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

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	8:30-8:35	Welcome and Introductions; Approval of 02/12/15 and 3/06/15 EOC Sub-Group Meeting Minutes	Alicia Cooper	Y- Minutes Approval	Attachment 1a: 02/12/15 EOC Sub-Group Meeting Minutes Attachment 1b: 03/06/15 EOC Sub-Group Meeting Minutes
2	8:35-9:55	Outstanding Issues and Scope of Work Review -Payer feedback regarding potential availability of representatives for detailing team -VHCURES or claims-extracts -Proposed report frequency -Vendor Scope of Work	Discussion	N	Attachment 2: Scope of Work
3	9:55-10:00	Public Comment and Next Steps		N	Next Meeting: April 16th, 9am-11am, Small Conference Room, 312 Hurricane Lane, Williston, VT

Attachment 1a

VT Health Care Innovation Project
Episodes of Care Subgroup Meeting Agenda
Thursday, February 12, 2015 9:00 AM – 11:00 AM.
Small Conference Rm, 312 Hurricane Lane, Williston, VT
Call in option: 1-877-273-4202
Conference Room: 2252454
Attendees: Cathy Fulton (VPQHC), Alicia Cooper (DVHA), Jim Westrich (DVHA), Amanda Ciecior (DVHA), Mike DelTrecco (VAHHS), Pat Jones (GMCB), Andrew Garland (MVP Health Care), Beth Tanzman (Blueprint for Health), Susan Aranoff (DAIL), Kelly Lange (BCBSVT), Amy Coonradt (DVHA), Sean Murphy (BCBSVT)

Topic	Notes	Next Steps
Welcome and Introductions	Alicia Cooper started the meeting at 9:05am. Those in attendance and on the phone introduced themselves, and for those unable to attend in person, a screen sharing option was available. Susan Aranoff moved to approve the minutes, Cathy Fulton seconded. The motion carried with one abstention.	
Updates and Follow Up	Beth Tanzman gave an overview of the Blueprint for Health HSA-level Profile (attachment 2). The following were key points of from the discussion and questions from workgroup members. • Reports are produced every 6 months; this is significantly faster than they were being produced at the start of this initiative. Currently, there are reports being done at both the HSA and practice level and for both adult and pediatric patients. Reports are also being distributed at an ACO level for internal analysis. • Beth noted that it is the long term goal of the Blueprint for profiles to be used to enhance collaboration among providers and ACOs and to improve clinical care and quality performance throughout the state. Results in these reports are normalized and the data does adjust for outliers, so it is easy to compare across HSAs throughout the State. • Susan Aranoff asked how inclusion in each HSA is determined. Beth responded that the HSA is made up of the residents that live there, not those who sought treatment in the HSA. This method allows for a better understanding of HSA residents and their particular patterns of care.	

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

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

	meeting. She reported that a request has been made to follow up on alignment between this initiative and the all payer waiver. Finally, the nursing home bundled payment program will be presented at the larger PMWG meeting, and staff is currently working on adding this to the next month's agenda.	
MVP Episodes Analytics Presentation	Andrew Garland presented on MVP's Episodes of Care program. The following are key points and comments on the presentation • This data uses unique TINs to identify providers/practices. • Key terminology in this presentation: efficiency is in reference to resource use while effectiveness references quality • The vendor MVP selected has their own episode definitions, although there is some flexibility in how to define episodes. There are 527 episodes, while the top 15 account for majority of volume in costs. Episodes are often separated out by severity of illness, giving way to levels 1, 2 and 3 for most episodes. Severity level 3 is always removed from analysis as there is significant variation occurring around this level of illness. Other factors contributing to the assigned severity level is if it is an acute or chronic condition as well as the age of the patient. • The first set of MVP's reports was generated using 2012 data, and they are about to produce their 3rd annual installment of reports using data from 2014. Each episode analysis allows for a three month claims run-out, ensuring all services are included. MVP's vendor is already using ICD 10 coding. • Episodes exclude comorbidities, as it adds too much instability to fairly analyze and compare each case. In the end, about 50% of the available episodes are thrown out. • Episode assignment is achieved by preponderance of care on the provider side; to be assigned a patient the provider must bill for at least 20% of non-hospital charges. Often there will be multiple providers attributed to one patient which can be beneficial when trying to understand the care pattern of patients within a particular episode. • Mike asked about changing current attribution to the ACO attribution model, and if that would be possible with this vendor. Andrew responded	

