Payment Models Work Group
Meeting Agenda 8-04-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday August 4, 2014 2:00 PM – 4:30 PM.
312 Hurricane Lane, Large Conf Room, Williston

Call in option: 1-877-273-4202

Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	2:00 – 2:05	Welcome and Introductions Approve meeting minutes	Don George and Steve Rauh	Y – Approve minutes	Attachment 1: Meeting Minutes
2	2:05 – 2:15	Update on Other Work Groups	Georgia Maheras	N	
3	2:15– 2:25	Follow-up Blueprint for Health discussion		N	
4	2:25 – 4:15	Review EOC Data	Brandeis/HCi3 Team	Y – Approve criteria	Attachment 4A: HCi3 Presentation Attachment 4B: Criteria for Episode Guide
5	4:15 – 4:20	Public Comment		N	
6	4:20 – 4:30	Next Steps and Action Items		N	Next Meeting: Tuesday, September 16, 2014 9:00 AM – 11:30 AM BCBSVT- 445 Industrial Lane, Berlin (Mtg Room 130s)

Attachment 1 - Payment Models Work Group Minutes 7-07-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting*:* Monday July 7, 2014 2:00 PM – 4:30 PM. EXE – 4th Floor Conf Room, Pavillion, Montpelier

Attendees: Don George, Stephen Rauh, Co-Chairs; David Martini, AOA; Kara Suter, Amanda Ciecior, Cecelia Wu, Bradley Wilhelm, Craig Jones, Erin Flynn, Alicia Cooper, Amy Coonradt, Carrie Hathaway, DVHA; Michael Curtis, Washington County Mental Health Services; Paul Harrington, Vermont Medical Society; Diane Cummings, AHS; David Martini, DFR; Richard Slusky, Pat Jones, Spenser Weppler, Annie Paumgarten, GMCB; Kelly Lange, BCBS; Lila Richardson, Julia Shaw, VT Legal Aid; Michael DelTrecco, VT Association of Hospital and Health Systems; Cathy Fulton, VT Program for Quality in Health Care; Bard Hill, Jen Woodard, DIAL; Sharon Winn, Bi-State Primary Care; Todd Moore, OneCare VT; Amy Cooper, Accountable Care Coalition of the Green Mountains; Carolynn Hatin, IFS; Lucie Garand, Downs Rachlin Martin PLLC; Sandy McGuire, HowardCente; Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
Welcome and Introductions Approve meeting minutes	Don George called the meeting to order at 2:00 pm. Phone participants were asked to email their attendance to Chrissy Geiler. Kelly Lange moved to approve the minutes and Paul Harrington seconded. The motion passed unanimously.	
Update on Other Work Groups	This agenda item was skipped for time saving purposes, any questions about other work group activities should be directed to DVHA staff.	
Review ACO SSP Quality Measure Recommended Changes for Year 2	Cathy Fulton presented attachments 3A-D to the work group. Cathy reported that the July meeting for the Quality and Performance Measures Workgroup will be used to discuss any comments or concerns from other work groups and a decision around final measures to be included in year 2 will be decided by July 29. The following were comments or questions from the workgroup: • Question about where breast cancer screening stands for year two. Discussion around the confusion in guidelines and studies that have recently come out reporting the lack of	

Agenda Item	Discussion	Next Steps
	evidence around breast cancer screenings has lead the Quality and Measures workgroup to remove it in year 2. It was then suggested that it be added to the pending measures list instead of complete removal. • Question regarding logistics and timeline of adding new measures, and ensuring there is enough time to adjust or decide on benchmarks. There was also discussion about those measures that might not have any evidence based benchmarks and how the gate and ladder will be decided for those measures. It was reported that one of the criteria for selecting measures, is having a benchmark to work from in place. Or, if there is not, the work group will decide on benchmarks by looking at changes over time. The lack of benchmarks is more difficult as there is a lag time in collecting data and determining a benchmark for the next year. • Paul Harrington said adding new payment and reporting measures might become burdensome for physicians. Also voiced the recommendation that the state should focus on the measures already in place as this is just a 3 year pilot, time is needed to appropriately evaluate the measures already in place. Cathy assured the work group that they were only taking additional measures under consideration after much discussion. • Kara Suter asked what measures had been added to year 2 to date. It was reported that cervical cancer screening and tobacco cessation have been approved so far, with tobacco cessation moving off from the pending list. Pat Jones clarified that the approved measures still needed to go to the steering committee for final approval. There was additional conversation around allowing for enough time to create appropriate gate and ladder benchmarks for year2. • Steve Rauh voiced that there were not enough measures with a patient focus. Cathy Fulton said that the patient survey attempts to remedy this and the survey is being expanded in year 2. Additionally, there are two patient focused measures on the pending list as of now; they are not yet ready to be added to the payment list. • Amy Cooper reemphasized the thoughts previously bought forth about introducing additional measures in year 2 and will likely see push back from the physicians.	
Review of Payment Models Integration	Richard Slusky took this time to set the stage for the Blueprint (BP) presentation. Citing the 2010 expansion of this organization, 'The BP is a program for integrating a system of health care for	

