience of care
- Enable patients to take an active role in their care

For providers

- Reward providers for high quality, efficient care
- Reduce or control the cost of care

How care is delivered

Population-based care

- Medical homes
- Health homes

Episode-based care

- Acute, procedures or defined conditions

Four aspects of broader program

- **Results-based payment and reporting**
- **Health care workforce development**
- **Health information technology (HIT) adoption**
- **Expanded access for health care services**

Payers recognize the value of working together to improve our system, with close involvement from other stakeholders…

Arkansas Medicaid

QualChoice HEALTH INSURANCE

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Coordinated multi-payer leadership…

- Creates **consistent incentives** and standardized reporting rules and tools
- Enables **change in practice** patterns as program applies to many patients
- Generates enough scale to justify investments in **new infrastructure** and operational models
- Helps **motivate patients** to play a larger role in their health and health care

1 Center for Medicare and Medicaid Services

Medicaid and private insurers believe paying for results, not just individual services, is the best option to improve quality and control costs

✓ Transition to payment system that **rewards value and patient health outcomes** by aligning financial incentives

✗ **Reduce payment levels for all providers** regardless of their quality of care or efficiency in managing costs

✗ **Pass growing costs on to consumers** through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)

✗ **Intensify payer intervention in decisions though managed care or elimination of** expensive services (e.g. through prior authorizations) based on restrictive guidelines

✗ **Eliminate coverage of** expensive services or eligibility

We have worked closely with providers and patients across Arkansas to shape an approach and set of initiatives to achieve this goal

500+	▪ **Providers, patients, family members**, and other stakeholders who helped shape the new model in public workgroups
21	▪ **Public workgroup meetings** connected to 6-8 sites across the state through videoconference
16	▪ **Months of research,** data analysis, expert interviews and infrastructure development to design and launch episode-based payments
Monthly	▪ **Updates with many Arkansas provider associations** (e.g., AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association)

The episode-based model is designed to reward coordinated, team-based high quality care for specific conditions or procedures

The goal

- **Coordinated, team based care** for all services related to a specific condition, procedure, or disability (e.g., pregnancy episode includes all care prenatal through delivery)

Accountability

- A provider ‘quarterback’, or **Principal Accountable Provider** (PAP) is designated as accountable for all pre-specified services across the episode (PAP is provider in best position to influence quality and cost of care)

Incentives

- **High-quality, cost efficient care** is rewarded beyond current reimbursement, based on the PAP’s average cost and total quality of care across each episode

Health Care Payment Improvement Initiative

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Wave 2 launch

- In the first half of 2013, will launch four new medical episodes: Cholecystectomy (gallbladder removal), Tonsillectomy, Colonoscopy, and Oppositional Defiant Disorder

- We are aiming to launch the next set of episodes in mid-2013. Some possibilities include:
  - Cardiac care
  - Orthopedic care: back pain, joint arthroscopy
  - Behavior health: Depression, Bipolar Disorder
  - Other specialty procedures: dialysis, hysterectomy
  - Stroke
  - NICU
  - Preschool children with developmental delays

- We will launch Long Term Support Services (LTSS) and Developmental Disability (DD) episodes. The assessment period for DD will begin this month, and for LTSS will begin in the first quarter of 2013.

- We also plan to launch Patient Centered Medical Homes and Health Homes for Behavioral Health.

Upcoming working groups

Episode Public Working group	Date & Time
Oppositional Defiant Disorder	Nov 20, 2012, 2:30-4:30 pm
Cholecystectomy	Nov 26, 2012, 4:00-6:00 pm
Colonoscopy	Nov 28, 2012, 5:00-7:00 pm
Tonsillectomy	Dec 4, 2012, 4:00-6:00 pm

Performance period updates

Topic	Stakeholder message
Wave 1b preparatory period	The performance period for Congestive Heart Failure and Total Joint Replacement (hip & knee replacement) will start on February 1, 2013. Providers will not be evaluated based on performance prior to that date. Providers will still receive their first full performance report reflecting settlement for risk and gain sharing payments in April 2014.
ADHD performance period	The performance period for ADHD will end on December 31, 2013. Providers will still be evaluated based on performance starting on October 1, 2012, and the ADHD episode length remains unchanged at 12 months. Providers will receive their first full performance report reflecting settlement for risk and gain sharing payments in April 2014.
Performance periods	Performance period dates for certain upcoming episodes and all active episodes can be found on the website.

Episode	Current or Upcoming Performance Period
URI	**Oct 1, 2012 to Sept 30, 2013**
Perinatal	**Oct 1, 2012 to Sept 30, 2013**
ADHD	**Oct 1, 2012 to Dec 31, 2013**
CHF	**Feb 1, 2013 to Dec 31, 2013**
TJR	**Feb 1, 2013 to Dec 31, 2013**

Questions

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The model rewards a Principal Accountable Provider (PAP) for leading and coordinating services and ensuring quality of care across providers

PAP role	What it means…
Core provider for episode	▪ **Physician, practice, hospital**, or **other provider** in the best position to influence overall quality, cost of care for episode
Episode **'Quarterback'**	▪ **Leads and coordinates the team** of care providers ▪ Helps **drive improvement** across system (e.g., through care coordination, early intervention, patient education, etc.)
Performance management	▪ Rewarded for **leading high-quality, cost-effective** care ▪ **Receives performance reports and data** to support decision-making

PAP selection:

- Payers review claims to see which providers patients chose for episode related care
- Payers select PAP based main responsibility for the patient's care

NOTE: Episode and health home model for adult DD population in development. Model will utilize lead provider and health home to drive coordination

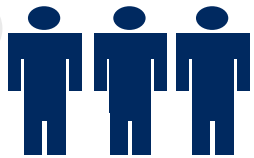
Ensuring high quality care for every Arkansan is at the heart of this initiative, and is a requirement to receive performance incentives

Two types of quality metrics for providers	Description
1 **Quality metric(s) "to pass"** are linked to payment	➢ **Core measures** indicating basic standard of care was met ➢ **Quality requirements** set for these metrics, a provider must meet required level to be eligible for incentive payments ➢ In select instances, quality metrics must be entered in portal (heart failure, ADHD)
2 **Quality metric(s) "to track"** are not linked to payment	➢ Key to understand overall quality of care and quality **improvement opportunities** ➢ Shared with providers but **not linked to payment**

How episodes work for patients and providers (1/2)

Patients and providers deliver care as today (performance period)

1



Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

Payers reimburse for all services as they do today

How episodes work for patients and providers (2/2)

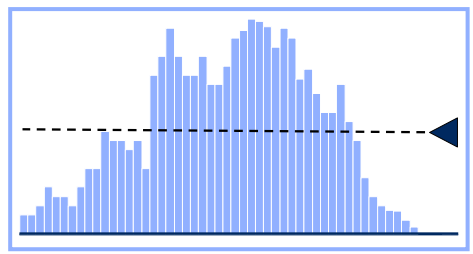
Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average cost per episode** for each PAP[1]

Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

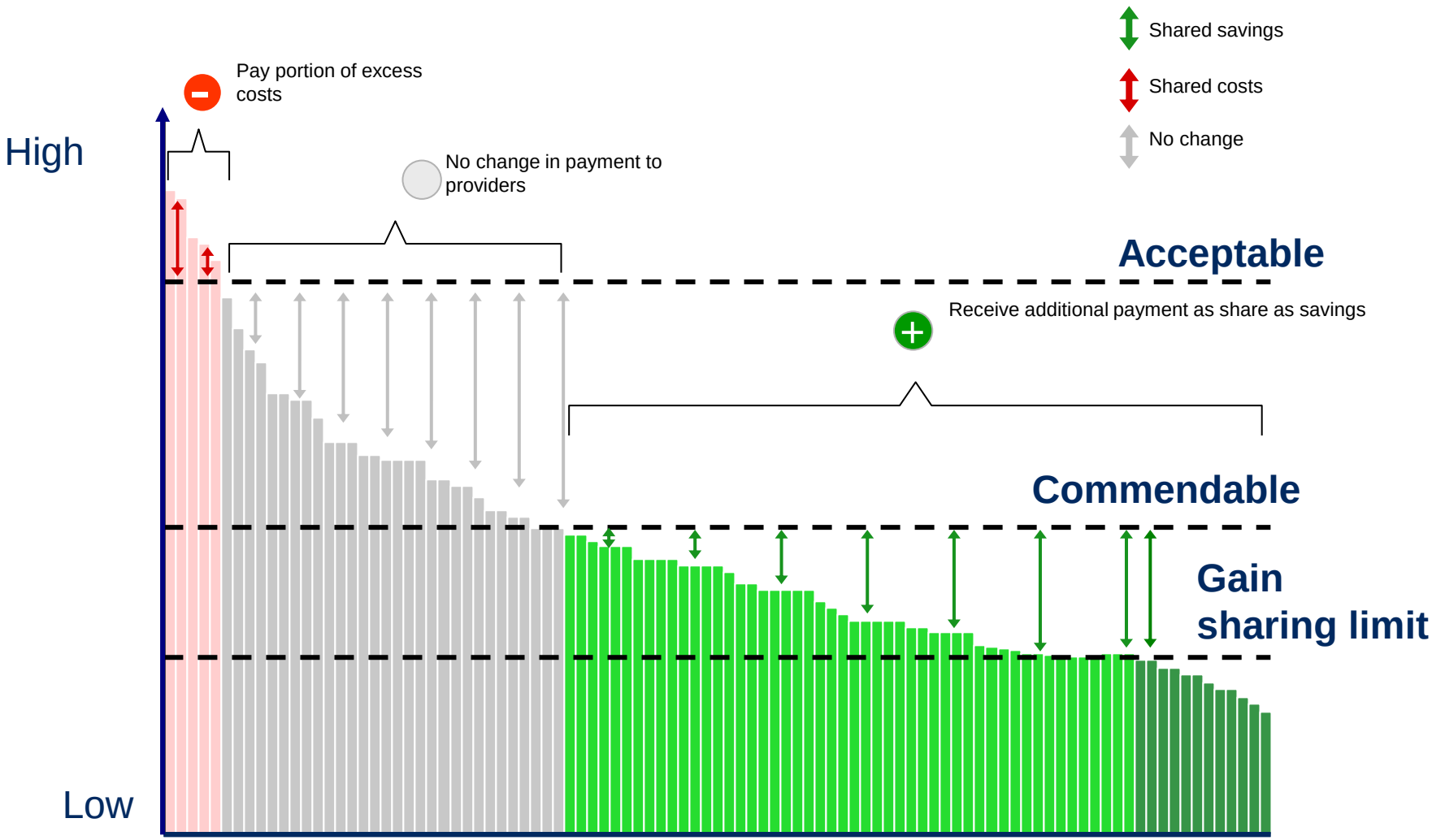


6 **Based on results, providers will:**

- **Share savings:** if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

1 Outliers removed and adjusted for risk and hospital per diems
2 Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations

PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit



Individual providers, in order from highest to lowest average cost

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

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Version 1.0 design elements specific to ADHD

1 Episode definition/ scope of services

- Any ADHD treatment (defined by primary diagnosis ICD-9 code), with exception of assessment CPT codes, is included in the episode
- Start of episode
  - For new patients, episode begins on date of treatment initiation
  - For recurring patients, new episode starts on date of first treatment after previous episode ends (e.g. office visit or Rx filled)
- The episode will have a duration of 12 months

2 Principal accountable provider(s)

- PCP, psychiatrist or licensed clinical psychologist eligible to be the PAP
  - For Version 1.0, RSPMI provider organization will be official PAP when listed as billing provider, but reporting will be provided at performing provider level where available
- If licensed clinical psychologist treats patient, a co-PAP is required and providers share gain / risk sharing

3 Patient severity levels and exclusions

- Includes all ADHD patients aged 6 – 17 without behavioral health comorbid conditions[1]
- Two patient severity levels will be included
  - Patients with positive response to medication management, requiring only medication and parent / teacher administered support
  - Patients for whom response to medication management is inadequate and therefore psychosocial interventions are medically indicated
- Severity will be determined by a provider certification

1. 4 – 5 year olds will continue to be paid fee-for-service in version 1.0 because of limited evidence-based treatment guidelines and consensus
2. Level II episodes will not be available in July due to lack of data from the provider portal. Level II episodes started on October 2012

Triggers	Level I subtype episodes are triggered by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD. Level II subtype episodes are triggered by a completed Severity Certification followed by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD.
PAP assignment	▪Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode. ▪If the provider responsible for the largest number of claims is a physician or an RSPMI provider organization, that provider is designated the PAP. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated PAP. If the provider responsible for the largest number of claims is a licensed clinical psychologist operating outside of an RSPMI provider organization, that provider is a co-PAP with the physician or RSPMI provider providing the next largest number of claims within the episode. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated co-PAP. ▪Where there are co-PAPs for an episode, the positive or negative supplemental payments are divided equally between the co-PAPs.
Exclusions	Episodes meeting one or more of the following criteria will be excluded: A. Duration of less than 4 months B. Small number of medical and/or pharmacy claims during the episode C. Beneficiaries with any behavioral health comorbid condition D. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim
Episode time window	The standard episode duration is a 12-month period beginning at the time of the first trigger claim. A Level I episode will conclude at the initiation of a new Level II episode if a Severity Certification is completed during the 12-month period.
Claims included	All claims with a primary diagnosis of ADHD as well as all medications indicated for ADHD or used in the treatment of ADHD.
Quality measures	<u>Quality measures "to pass":</u> 1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes <u>Quality measures "to track":</u> 1. In order to track and evaluate selected quality measures, providers are asked to complete a "Quality Assessment" certification (for beneficiaries new to the provider) and a "Continuing Care" certification (for beneficiaries previously receiving services from the provider) 2. Percentage of episodes classified as Level II 3. Average number of physician visits/episode 4. Percentage of episodes with medication 5. Percentage of episodes certified as non-guideline concordant 6. Percentage of episodes certified as non-guideline concordant with no rationale
Adjustment	Total reimbursement attributable to the PAP for episodes with a duration of less than 12 months will be scaled linearly to determine a reimbursement per 12-months for the purpose of calculating the PAP's performance.

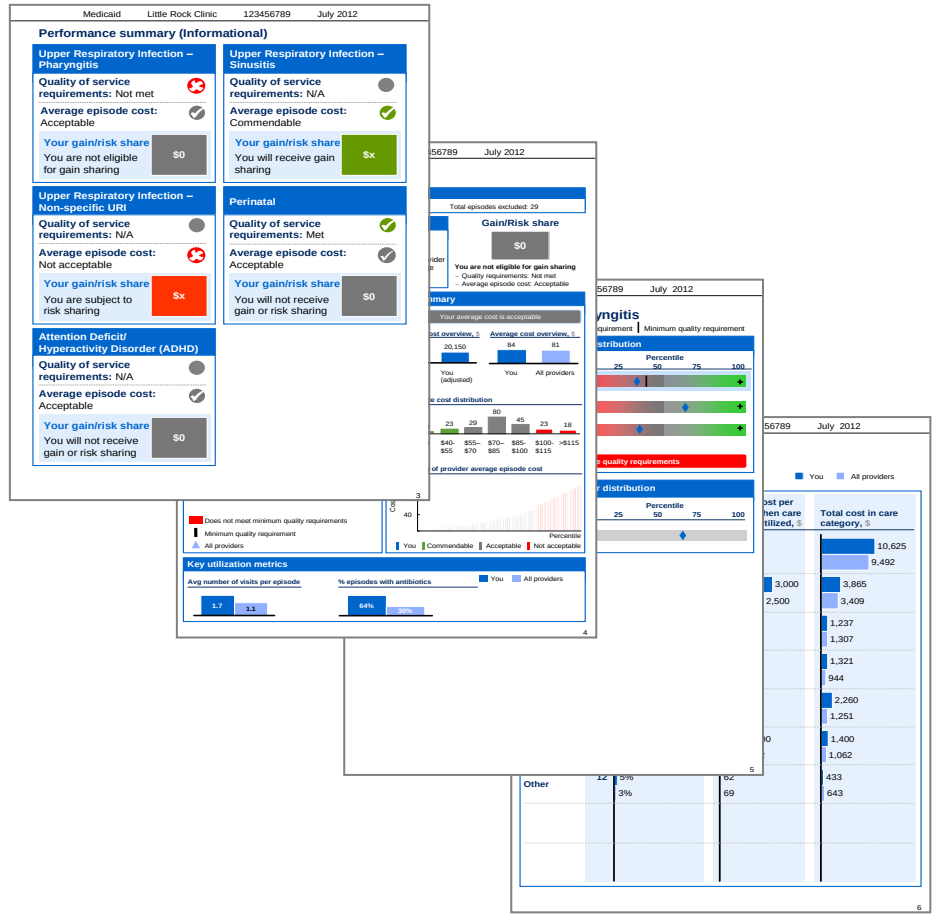
Trigger codes	Diagnosis or medication that would trigger the episode **ICD-9 codes (on Professional claim):** 314.xx **HIC3:** H7Y, H8M, H2V, J5B **CPT codes for assessment:** 90801, 96101, 96118, T1023
Exclusion codes	The following ICD-9 diagnoses exclude an episode. The same diagnosis must appear at least twice within the year to qualify for exclusion. **ICD-9:** 290.xx, 291.xx, 292.xx, 293.xx, 294.xx, 295.xx, 296.xx, 297.xx, 298.xx, 300.xx, 301.xx, 302.xx, 303.xx, 304.xx, 305.xx, 306.xx, 307.xx, 308.xx, 309.xx, 310.xx, 311.xx, 312.xx, 313.xx These codes represent the set of business and clinical exclusions described previously
Included claim codes	Any claim with a primary diagnosis of ADHD – defined by the following ICD-9 codes – is included. **ICD-9-CM code:** 314.xx Further, all pharmacy claims for medications with the following HIC3 classification are included. **HIC3 code:** A4B, H2E, H2G, H2M, H2S, H2U, H2V, H2W, H2X, H7B, H7C, H7D, H7E, H7J, H7O, H7P, H7R, H7S, H7T, H7U, H7X, H7Y, H7Z, H8H, H8I, H8J, H8M, H8O, H8P, J5B List of CPT codes for psychosocial therapy claims within the episode **'OFFICE' codes:** 01, 02, 03, 04 **Psychosocial visits:** 90846, 90847, 90849, 90853, 97110, 97150, 97530, 97532, 97535, H0004, H0046, H2011, H2015, H2017, H2012