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

Episode Selection	Alicia Cooper started the conversation around choosing which episodes to prioritize for Vermont's planned episode analytics, and pros and cons were discussed around choosing a universe of episodes versus identifying specific episodes for analysis. • Pat Jones said she was leaning towards a broader approach, and then prioritizing which episodes to share. She thinks the cost for a larger set of episodes will not change much, and is therefore worth it. • Cathy Fulton would like to know more about the process to follow after we collect this information, and how we would deliver the reports and what resources we would have to educate report recipients on the information gathered. She also supported a broader approach, but would like to further discuss how we will then manage the distribution of this information once it is available. • Alicia commented if the group feels a broader approach might be best, then we can -shift our focus in the near-term to discussion about a dissemination plan instead of episode-specific methodology considerations. • Susan commented that there should be as much overlap as possible between any new reports and what is already produced by the ACOs and BP. Pat Jones mentioned that it is important to keep in mind that BP and ACO measures are focused on primary care. Additionally, BP reports are focused on the PCMH population, and ACOs on their own populations, and that there may be a unique opportunity for Episodes information to be used population-wide. • Kelly also identified some potential challenges for future discussion: Presentation of the data presents a challenge with sustainability, particularly when the SIM grant ends. She also whether this initiative might want to require any actions or improvement by providers. • Alicia asked the payers if there may be an alternative to using VHCURES to provide claims to a vendor. Andrew responded that MVP would be able to provide files in a common format; Kelly agreed that it could be done. While it would take time to generate and share extracts on an ongoing basis, there is no immediate barrier to pursuing such an alternative option VHCURES proves unsuitable for this type of analysis. • Pat noted that the ACOs have a lot of specialists in their networks, and are continuing to develop their specialist participation. It will be important to	Feasibility of using VHCURES for future episode analytics work

	leverage those networks when thinking about how to distribute this information to the appropriate people. • It was noted that the Northern New England Accountable Care Collaborative (NNEACC) might have something currently available to OneCare around Episodes and we need to make sure we identify what is already being done before potentially duplicating efforts. • Blueprint has had conversations around bringing in a specialist focus through an Episode lens before, but no current work is occurring on this front. It would seem like a natural next step. • The question of a small sample size in Vermont arose. Andrew responded that MVP has meaningful data for roughly 25 specialty types in VT – should not be a concern in going forward.	
Public Comment and Next Steps	• Next meeting will be focused on plans for disseminating analytics as well as long term sustainability beyond the life of the SIM grant. • Discussion of the group's VHCURES flag "wish list" will be postponed until a later meeting.	Next Meeting: March 6th, 9am-11am, EXE 4th Floor Conference Room, Montpelier, VT

Attachment 1b

VT Health Care Innovation Project
Episodes of Care Subgroup Meeting Agenda
Friday, March 6, 2015 9:00 AM – 11:00 AM.
109 State Street, Montpelier, EXE - 4th Floor Conf Room
Call in option: 1-877-273-4202
Conference Room: 2252454
Cathy Fulton (VPHCQ), Andrew Garland (MVP), Pat Jones (GMCB), Kelly Lange (BCBSVT), Alicia Cooper (DVHA), Amy Coonradt (DVHA), Jim Westrich (DVHA), Mandy Ciecior (DVHA)

Topic	Notes	Follow up Items
Welcome and Introductions; Approval of 02/12/15 EOC Sub-Group Meeting Minutes	Alicia Cooper started the meeting at 9:15. A quorum was not present so the sub-group was unable to approve the minutes. Both the February 12th and March 6th minutes will be approved at the next sub-group meeting.	
Arkansas Reports	Alicia Cooper introduced two reports that the Arkansas SIM project is using to disseminate their Episodes of Care and PCMH analysis to providers and practices. The following were questions or comments on attachments 3a and 3b. • For the Arkansas Episodes pilot, payments are still provided on a fee for service basis; however, they incorporate financial incentives (and penalties) based on retrospective comparison of providers to their peers. Providers can fall into the commendable, acceptable or unacceptable ranges – leading to additional payments or loses. Andrew Garland noted that Medicare is now using this approach as well for some of their episode-based initiatives. • Pat Jones asked for clarification around the term gain sharing. Gain sharing is the redistribution of any cost savings that is achieved by the commendable providers. In addition, Pat asked who provides this data to the practices. Alicia responded that it is presently a Medicaid and commercial initiative (Medicare has not yet agreed to participate). Both Medicaid and Commercial payers have agreed to use the same approach in their methodology and distribution but are not using the same vendor for analytics and report generation. Arkansas Blue Cross and Blue Shield has a strong analytics team so they are able to conduct this analysis internally. Arkansas Medicaid chose to contract with General Dynamics	