Agenda Item	Discussion	Next Steps
Goals	patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management'. BP works with stakeholders to implement new health service models. Recently, the CMMI SIM grant allowed the state to test three new payment models through 2016. In order to be successful with these payment models, the state needs further collaboration as we move forward. Craig Jones will present his ideas and around how this may look in the future.	
Presentation: *Medical Homes, Community Health Teams and Networks* from Blueprint for Health	Craig Jones presented on *Medical Homes, Community Health Teams and Networks*. The following comments were made on Attachment 5A: • It is expected that the recommendations made in the PMWG will inform the Blueprint in their report to legislature • There is potential for extending the multi-payer demonstration past Dec 2014, if it is seen as a successful strategy by CMMI. BP has asked for a decision by Sept so people can plan for an end or extension in funding. • Richard Slusky asked if the PCMH scores are publically available. Craig Jones said that the level of recognition is available through NCQA but does not go into the scoring breakdown. • Paul Harrington made a note that the alignment of ACOs and PCMH scoring is irrelevant to Vermont as the state is not using NCQA standards for ACOs. Todd Moore commented that he was still glad to see the alignment was there between the two. • Kara Suter asked about how often specialty standards are being used. Craig Jones reported that there have been a few demonstrations of using the specialty standards to align the goals of PCPs and Specialists and saw positive results. Amy Cooper commented that this type of coordination is a goal over the next year and current PCPs need more formalized instructions around collaboration with specialists, adding that some sort of fiscal incentive would be ideal. • Todd Moore asked for clarification around how many of the VT PCMH recognized practices or hospitals had patients attributed to an ACO. Craig Jones could not provide an exact percentage – but believed it to be a significant amount. • Paul Harrington asked about the lacking Medicare data in comparison on slide 10. Data was not ready at time of comparison. Next comparison will include all three types of	

Agenda Item	Discussion	Next Steps
	health insurance. • Richard Slusky asked for clarification as to why expenditures for special Medicaid services are declining. It was discussed that there were a couple policies that came into play that reduced these expenditures to patients, as well as a change in a how the billing is being done. Brought forth additional conversation around issues related to total cost of care for this population and how the breakdown for analysis will be done in the future. • Kara Suter asked how much of the Blueprint functioning is done through grants, how much do they support annually? Craig Jones said that funds paid for most of the personnel and project managers as well as learning forums. As this is a significant amount of the budget funded through federal dollars, coordination and integration of departments in important. • Lila Richardson asked how does the BP work for conditions that are lower incidence, what is done for those patients? Craig Jones reported that care teams are not condition specific, teams are there for the people. The majority of practices are working on diabetes as an issue but the teams help to support people with other issues as well. There are generally not enough teams out there to touch all people with all health issues. Todd Moore cited that he sees this problem with rare cases that are very expensive as also being an issue. Kelly Lange emphasized the importance of knowing who is being touched by the CHTs. • Todd Moore mentioned that he felt it was time to start seeding new ACO model with payment incentives instead of waiting to finish up current pilots. • Don George said the work the BP did around PCMH was a critical foundation to other reforms and started conversation around continued support of BP initiatives. Paul Harrington asked if we assume BP is providing value for primary care, do we continue the BP as a free standing structure or does it get consumed by the ACOs with the state no longer the overseer. Does it help the ACOs to succeed by having an agency with duplicative efforts running out of the state government instead of working within the ACO? Felt there needs to be better integration and more say on the part of the ACO • Amy Cooper agreed the PCMH work is a great foundation to becoming an ACO. Did not agree with throwing the PCMH model in with the ACO, as the ACO is not yet a proven model and PCMH is proven to be very successful in Vermont. Providers are also still	