PAPs will be provided tools to help measure and improve patient care

Reports provide performance information for PAP's episode(s):

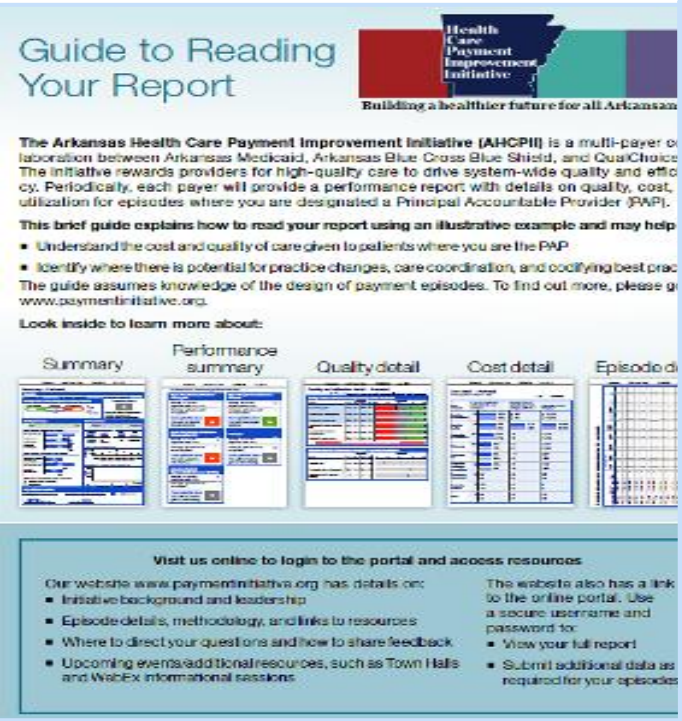
- Overview of **quality** across a PAP's episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP's average episode cost

Example of provider reports



NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.

PAP performance reports have summary results and detailed analysis of episode costs, quality and utilization


Guide to Reading Your Report

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

The Arkansas Health Care Payment Improvement Initiative (AHCPII) is a multi-payer c
laboration between Arkansas Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice
The initiative rewards providers for high-quality care to drive system-wide quality and effic
cy. Periodically, each payer will provide a performance report with details on quality, cost,
utilization for episodes where you are designated a Principal Accountable Provider (PAP).

This brief guide explains how to read your report using an illustrative example and may help

- Understand the cost and quality of care given to patients where you are the PAP
- Identify where there is potential for practice changes, care coordination, and codifying best prac

The guide assumes knowledge of the design of payment episodes. To find out more, please g
www.paymentinitiative.org.

Look inside to learn more about:

Summary | Performance summary | Quality detail | Cost detail | Episode d

Visit us online to login to the portal and access resources

Our website www.paymentinitiative.org has details on:

- Initiative background and leadership
- Episode details, methodology, and links to resources
- Where to direct your questions and how to share feedback
- Upcoming events/additional resources, such as Town Halls and WebEx informational sessions

The website also has a link to the online portal. Use a secure username and password to:

- View your full report
- Submit additional data as required for your episodes

Details on the reports

- First time PAPs receive detailed analysis on costs and quality for their patients increasing performance transparency
- Guide to Reading Your Reports available online and at this event
  - Valuable to both PAPs and non-PAPs to understand the reports
- Reports issued quarterly starting July 2012
  - July 2012 report is informational only
  - Gain/risk sharing results reflect claims data from Jan – Dec 2011
- Reports are available online via the provider portal

NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Arkansas Health Care Payment Improvement Initiative Provider Report

Medicaid
Report date: July 2012

Historical performance: January 1, 2011 – December 31, 2011

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. For more information, please visit www.paymentinitiative.org

Table of contents

Acme Clinic Performance Summary

Medicaid [redacted] [redacted] July 2012

Performance summary (Informational)

Upper Respiratory Infection - Pharyngitis

Quality of service requirements: N/A

Average episode cost: No eligible episodes

Your gain/risk share
You are not subject to gain or risk sharing [redacted]

Upper Respiratory Infection - Sinusitis

Quality of service requirements: N/A

Average episode cost: No eligible episodes

Your gain/risk share
You are not subject to gain or risk sharing [redacted]

Upper Respiratory Infection - Non-specific URI

Quality of service requirements: N/A

Average episode cost: No eligible episodes

Your gain/risk share
You are not subject to gain or risk sharing [redacted]

Perinatal

Quality of service requirements: N/A

Average episode cost: No eligible episodes

Your gain/risk share
You are not subject to gain or risk sharing [redacted]

Attention Deficit/Hyperactivity Disorder (ADHD)

Quality of service requirements: N/A

Average episode cost: Acceptable

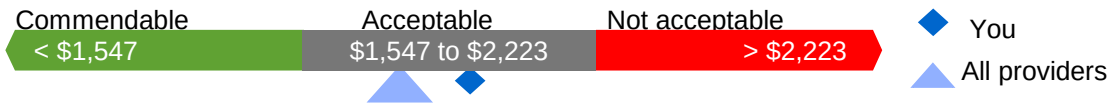
Your gain/risk share
You will not receive gain or risk sharing $0

Summary – ADHD

1 Overview

Total episodes: 262 Total episodes included: 233 Total episodes excluded: 29

2 Cost of care compared to other providers



Gain/Risk share

$0

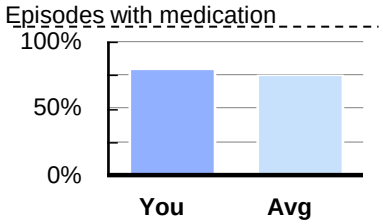
You will not receive gain or risk sharing
- Selected quality metrics: N/A
- Average episode cost: Acceptable

3 Quality summary

No quality metrics linked to gain sharing at this time

Linked to gain sharing

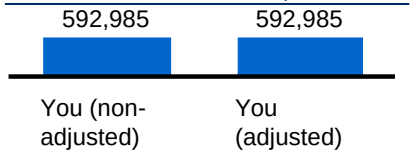
There are no quality metrics linked to gain sharing generated from historical claims data. Provider certifications submitted on the Provider Portal since October 1, 2012 will generate additional quality metrics for future reports.



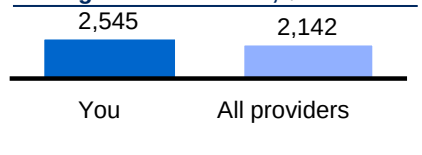
4 Cost summary

Your average cost is acceptable

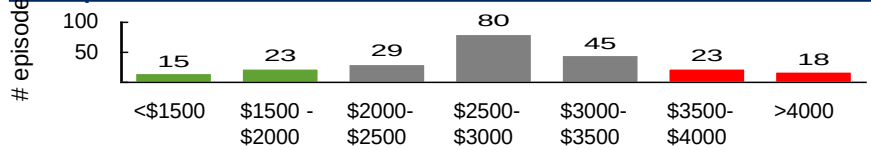
Your total cost overview, $



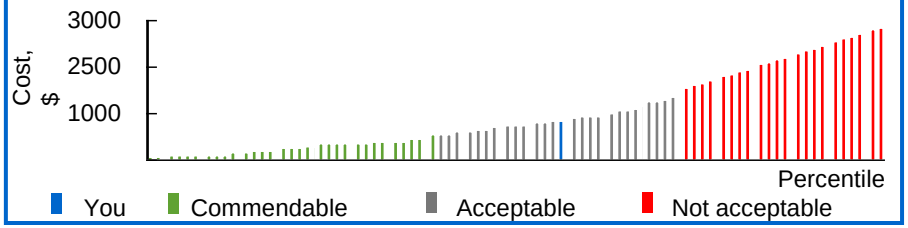
Average cost overview, $



Your episode cost distribution



Distribution of provider average episode cost



5 Key utilization metrics

Average number of visits per episode

Average number of psychosocial visits per episode

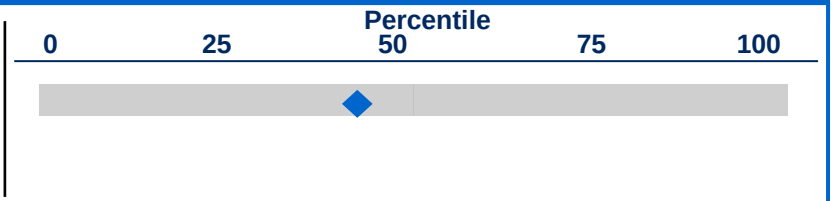
You All providers

Quality and utilization detail – ADHD

You | Metric linked to gain sharing | Minimum standard for gain sharing

Quality metrics: Performance compared to provider distribution

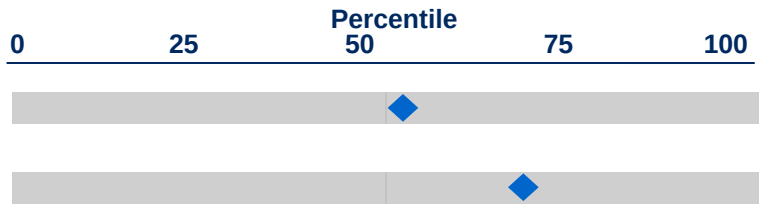
Metric	You	Percentile 25th	50th	75th
% of episodes with medication	88%	50%	90%	98%



