Payment Models Work Group Meeting Agenda 6-02-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday June 2, 2014 2:00 PM – 4:30 PM.
312 Hurricane Lane, Large Conference Room, Williston
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 1: Meeting Minutes
2	2:05 – 2:10	Introduction of Speaker	Kara Suter	Attachment 2: Speaker Bio
3	2:10– 3:30	Presentation: Episodes of Care *Experience from the field*	François de Brantes, Executive Director, Health Care Incentives Improvement Institute (hci3)	Attachment 3: Presentation
4	3:30 – 3:50	Update on Shared Savings Programs	Kara Suter/Richard Slusky	Attachment 4: VMSSP Update Presentation
5	3:50 – 4:00	Updated from Other Work Groups	Georgia Maheras	
6	4:00 – 4:15	Review of Criteria and Draft Survey	Kara Suter	Attachment 6a: Criteria Attachment 6b: Draft Survey
7	4:15 –4:25	Public Comment	Don George and Steve Rauh	
8	4:25 – 4:30	Next Steps and Action Items	Don George and Steve Rauh	Next Meeting: Monday, July 7, 2014 2PM – 4:30PM EXE – 4th Floor Conf Room, Pavillion, Montpelier

Attachment 1 - Payment Models Work Group Minutes 5-12-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting: Monday May 12, 2014, 1:00 PM – 3:30 PM, Blue Cross Blue Shield, Berlin.

Call in: 877-273-4202, Passcode: 2252454

Attendees: Don George, Stephen Rauh, Co-Chairs; Georgia Maheras, AoA; Nancy Hogue, Kara Suter, Alicia Cooper, Amy Coonradt, DVHA; Michael Curtis, Washington County Mental Health Services; Bard Hill, Jen Woodard, DAIL; Richard Slusky, Pat Jones, Spenser Weppler, GMCB; Lila Richardson, VT Legal Aid; Heather Bushey, Planned Parenthood; Paul Harrington, Vermont Medical Society; David Martini, DFR; Julie Wasserman, Carolynn Hatin, Diane Cummings, AHS; Heidi Hall, DMH; Joyce Gallimore, Bi-State; Kelly Lange, BCBS; Carmone Austin, MVP Health Care; Michael Bailit, Bailit Health Purchasing; Marlys Waller, VT Council of Dev. and MH Services.; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Don George called the meeting to order at 1:04 pm and asked for discussion on the minutes. There was no discussion or questions. Paul Harrington moved to approved the minutes and Lila Richardson seconded. The motion passed unanimously.	
2. Update on ACO/SSP	Kara Suter stated that implementation of the ACO Shared Saving Program (SSP) has begun. They will work with the ACOs to adjust timelines quoted in the contracts, regarding implementation milestones, beneficiary notices, etc. They will be putting out more formal documentation within the next few weeks. They received some preliminary beneficiary attribution numbers and provider rosters but have not shared those yet with providers so she will wait until the next meeting to share that information. The deadline for SSP participation has passed for ACO participants who will attribute lives, but the deadline has been flexible for other entities that may choose to participate but not attribute lives.	

Agenda Item	Discussion	Next Steps

	Paul Harrington asked if children under the SCHIP program are included. Kara stated that if anyone has an additional form of insurance they are excluded from participating (included/excluded refers only to lives for calculating shared savings). Those included must have insurance with the payer for 10 non-consecutive months. Children however, are included.
	
	Richard Slusky gave the following update on the Commercial ACOs:
	• On Thursday, May 15 the commercial payers will provide ACOs with their attribution numbers.
	• By May 31, the equivalent of the claims costs extract (medical costs of premiums associated to the providers) that would make up the expenditure target for 2014, will be available.
	• The analytics contractor has been selected and the GMCB will define deliverables and scope of work. Discussions are going well and he has no concerns at this point.
	• Regarding those who have dual insurance: Kara stated that it would depend on eligibility requirements of other shared savings programs.
	• Don confirmed with Richard that regarding the ACO gain sharing, there would not be any new data to run for the first time.
	• The insurance companies with Exchange plans are BCBS and MVP. BCBS has contracts with all three ACOs. MVP has only signed with OneCare.
	• The VT Collaborative Physicians (VCP) was created by Healthfirst and is the name of their commercial ACO. If VCP and CHAC do not meet the number of attributed lives, they may not be able to join the program.
	• Membership thresholds:
	  o Membership extract will accurately reflect members that are on the Exchange. Payers will need to attest to the accuracy.
	  o The deadline for membership is June 30 and this will help ensure accuracy with payer attestation.
	  o The minimum number of lives in order for the ACO to maintain their contract is 5000 with one payer, and 3000 lives with each payer if contracting with multiple payers (for a total of 6,000 lives).	