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

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

	• Arkansas chose to focus on acute episodes as these are more sensitive to changes occurring over a shorter period of time. They felt that it is the goal of the PCMH initiative to focus on chronic care as primary care has the ability to achieve longer term health maintenance and improvement.	
Approach for Sharing Reports	The sub-group went on to discuss what they would like to see in the RFP and shared their thoughts on dissemination of the Provider Reports • The vendor's ability to produce reports after their analysis is a characteristic the sub-group would like to see in an application. Andrew believes it is fairly usual for a vendor to be able to create a final report for providers. The sub-group agreed that the selected vendor should be able to create the reports, rather than relying on a separate group or organization for report generation. • The group went on to discuss how to best use the developed reports as an educational tool and how to approach the dissemination process. Pat suggested that primary care should not be a focus of this project; instead we need to start looking at specialty care. So far there is a lot of information available to primary care providers, and they are the focus of many payment reform initiatives. Thus far there has been little effort directed at helping to cut costs in specialty areas. Pat also supported the idea of not just sending the reports, but walking providers through the information in targeted education sessions. • Kelly Lange discussed the importance of creating a synergy among payers and creating a powerful front for providers to drive change. She also suggested focusing efforts on providers that are the worst performing as well as those that are the best performing in order to create opportunities for practices to learn from one another. In the absence of financial incentives or penalties, we need to clearly identify the areas of opportunity and improvement. Another issue relates to acute episodes occurring at the hospital; for information to be used effectively it would be important to approach the physicians delivering care and not the hospital administration. The group went on to discuss the potential for a regionally focused discussions or collaboratives for education and information sharing, especially in Southern Vermont where there are two large hospitals in the same region. • Pat suggested that each practice or hospital receives their own report, blinded, to see how they perform relative to peers. Andrew responded by saying MVP benchmarks regionally (and that for their network Vermont is considered a single region), to show how a practice is performing against their peers. For a multi-payer initiative he would suggest splitting Vermont into two regions, North and South, for	

benchmarking purposes.

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

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

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

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

Quality Measures	• Discussion took place around whether the sub-group will request input on quality measures identified by the vendor. The goal of seeking input and allowing for alternative measures would be to achieve alignment with ongoing State initiatives. Pat suggests looking at existing measure sets related to the specialties which are selected, this would lead to a broader alignment with what is occurring in healthcare, not necessarily just in Vermont. • Andrew noted that if we go outside the vendor scope, we will need a lot more clinical expertise involved in developing additional measures. In addition, he also reported that the specialty providers he works with rarely look at the quality measures (as the majority of measures being used by state and federal programs focus on primary care). • As there is no payment component in this initial run, it makes sense to use the measures that are available through the vendor. The subgroup can then adjust the measures after the first year if needed. • There will be opportunity for the Quality and Performance Measures work group to review the proposed measures for each episode once a vendor has been selected.	
Public Comment and Next Steps	• Staff needs to be sure the funding request incorporates the new Steering Committee priorities. • The next meeting will be used to nail down the details of the funding request while the final meeting in April will focus on the RFP. • Cathy suggests revisiting the HCi3 RFP to ensure we get the correct outcomes with the new RFP. • Andrew suggests creating a 5 year roadmap to ensure what we are doing in the short term aligns with the ultimate goals of this project.	Next Meeting: March 26th, 9am-11am, AHS Training Room, 298 Hurricane Lane, Williston

Attachment 2

1. ATTACHMENT A SPECIFICATION OF WORK TO BE PERFORMED

1.1. Overview

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

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

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

Specifically, the grant will support:

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

1.2. Scope of Work and Contractor Responsibilities:

The contractor will use Episode grouper programs (either proprietary or non-proprietary) to organize Vermont health care claims data into predetermined episodes in order to provide a statewide analysis of healthcare costs and utilization through an episodic lens.

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

1. Episode Grouper Programs

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

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

2. Software/Program Detail

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

a) The trigger event(s) and information within the claims data that define whether an episode took place
b) The definition of the attributing provider(s) , defined as the provider(s) in the best position to influence the cost and quality of an episode

c) The episode time window, defined as the start and stop points that encompass the episode (including a pre-trigger window, a trigger window, and a post-trigger window as applicable)
d) Codes and information from claims data used to determine inclusion in and exclusion from each episode
e) Episode-specific quality and utilization metrics
f) Patient-level and provider-level risk adjustment factors

3. Data Hosting and Access

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

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

4. Provider Reports

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

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

5. Additional Potential Activities

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

a) Perform a re-pricing of historic Medicaid payment claims for years 2012 and 2013 to current payment polices and rates. Re-pricing will also be done for Medicare data and supplemental payments.

b) Deliver interactive webinars for providers, ACOs and other interested parties to answer questions about reports.

c) Coordinate with the State and other stakeholders in developing a sustainability plan for ongoing episode analytics.