No quality metrics linked to gain sharing at this time

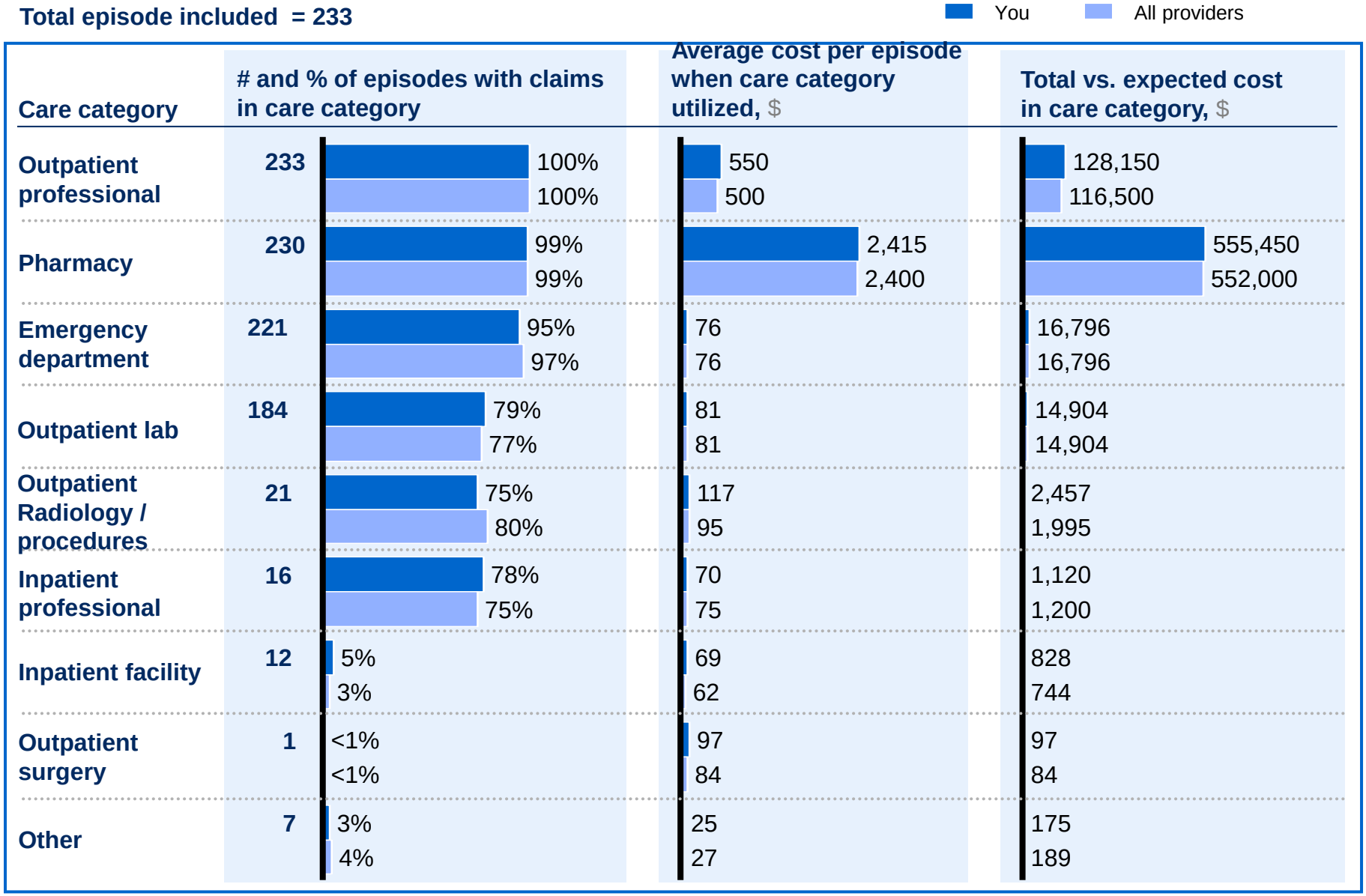
Utilization metrics: Performance compared to provider distribution

Metric	You	Percentile 25th	50th	75th
Average number of visits per episode	4.1	2.3	3.9	4.3
Average number of psychosocial visits per episode	62	15	38	74



Cost detail – ADHD

Total episode included = 233



Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

- Angela Littrell, Medicaid Health Innovation Unit Infrastructure Development and Implementation Manager - **Overview of the Healthcare Payment Improvement Initiative**
- Shelley Tounzen, Medicaid Health Innovation Unit Public Information Coordinator – **Initiative Update**
- Dr. William Golden, Medicaid Medical Director – **ADHD Providers , Patients & Quality**
- Wanda Colclough and Paula Miller – HP Enterprises Technical Consultant and HP APII Analyst - **Episode Descriptions & Reports**
- Patricia Gann – ValueOptions, Program Director - **Portal & Certifications**

The provider portal is a multi-payer tool that allows providers to enter quality metrics for certain episodes and access their PAP reports

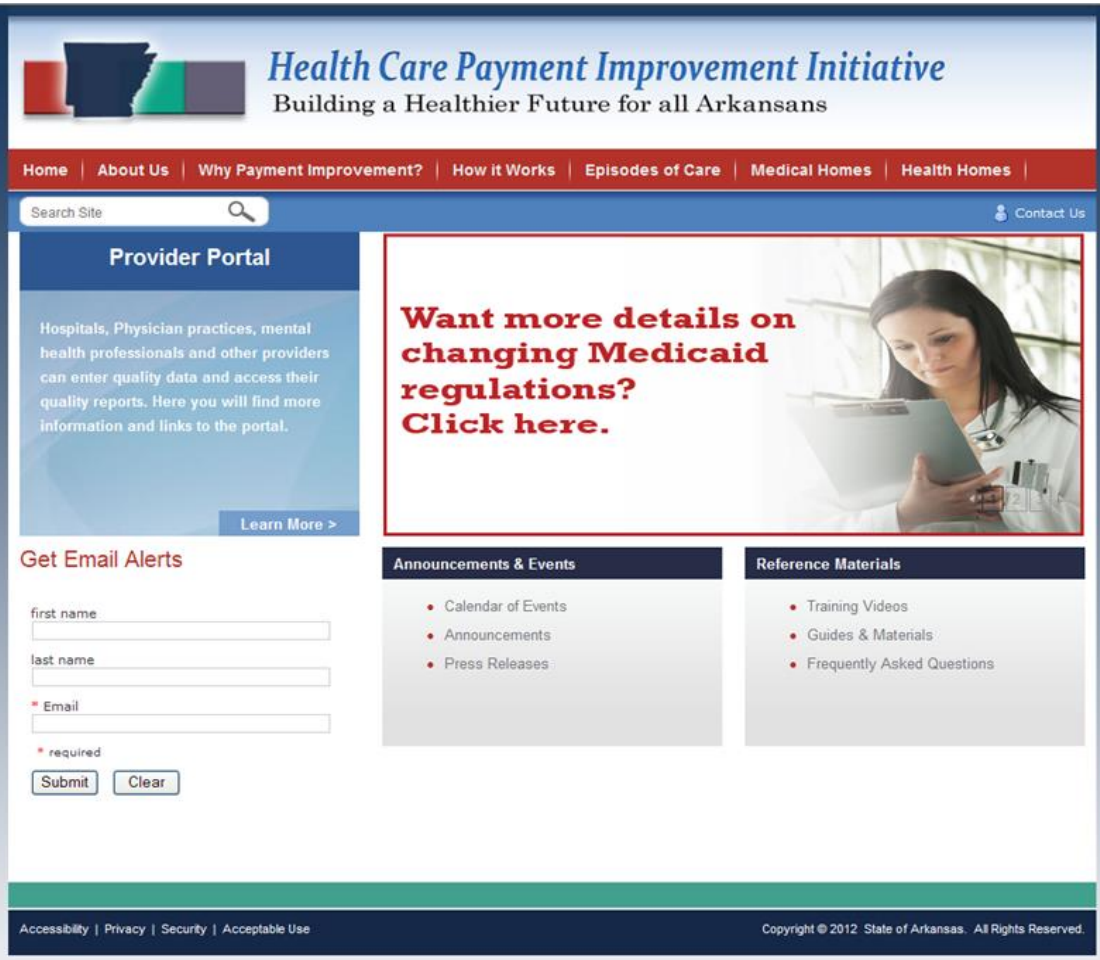
Login to portal from payment initiative website

Details on the provider portal

- Accessible to all PAPs
  - Login with existing username/ password
  - New users follow enrollment process detailed online
- Key components of the portal are to provide a way for providers to
  - Enter additional quality metrics for select episodes (Hip, Knee, CHF and ADHD with potential for other episodes in the future)
  - Access current and past performance reports for all payers where designated the PAP

NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.