Agenda Item	Discussion	Next Steps
	questioning whether or not to continue with BP b/c of low incentives. Speaking on behalf of Dr. Rice, practices feel that PCMH level of care is not possible with current funding and has not been for the past 3-5 years. • Todd Moore expressed that OneCare is ready to pay prospective payment structure, and is 18 months away from downside risk. Something has to change to allow physicians to control the health of their patient population before this risk begins. • Richard Slusky remembered that one of the goals of this transformation needs to be provider lead and regulated. He felt there has been progress toward this in past years. However, we are too distracted by financing and looking less at efficiency and coordination. This project owes it to the providers and citizens of Vermont to come up with an efficient and integrated operating system. • Don George added that the essence of reform is trying to take a fragmented system and integrate it and it is imperative that we fix this now as ACOS are gearing up to take full global risk. A future recommendation to steering committee should be how to integrate all this. • Richard reported that if the State will be involving CMS in waivers, we must have a united front. • Craig Jones closed by saying this issue of alignment is a great opportunity and a great challenge. Any changes to current infrastructure must be done carefully.	
Update on EOC	Kara Suter updated the group and anticipates data analytics from Brandeis, soon. The plan is to send out data before next work group meeting and then discuss next month. This BP discussion will also be continued. Clinical priorities snap shot survey is ready to be sent out, working out logistics of how to send out to providers to ensure there is little duplication in reporting and there is the ability to break down by practice type.	
Public Comment	No further public comments were offered.	
Next Steps and Action Items	Kara Suter asked if the workgroup would be interested in extending the BP conversation to the next meeting and saw no objections. **Next Meeting:** Monday August 4, 2014 2:00 PM – 4:30 PM, DVHA Large Conference Room, Williston.	

Attachment 4A - Updated HCI3 Presentation

Review of Initial Medicaid Analysis

August 4th 2014

Agenda

- Brief review of HCI^3 and ECR Analytics methodology
- Overview of Medicaid Analysis
- Live reports of Medicaid “super-utilizers”

HCI^3 Overview

- Not-for-profit based in Newtown, CT
- Focused on payment and benefit programs to improve incentives for providers and plan members
- Developed Bridges To Excellence and PROMETHEUS Payment
- Created the ECR Analytics as a result of PROMETHEUS Payment and working on the Medicare Grouper

HCI^3's Evidence-informed Case Rates (ECRs)

- HCI^3's episodes of care, or Evidence-informed Case Rates (ECRs), are episode definitions that can be used for multiple purposes including bundled payment and ACO programs, reference pricing initiatives and cost and quality analysis of providers.