Agenda Item	Discussion	Next Steps
3. Update on Other Work Groups	Georgia Maheras gave the following updates: • VHCIP Provider Grant Program: starting next week the Core Team will review the VHCIP Provider Grant Program application criteria to prepare for the second round. They anticipate soliciting proposals in late July/early August. There is roughly $2.7 million available for round two. The Core Team is looking at criteria and potential modifications. They will also give extra time for submissions and decisions will be made in late September/early October. • HIE work group is focusing on telemedicine/telehealth/telemonitoring. $1.2 million of SIM funding was awarded to the work group for telehealth related projects. They are also working on the State's HIT plan. • CMCM work group is focused on criteria for care models. • Population Health work group will have a presentation at their May meeting from Northwestern Medical Center on wellness programs. • DLTSS work group has been focused on providing recommendations on quality measures. • QPM work group is looking at measures for the year two ACO Shared Savings Programs. • Workforce work group was appointment by the Governor. There are limited SIM dollars available to this group so they are also working on project recommendations to the governor for the FY16 budget.	**If participants have recommendations for the grant program please contact Georgia directly.**
4. Review of Updated Work Plan	Kara asked the group to review the work plan and update: work taking place; accomplishments; identify areas for strategic improvement and how to roll out initiatives tasked to this work group. • The materials packet contains agendas for May, June, and July. The group will receive data from Brandeis for review in July. • The speaker for the June meeting is Francios de Brantes who developed the PROMETHEUS bundled payment program. • The group will make recommendations to the CMCM and QPM work groups around what is learned from evaluating data in July. • CMCM work group is developing learning collaboratives. Recommendations to the QPM work group will be based on findings from Episodes of Care (EOC) data analysis. • Regarding EOC: how do we build on those recommendations to CMCM, payment model or incentives for EOC? During the summer, the group will release a Request for Information	**The group will review the work plan in more depth at the May meeting.**

Agenda Item	Discussion	Next Steps
	(RFI) and may have a draft for input at the next meeting. • The group may need to increase meetings over the next few months or hold sub-group meetings to focus on specific areas of work. • The purpose behind the RFI is to gather input from a broad range of stakeholders in the State, so if we build a payment model around EOCs, we will understand their experiences. The group can work on the RFI specifically to keep it from being too general.	
5. Breakout Groups	Kara Suter and Alicia Cooper lead two breakout groups to develop criteria for EOC data that is going to be presented in July. The timeline for launching the EOC program will be easier defined when the type of model the group is trying to implement is more apparent. Timeframes are different between incentive plan and payment models Representatives from Payment Models work group will most likely present to other work groups in September.	
6. Report on Break Out Group Recommendations	Richard gave the following report from his breakout group: • Operation feasibility: comments were to define start and stop dates for each episode. o Consider obstacles to this: confirm that there are interested parties; possibly build on the Medicare model so we don't have three different models for each types of insurance and instead focus on an all payer approach. • Need ability to measure success and evaluate the success of the initiative. • Consider revenue loss of hospitals under certain payment models. • Incorporating the duals is a potential obstacle: multiple payers involved in the same episode. • Interventions: Potential for statewide and regional initiatives as well as individual providers. It may be better to go statewide for certain episodes, because you may not have enough numbers for individual providers. • If it's a cardiology episode, consider bringing the physician and State together. • Will it be voluntary or required participation? • Successful interventions improve coordinated care in a local area or region, so the area	**Kara will finalize the comments and send out to the group for next meeting.**