Provider Portal



Provider Portal

Health Care Payment Improvement Initiative
Building a Healthier Future for all Arkansans

Home | About Us | Why Payment Improvement? | How it Works | Episodes of Care | Medical Homes | Health Homes

Search Site

Contact Us

Portal Provider

Portal Access

Home > Portal Provider

Provider Portal

The goal of the initiative is to reward providers who deliver high-quality, coordinated and cost-effective care for certain certain medical episodes. The Provider Portal is a key component of the payment initiative approach. The portal is a HIPAA-compliant online tool that allows hospitals, physicians, mental health providers and other providers to submit a limited set of additional quality metrics data that will to be tied to the initiative's financial incentives. The portal also allows providers who are designated as PAP access to comprehensive reports of their average quality, costs, and utilization for episodes during a given time period. This is the first time that Medicaid and the state's private insurance companies will make such detailed analytical information available to providers. To help providers navigate the reports, we have created an easy-to-understand guide that explains how to read the report using an illustrative example. For those needing assistance using the portal, here you will find step-by-step instructions.

During a three- to six-month preparatory period beginning in July, data submission of additional quality metrics beyond those captured by claims will be available through the portal. At the end of July, PAP performance reports will be posted to the portal for physician/hospital providers or available via secure messaging for non-physician providers. After the preparatory period, the payers will use some of the data entered into the portal for the ADHD, Congestive Heart Failure and Hip and knee replacement episodes to determine whether a provider is eligible to share in savings or excess costs across their episodes. No additional data will be required for Upper Respiratory Infection or Perinatal episodes. All future reports are expected to all be available online.

Physician practices, hospitals, RSPMI providers and other qualifying providers can click here: Advanced Health Information Network to access the portal using an existing Advanced Health Information Network (AHIN) username and password. If you do not have an active AHIN account and would like to register contact Customer Support (501) 378-2336 or email customersupport@ahin.net

Arkansas Medicaid has opted to use the AHIN Provider Portal for RSPMI, psychologists and other mental health providers who are participating in the Attention Deficit/Hyper Activity Disorder episodes of care. Access is free. Beginning Oct. 1, 2012, provider portal data entry of quality metrics is required to be eligible for gain-sharing for selected episodes. If you have questions, please contact the Medicaid payment initiative customer service center at 501-301-8311 or at ARKPII@hp.com.

Provider Portal

Logon

User Id:

Password:

Logon

Questions

Reset/Forgot Your Password?
Learn More about AHIN?
How do I select AHIN as my clearinghouse?

Links

Arkansas Blue Cross and Blue Shield
Health Advantage
Health Advantage Customer Service
Arkansas Medicare
Arkansas Medicaid
Blue Advantage Administrators of Arkansas
Medi-Pak Advantage PFFS

Arkansas Payment Improvement Initiative

Click here to enroll for APII access if not a current AHIN user
APII Provider Portal Documentation
User Assignment for the APII Portal

AHIN Alerts

10/11/2012 ***MANDATORY* Medi-Pak Advantage Compliance and Code of Conduct Training - Must Complete by 12/31/2012**

Arkansas Blue Cross and Blue Shield is required by the Centers for Medicare & Medicaid Services (CMS) regulations to develop and maintain a compliance program and to provide annual training to all first-tier, downstream and related entities. Providers are considered first tier entities because there is a direct contract for Medicare Services between Arkansas Blue Cross and each provider. As a contractor with CMS to provide Medicare Advantage (MA) and Prescription Drug Program (PDP) plans, we are required to provide compliance and Code of Conduct training materials to you annually. This training and attestation is MANDATORY for all that provide services for Medi-Pak Advantage members. Click here to view the training materials and attestation form. If you have questions, contact the Arkansas Blue Cross Blue Shield Medicare C & D Compliance Office at 501-378-2525, or email us at medicarecdcompliance@arkbluecross.com

Provider Portal

Clinical Data Entry - ADHD Episode

*Payer: Medicaid

*Facility name: [redacted]

*Provider:

*Patient first: [redacted] Patient middle: *Patient last: [redacted]

*Member ID: 0000000455 *Patient DOB: [redacted] *Date of service: 09/20/2012

Have you previously treated this patient for ADHD? Yes No

Is this a severe patient who requires Level II care? Yes No

Continuing Care Certification:

I hereby certify and attest that I have completed and documented the following in the care of my patient with ADHD. This certification should be completed for any patient you have treated previously for ADHD. Please select "Yes" or "No" to each question:

I evaluated patient's ongoing symptoms, impairment, and activities to determine continued necessity of treatment for ADHD, screening for comorbidities if appropriate. Yes No

I provided psychoeducation to the parent and/or guardian of the patient regarding the diagnosis and treatment of ADHD. Yes No

I am providing guideline concordant medication management, or... Yes No

I have documented complete rationale for care outside of guidelines. Yes No

(If not the PCP) I alerted the PCP to any changes in treatment regimen and side effects of medication. Yes No

***Please enter your e-signature here:** **09/26/2012**

Submit Episode Data ▶ Submit Data and Add Another Episode ▶

Provider Portal

Severity Certification:

This certification should only be completed for severe patients who require Level II care. I hereby certify that I diagnose the patient with ADHD, have screened for and not found comorbid conditions, that the patient has an inadequate response to guideline concordant medication management, and that further treatment is clinically necessary for one or more of the following rationale (select one or multiple reasons):

- Inadequate response to medication management. ☐
- Severe side effects of medication. ☐
- Major environmental or familial complications (e.g. trauma, homelessness, high likelihood of medication diversion). ☐
- Other reason patient is more severe (please enter explanation below). ☐

***Please enter your e-signature here:** **09/26/2012**

Submit Episode Data ▶ Submit Data and Add Another Episode ▶

Provider Portal

Have you previously treated this patient for ADHD? ○ Yes ◉ No

Is this a severe patient who requires Level II care? ○ Yes ◉ No

Quality Assessment Certification:

I hereby certify and attest that I diagnosed the patient with ADHD and have completed and documented the following in my diagnosis. This certification should be completed for any patient you have not treated previously for ADHD. Please select "Yes" or "No" to each question:

I completed and documented a vision and hearing test OR I confirmed the test was completed within the year by a qualified provider. ○ Yes ○ No

I diagnosed the patient through in-person assessment and reports from at least two settings. ○ Yes ○ No

I evaluated the patient for ADHD in accordance with the DSM-IV criteria. (see below) ○ Yes ○ No

- I found [ ] of the nine inattentive symptoms present for at least six months. (insert number)

- I found [ ] of the nine hyperactivity-impulsivity symptoms present for at least six months. (insert number)

I screened the patient for common comorbidities, using a broadband diagnostic or similar tool. ○ Yes ○ No

I obtained the patient's family history, including any incidence of the disorder in parents or guardians which might influence treatment pathway OR I attempted to collect a family history but was unable to obtain. ○ Yes ○ No

I alerted the PCP to my diagnosis and any initial treatment I have prescribed. (If not the PCP) ○ Yes ○ No

***Please enter your e-signature here:** [ ] **09/26/2012**

Provider Portal
DMS-IV Guidelines

DSM-IV guidelines:

DSM-IV Criteria
I. Either A or B:

A. Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is inappropriate for developmental level:
Inattention
1. Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has trouble keeping attention on tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has trouble organizing activities.
6. Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
7. Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).
8. Is often easily distracted.
9. Is often forgetful in daily activities.

B. Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:
Hyperactivity
1. Often fidgets with hands or feet or squirms in seat when sitting still is expected.
2. Often gets up from seat when remaining in seat is expected.
3. Often excessively runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
4. Often has trouble playing or doing leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor".

Provider Portal
DMS-IV Guidelines

6. Often talks excessively.

Impulsivity

7. Often blurts out answers before questions have been finished.
8. Often has trouble waiting one's turn.
9. Often interrupts or intrudes on others (e.g., butts into conversations or games).

II. Some symptoms that cause impairment were present before age 7 years.

III. Some impairment from the symptoms is present in two or more settings (e.g. at school/work and at home).

IV. There must be clear evidence of clinically significant impairment in social, school, or work functioning.

V. The symptoms do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The symptoms are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Submit Episode Data ▶ | Submit Data and Add Another Episode ▶

Certification would be required at the key points in care: entry into system, episode recurrence, and increase in severity

	For which patients?	Completion details	Description
A 'Quality Assessment' certification	▪ All patients new to treatment and entering episode model	▪ Completed after assessment, to initiate treatment ▪ Completed by provider who will deliver care	▪ Requires providers to certify completion of several guideline-concordant components of assessment ▪ Encourages thoughtful and high-quality assessment and diagnosis ▪ Encourages appropriate diagnosis of comorbid conditions
B 'Continuing care' certification	▪ All recurring ADHD patients within episode model	▪ Completed at episode recurrence (every 12 months) ▪ Completed by provider who will continue care	▪ Requires providers to certify adherence to basic quality of care measures and guideline concordant care ▪ Encourages regular re-evaluation of patient and management at physician level
C 'Severity' certification	▪ All patients escalated to level 2 care, whether first-time or recurring	▪ Completed at initial escalation and every level two episode recurrence ▪ Completed by provider who will deliver level two care	▪ Requires providers to certify severity for patients placed into level two care ▪ Completed by physician providing level two care

Questions

For more information talk with provider support representatives…

Online

- **More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org**
  - Further detail on the initiative, PAP and portal
  - Printable flyers for bulletin boards, staff offices, etc.
  - Specific details on all episodes
  - Contact information for each payer's support staff
  - All previous workgroup materials

Phone/ email

- **Medicaid:** 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state) or **ARKPII@hp.com**
- **Blue Cross Blue Shield:** Providers 1-800-827- 4814, direct to EBI 1-888-800-3283, APIICustomerSupport@arkbluecross.com
- **QualChoice:** 1-501-228-7111, providerrelations@qualchoice.com

Attachment 6 - Rutland CHF Presentation

Community-Wide Congestive Heart Failure Collaborative

(aka Bundled Payment Project)

Darren Childs, Director Quality Improvement Services
Stan Shapiro, MD Cardiology Medical Director
Kim McDonnell, Reimbursement Advisory Analyst

March 3, 2014

Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

The Beginning

- Discussions about a CHF project began in 2011
- Initial Meetings facilitated by:
  - Vermont Association of Hospitals and Health Systems (VAHHS)
- Focus on reducing the number of patients coming back to the hospital and being readmitted.
  - 30 day readmission rate

The Beginning

- Quickly realized, limited improvement if only hospital based improvement project.
- Needed to look at the “big picture” of care in the Rutland area.
- Work together as one team.

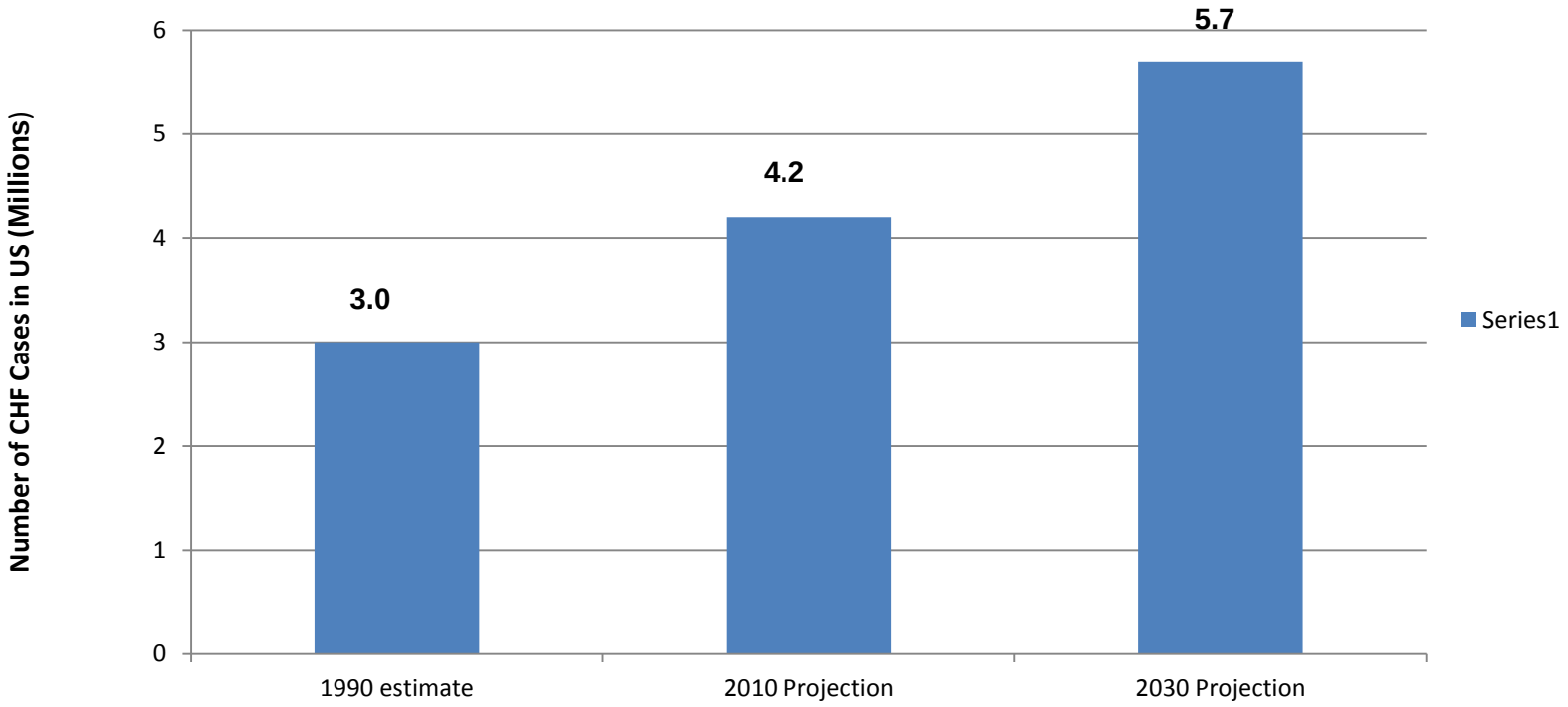
The Beginning

- Decision made to try to form a Community-Wide Team ("Collaborative")
- Reached out to Physicians, Skilled Nursing Facilities, Home Health Agencies, Other Agencies to ask for their participation
- Overwhelmingly positive response
- All had same focus: Improving care for patients with heart failure

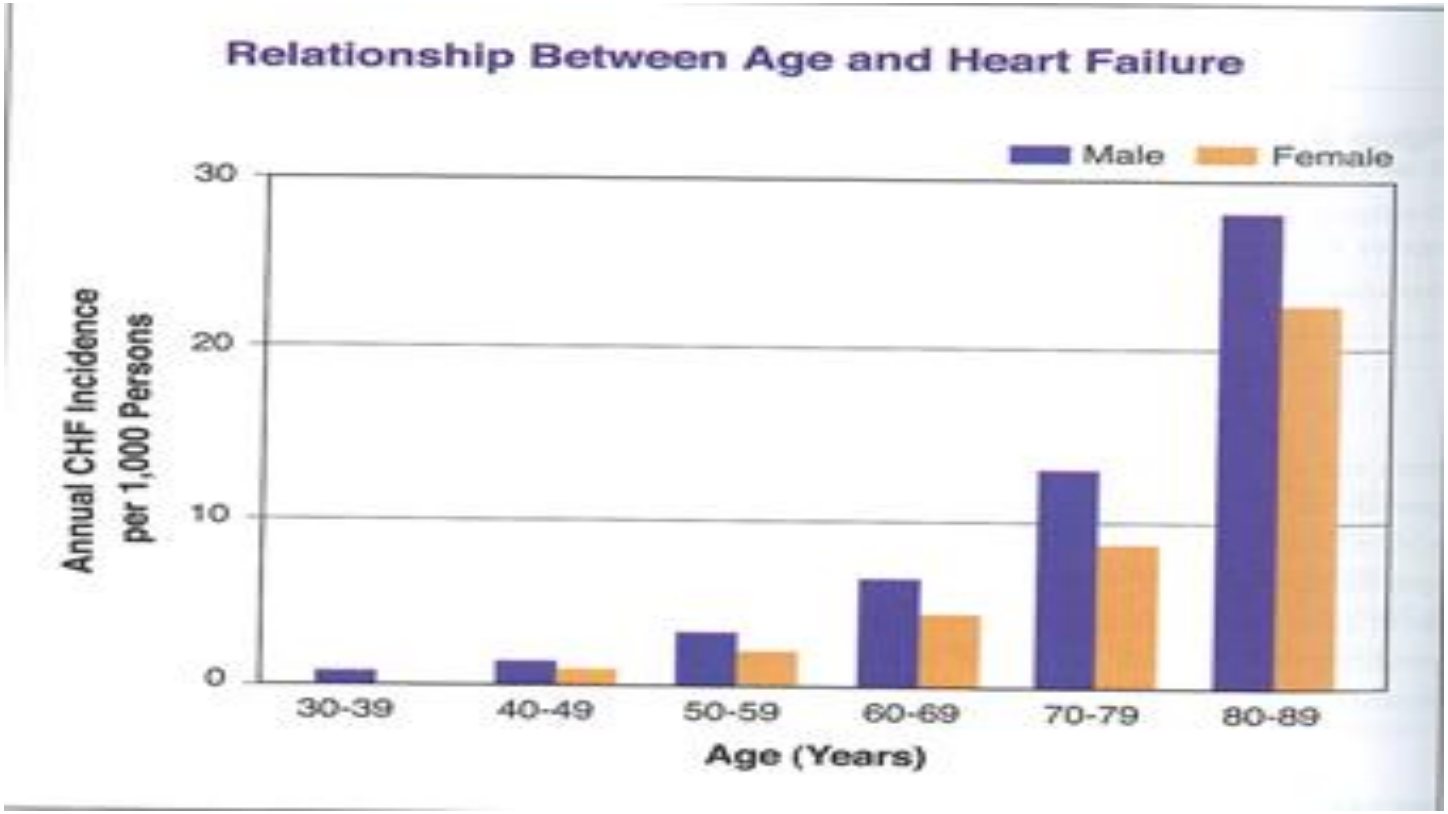
Why Congestive Heart Failure ?