Agenda Item	Discussion	Next Steps
	outside the hospital is critical. • How would you evaluate people who have a specific conditions and how that is divided among payer? • Change the phrase "prevalence of disease" to "prevalence of condition". • Would analysis be done by payer? And could we have data to show variation by payer. Kara gave the report for her group: • Understand the sample size: will they be large enough among the provider groups to warrant analytics? • She will follow up Brandeis to confirm if they can breakout the data by payer. • Opportunities to bridge gaps on provider settings and improve care coordination. This is a high priority. • Add provider leadership and engagement. • Sense of clinical priorities across a range of stakeholders. Can we do a simplistic survey tool to see what they think are the most prevalent conditions? • Operational feasibility: leave options open to look nationally for the work of Arkansas etc., but start first with what we have in the State. • Prioritize the work of successful interventions that are already going on in the State. Recommendations from the group should have best practices and evidence based clinical practice in which to build the episode around. • Variation in utilization: need to understand what's driving utilization and not just look at variation.	
5. Public Comment	No further public comments were offered.	
6. Next Steps and Action Items	**Next Meeting:** Monday June 2, 2014 2:00 PM – 4:30 PM, 312 Hurricane Lane, Large Conference Room, Williston **Next Steps:** • At the next meeting there will be a substantive update on membership of ACOs. • Final criteria and a scorecard will be developed using input from the breakout sessions (knowing that after the presentation from Brandeis, the criteria may be refined, Paul	

Agenda Item	Discussion	Next Steps

	suggested changing the language to tentative instead of final).
	• The RFI will be reviewed at a high level at the June or July meeting, participants are welcome to review and provide input to Kara before the meeting.
	• Brandeis consultants will present Vermont specific data on EOC at the July meeting (hopefully).
	• Richard suggested inviting the ACOs ACCGM and OneCare to discuss their experiences and lessons learned with the Medicaid ACO program.
	  o This could be a good way to kick off thoughts about the year two SSP at the August or September meeting.
	  o The Care Models and Care Management work group will host a webinar with OneCare to review preliminary quality metrics and they will extend the invitation to all the work groups.
	• The GMCB is talking with RRMC on global budget and that could be a future agenda item.	

Attachment 2 - Speaker Bio

Francois de Brantes, MS, MBA
Executive Director, HCI3

As Executive Director of HCI3, Mr. de Brantes is responsible for setting and implementing the strategy of the organization. This includes supervising the implementations of Bridges to Excellence and PROMETHEUS Payment pilots, leading the development of new programs, and designing incentive efforts for employers, health plans and provider organizations.

Previously, Mr. de Brantes was the Program Leader for various healthcare initiatives at GE Corporate Health Care Programs, responsible for developing the conceptual framework and the implementation of GE's Active Consumer strategy.

Mr. de Brantes attended the University of Paris IX - Dauphine where he earned a MS in Economics and Finance. After completing his military service as a platoon leader in a Light Cavalry Regiment, he attended the Tuck School of Business Administration at Dartmouth College, where he graduated with an MBA.

Attachment 3 - Presentation: Episodes of Care

Lessons From The Growing Field

June 2nd 2014

Agenda

- Brief Overview of Subject Matter Expertise
- Driving Principles in Implementations
- Lessons Learned
- If I Was Prince For A Day…

Relevant Experience

- Designed, built and launched Bridges To Excellence and PROMETHEUS Payment
  - BTE was the first national P4P effort. It's responsible for creating the original PCMH survey
  - PROMETHEUS Payment was the first national bundled payment program. It's the basis for the BPCI
- Deep focus on key drivers of markets – transparency in price and quality, rapid feedback loops, incentives
  - Authored two books on incentives
  - Authored multiple papers on quality and cost of care
  - Helped build provider quality scorecards and multiple episode of care systems

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Implementations

- Statewide, multi-payer initiatives only work when the state takes the lead and pushes through Medicaid and the public employee plan
- Multi-payer payment reform initiatives outside of state-led have mostly failed to have a significant effect when there's downside risk for providers
- Ultimately what works is the "Incentives drive Functions and Functions shape Organizations" logic chain

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Key Lessons Learned

- It's all about feedback, market pressures, and the distance between those affected by incentives and the clinical front lines
  - Feedback – mostly clinical data and measuring continuous performance of clinicians (HCI³'s potentially avoidable complications have been very useful). Financial data reflecting budget to actual has to be at least quarterly and actionable
  - Market pressures – if there's no prospect of loss or gain of business, it's tough to generate a sense of urgency
  - Distance to front line – trickle-down incentives don't work very well
- The most important factor correlating with success is the level of CEO engagement (payer and provider)