- 5.8 million people with CHF
- 1 million hospitalizations annually US
- ~27% readmit within 30 days
- $37.2 billion dollars annually
- Acute in hospital care is responsible for 70% of costs

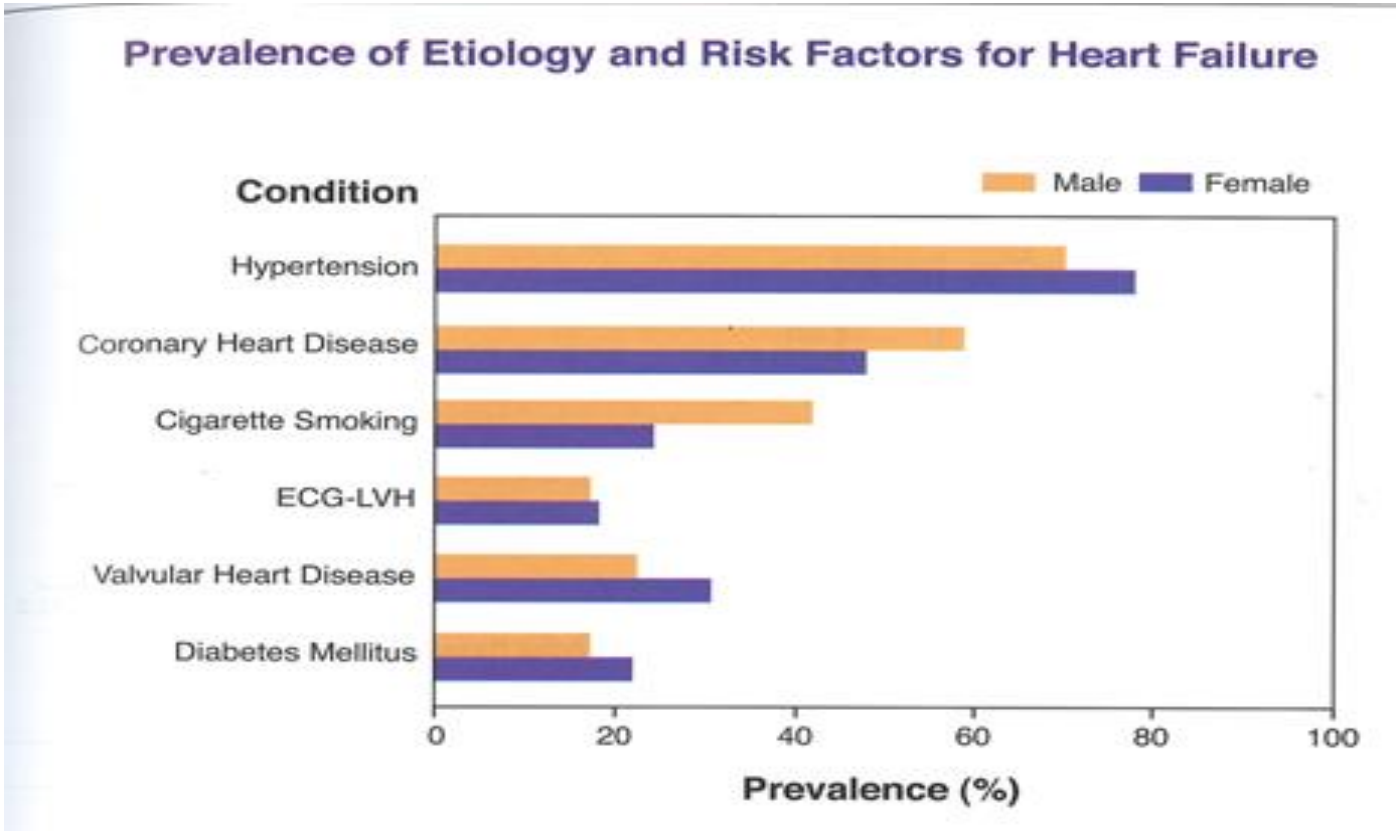
CHF Prevalence to Nearly Double by 2030 as US Population Ages



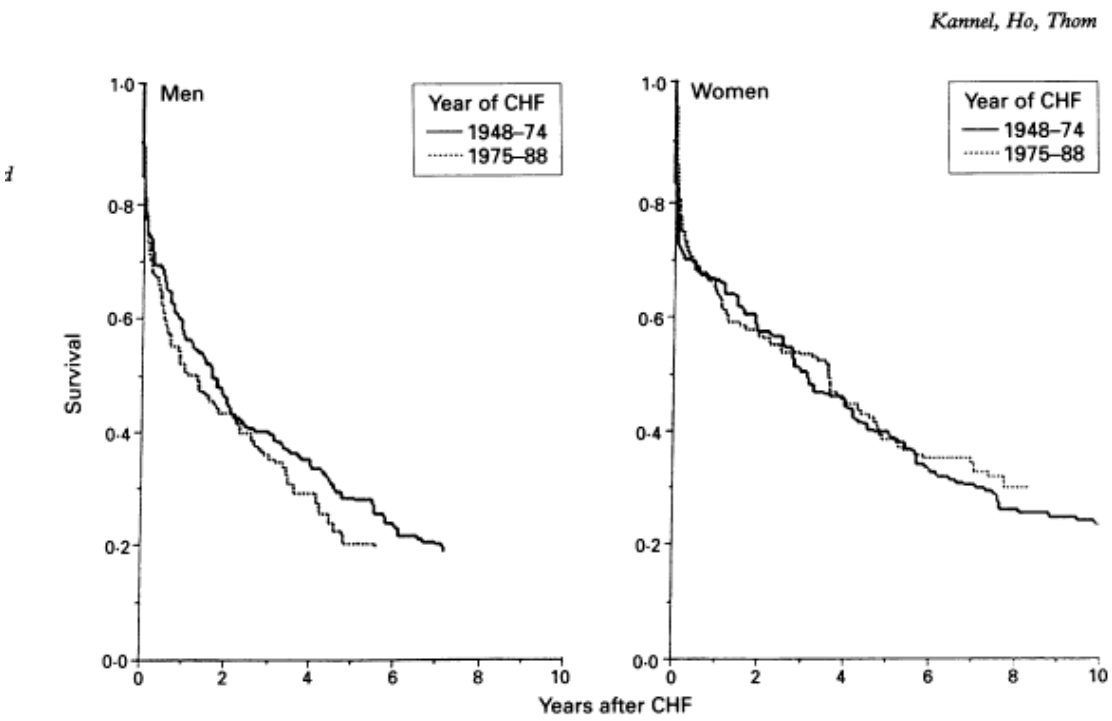
Relationship between Age and Heart Failure



Prevalence of Etiology & Risk Factors for Heart Failure



AGE Adjusted Survival Rates after Diagnosis of Heart Failure



- Age adjusted survival rates by calendar year after the first diagnosis of CHF for men and women in the Framingham Study. No significant change in survival over 40 years of follow-up was found, despite a considerable decline in coronary artery disease mortality

ACC/AHA Guidelines
Heart failure diagnosis and management

Stage A
at high risk for HF but without structural heart disease or Sx of HF

Patients with:
Hypertension
CAD
Diabetes Mellitus
or
Patients Using cardiotoxins with FHx CM

Structural Heart Disease

Therapy

Treat HTN
Encourage smoking cessation
treat lipid disorders
Encourage regular exercise
Discourage alcohol intake, illicit drug use
ACE inhibition in appropriate patients

Stage B
Structural heart disease but without Sx of HF

Patients with: Previous MI
LV systolic dysfunction
Asymptomatic valvular disease

Sx of HF develop

Therapy

All measures under Stage A
ACE inhibitors in appropriate pts
Beta-blockers in appropriate pts

Stage C
Structural heart disease with prior or current Sx of HF

Patients with:
Known structural heart dz
Shortness of breath and fatigue, reduced exercise tolerance

Refractory Sx of HF at rest

Therapy

All measures under stage A
Drugs for routine use:
Diuretics
ACE inhibitors
Beta-blockers
Digitalis
Dietary *salt* restriction

Stage D
refractory HF requiring specialized interventions

Patients who have sx at rest despite maximal medical therapy (e.g. those who are recurrently hospitalized or cannot be safely discharged from hospital without specialized interventions

Therapy

All measures under Stages A, B and C
Mechanical assist devices
Heart transplantation
continuous (not intermittent) IV inotropic infusions for palliation
Hospice care

Establish Goals

- 1st Collaborative Meeting in August, 2011

"Triple Aim"

- Improve the patient experience of care
  - Quality and Experience
- Improve the health of populations
- Reduce the per capita cost of health care.