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If Only I Could, I Would…

- Start at two levels simultaneously:
  - Establish clear and unambiguous targets for the payment reform activity (e.g. 0% inflation for 5 years)
  - Develop clinical dashboards for line clinicians focused on:
    - Major chronic conditions
    - Major areas of clinical "defects"
- Then focus on tying CEO compensation to general target, demanding sub-dashboards from each organization with target reductions that create line of sight to general target, and quarterly meetings to update on progress to targets and action plan
  - Deal with each organization separately and never try to align all interests because it's not possible

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For contact information:

www.HCI3.org

www.bridgestoexcellence.org

www.prometheuspayment.org

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Attachment 4 - VMSSP Update Presentation

Payment Models Work Group: VMSSP Update

June 2, 2014

Kara Suter, MS

Director of Payment Reform

Department of Vermont Health Access

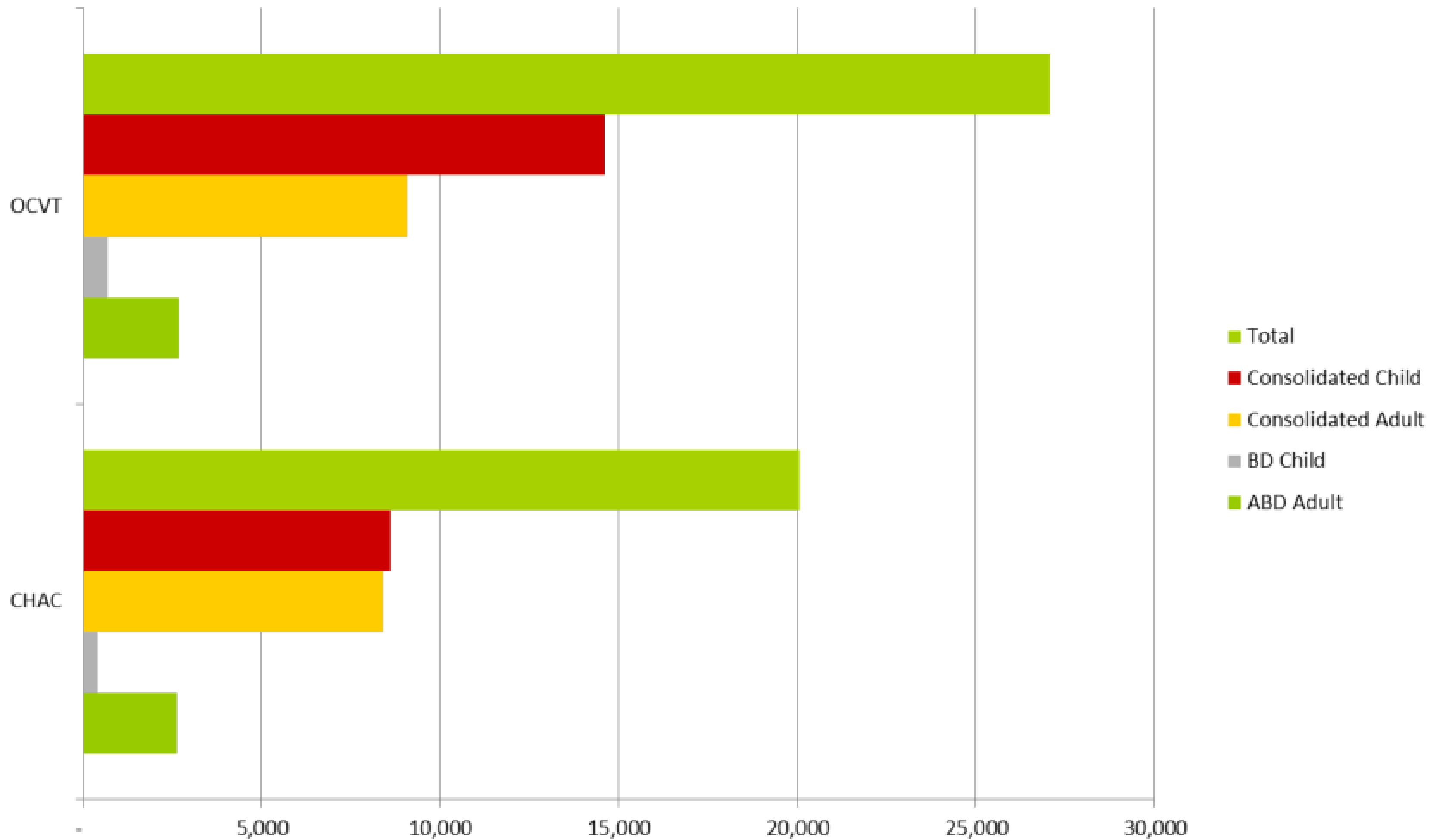
Vermont Health Care Innovation Project

VMSSP Populations

VMSSP evaluates spending and trends across four populations:

Population	Description
Aged, Blind, and Disabled Adult (ABD Adult)	• *similar to dual-eligible population but given eligibility, primary is Medicaid*
Blind and Disabled Child (BD Child)	• *similar to dual-eligible population but given eligibility, primary is Medicaid*
General Child (GC)	• *similar to commercial child*
General Adult (GA)	• *similar to commercial adult*

Estimated Attributed Lives by ACO (2013 Data)



Vermont Health Care Innovation Project

Next Steps PMWG

Make recommendations to Steering Committee and Core Team about changes to program for year two

1. Define additional cost categories for the optional incentive program for Year Two
2. Make recommendations on quality or performance scoring methodology used to allocate earned savings
3. Any other programmatic adjustments identified in the review of data analysis or other proposals

Attachment 6a - Criteria

Payment Models Work Group
Criteria for Evaluating Episodes of Care Data

EOC	EOC is consistent with state-wide clinical priorities or other health reform efforts	EOC has adequate sample size across payers and providers	EOC has high potentially avoidable complication rate or other defined opportunities for improvement	EOC has high resource variation	EOC represents opportunities to improve coordination of care among primary care, specialists and other specialized service providers (e.g., MH, SA, DTLSS)	EOC has evidence based guidelines or clinical pathways that could improve care delivery system or quality of care provided
CAD						
CHF						
AMI						
PNE						
COPD						
ASTHMA						
CxCABG						
PCI						
DIAB						
KNRPL						
KNARTH						
HIPRPL						
GERD						
EGD						
COLON						
COLOS						
GSBURG						
HYST						
VAGDEL						
CSECT						
HTN						
STR						
PREGN						

Attachment 6b - Draft Survey

Episodes of Care (EOC) Program Development: Assessment of Priorities and Opportunities in Vermont

Episodes of Care (EOCs) are an emerging model in payment reform efforts nationwide. EOCs offer a new way of looking at healthcare utilization. Individual services and providers are grouped together for acute and chronic episodes of care and compared across patient populations to understand variation in treatments for specific conditions and procedures and the impact of that variation on cost and quality.

EOC programs can improve quality and reduce health care costs by rewarding:

- effective coordination among specialists and primary care providers;
- adherence to evidence-based clinical guidelines and pathways;
- improvements in transitions of care;
- provision of services in the least costly setting of care; and
- shifting the focus provider financial performance from volume to value.

EOCs have been used successfully as:

- Data to inform continuous quality improvement efforts (CQI)
- Rewards-based programs
- Alternative payment models (i.e., bundled payments)

The Payment Models Work Group of the Vermont Health Care Innovation Project (VHCIP) seeks your valued clinical input on both priorities in your practice as well as where you see the best opportunities for improved quality and reduced health costs among the episodes of care under evaluation. Participation in this survey will directly inform the development of health reform initiatives and should take no longer than 10 minutes and a summary of the results will be made available at (insert VHCIP link).

<u>Q1: What type of provider are you?</u>

Are you: hospital system owned, independent or group practicing, other affiliation (nursing home, home health agency, designated agency)?

<u>Q2: Size</u>

What is the size of your practice?

<u>Q3: Geographic Region</u>

What is your zipcode?

<u>Q4: Number of Patients Seen</u>

What is your average monthly patient load?

<u>Q5: Estimated Payer Mix</u>

What is your estimated payer mix?

Q6: General EOC Interest

Of the following, which are top three conditions or procedures of interest to your practice?

[Insert list of EOCs from Brandeis data analysis]

Q7: General Opportunities

Of the following, what are the top three conditions or procedures that offer the best opportunities for improving quality and reducing costs?

[Insert list of EOCs from Brandeis data analysis]

Q8: QIPs?

In the last two years, were any of the following conditions or procedures the focus of financial or quality improvement projects?

[Insert list of EOCs from Brandeis data analysis]

Q9: Other Conditions?

What conditions or procedures not mentioned above are focused on in your practice?

[insert list with other write-in option]

Q10: Other Conditions?

What conditions or procedures not mentioned above good candidates for improved quality and cost reductions?

[insert list with other write-in option]

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