Community Participation

- Community Health Centers of Rutland Region
  - Primary Care Physicians
  - Nursing
  - Care Coordinators
  - Quality Improvement
- Marble Valley HealthWorks
  - Primary Care Physicians
- Rutland Area Visiting Nurse Association & Hospice
- Bayada Home Health Care
- Genesis Healthcare Mountain View Center
- The Pines
- Indian River Nursing Facility
- Rutland Rehabilitation & Healthcare
- VT Program for Quality in Health Care
- Others

RRMC Participation

- Leadership
- Performance Improvement
- Cardiologists
- Hospital Based Physicians
- Nursing
- Case Management
- Emergency Department
- Social Workers
- Palliative Care Nurses
- Educators
- Dietician
- Clinical Informatics
- Pharmacists
- Blueprint Community Health Team

Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

Green Mountain Care Board

- Reached out to RRMC
- New model of service delivery: “Bundled Payment” for Care Improvement
- Innovation Center at Center for Medicare & Medicaid Services
  - Achieve Triple Aim

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Bundled Payments Program

- Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment.
- This approach can result in fragmented care with minimal coordination across providers and health care settings.
- Payment rewards the quantity of services offered by providers rather than the quality of care furnished.
- Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.

Bundled Payments Program

- Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability
- Must apply to CMS and be approved to participate.
  - 3 year agreement.

Bundled Payments Initiative

- A bundled payment can be thought of as a budget. A target price is established for the episode of care, and the group of providers agree to work together to ensure that care is coordinated and the total cost of an episode is within the target price.
  - Risk and/or Gain Sharing
- To ensure that these financial incentives don't adversely affect other aspects of quality, it is also critical to measure and monitor patient experience and outcomes.

Bundled Payment

- Chose Model #2: Retrospective Acute Care Hospital Stay plus Post-Acute Care
  - Includes the inpatient stay in the acute care hospital and all related services during the episode.
  - The episode will end either 30, 60, or 90 days after hospital discharge.
  - Participants can select up to 48 different clinical condition episodes.
- For Rutland, primarily a patient care focused decision

Bundled Payment

- Established a target price for the CHF episode of care
  - CMMI provided Data for Historical Claims by Provider Type
  - The Target for CHF bundle will be updated over time based on actual results
- CMMI Risk Track selection was required to allow Participants to reduce impact of high cost outliers
- Ongoing monitoring of Financial performance is based on beneficiary paid claims

Bundled Payment

- RRMC is the initiating partner and responsible for financial losses associated with CHF Bundle
- All partner Medicare reimbursements remain unchanged during participation in the BPCII
- Quarterly CMMI reporting will report episode costs and benchmark against the target cost.
- Annually, RRMC will settle with CMS for total costs above target. If costs are below target, a gain sharing payment to partners is made.
    - There is no partner infrastructure or reporting to support verification of claim payments against benchmarks
- CMMI needed IRS and OIG Waivers to clarify activities related to Gain Sharing Agreements.

Bundled Payment

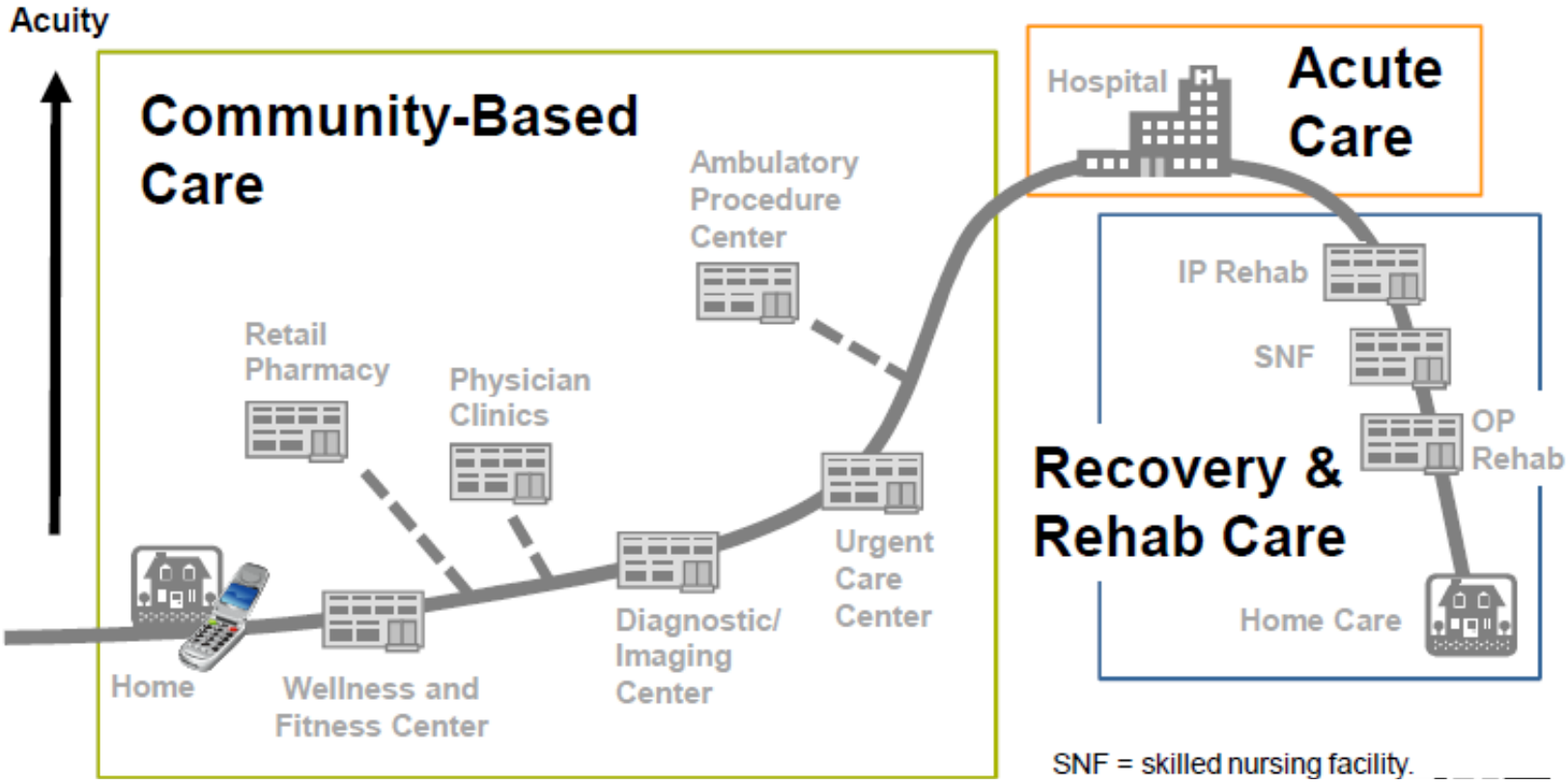
- Ongoing management of the BPCII
  - Manage the BPCII administrative requirements
  - Engage participants
  - Planning & implementing improvements
  - Clinical quality measure data
  - BCARE tool
  - Learning the BPCII process & complying with requirements

Green Mountain Care Board

- Assisted RRMC in developing our application for CHF for Medicare patients
- Approved by CMS
- Provides structure & oversight
- Opportunities to share and learn from other groups

Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

Where are the Improvements?



Summary of Patient Readmit Data

2009 CHF Readmissions

- Total # readmits: 31
- # pts readmitted more than once 2;
  - 1 patient 2 times,
  - 1 patient 4 times
- Average age 78, ranging from 48-96
- Breakdown by gender: 12/31-male 19/31-female
- ALOS 4.3 days
  - shortest stay 1 day
  - longest stay 9 days
- # that have PCP 31/31
- # that were d/c to home 19/31
- # with insurance 31/31
- # with Medicare as insurance 28/31
- # with chronic dz other than CHF 31/31
  - COPD 13/31
  - renal impairment 7/31
  - Diabetes 9/25
- # with mental health issues 9/31
- # with palliative care consultation 0
- # with communication barriers 28/31

2010 CHF Readmissions

- Total # readmits: 25
- # pts readmitted more than once
  - 1 patient-seven times
- Average age 74, ranging from 57-92
- Breakdown by gender: 7/25 male, 18/25 female
- ALOS 3.5 days
  - shortest stay 1 day
  - longest stay 7 days
- # that have PCP 25/25
- # that were d/c to home 20/25
- # with insurance 25/25
- # with Medicare as insurance 23/25
- # with chronic dz other than CHF 25/25
  - COPD 15/25
  - renal impairment 6/25
  - Diabetes 16/25
- # with mental health issues 11/25
- # with palliative care consultation 2/25
- # with communication barriers 23/25

Improvements Made

- Made this a priority for all organizations
- Communication between organizations
- Emergency Department resources
- Electronic Health Record
  - Order Sets
- Involvement of Dieticians, Physical Therapists, and Social Workers
- Better engage our patients

Improvements Made

- Patient Education Information & Materials
- Patient Education Method
- Pharmacist teaching about medications
- Post-Discharge Appointments
  - Primary Care Physician
  - Cardiologist
- Post-Discharge Telephone Calls
- Use of Community Health Team

Improvements Made

- Increased use of Palliative Care consultation
- Increased referrals for Home Health
- Home Health
  - Increased ancillary services
  - Increased use of Tele-monitoring
  - Patients meet criteria
- Working as a Team and Collaborating to improve care
  - Clinical Case Reviews

So how are we doing?

- Congestive Heart Failure 30-day readmission rate
- Historical average at RRMC ~ 24-25%
- Target 18.5% or less by end of FY13.
- **2013 Results: below 15%**

- Foundation for the future and making other improvements to our patients & community

In Conclusion

Questions?

Thank you.