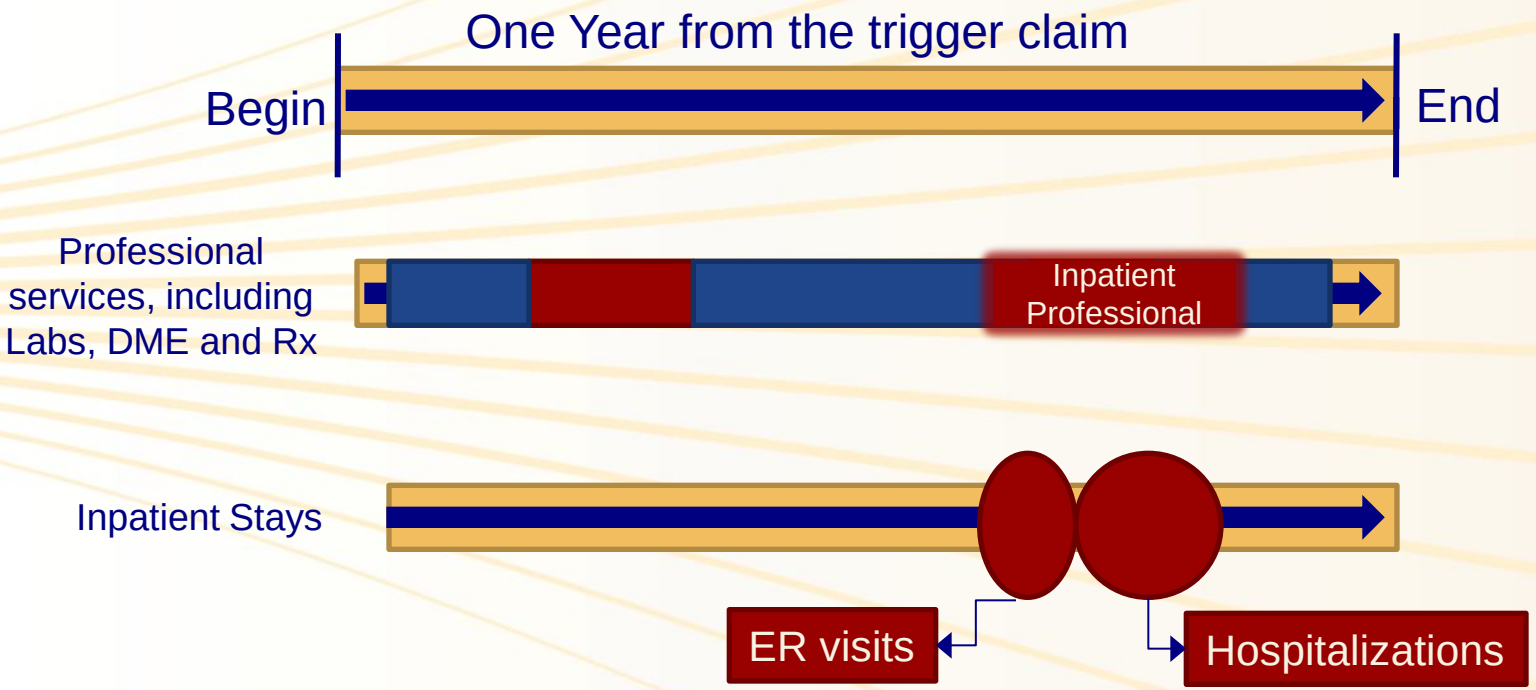
ECR Development

- Development funding and support from charitable foundations:
  - Robert Wood Johnson Foundation
  - Commonwealth Fund
  - NY State Health Foundation
  - Colorado Health Foundation
- Produce, test and refine with volunteer clinical experts assembled in Clinical Working Groups

ECR Key Features

- Distinguish typical and routine services from those associated with potentially avoidable complications (PACs).
  - PAC measures for certain chronic conditions and acute events have been endorsed by the NQF as comprehensive outcomes measures.
- Potentially avoidable services identified as overused services by the Choosing Wisely campaign are flagged within specific ECRs.
- Core services for certain conditions based on evidence-informed guidelines or expert opinion
  - help identify gaps in care or underuse in the management of an episode.

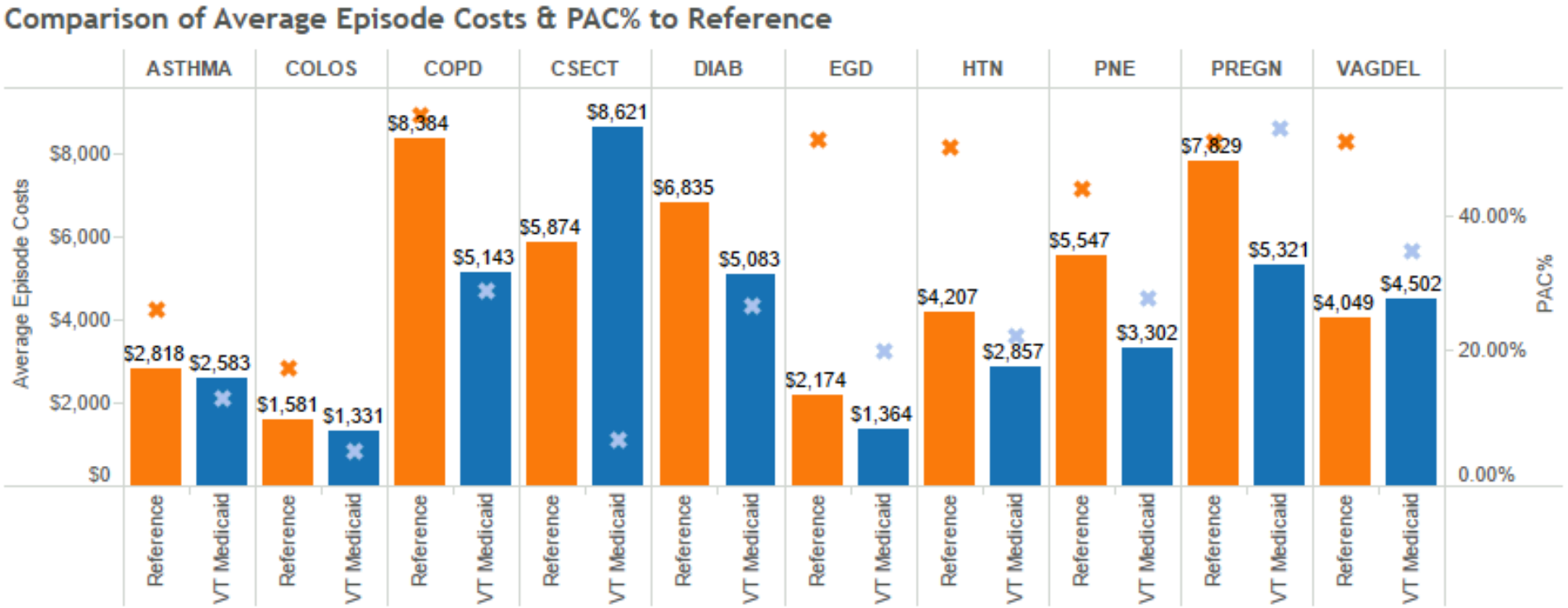
Components Of A Chronic Care ECR



What are PACs ?

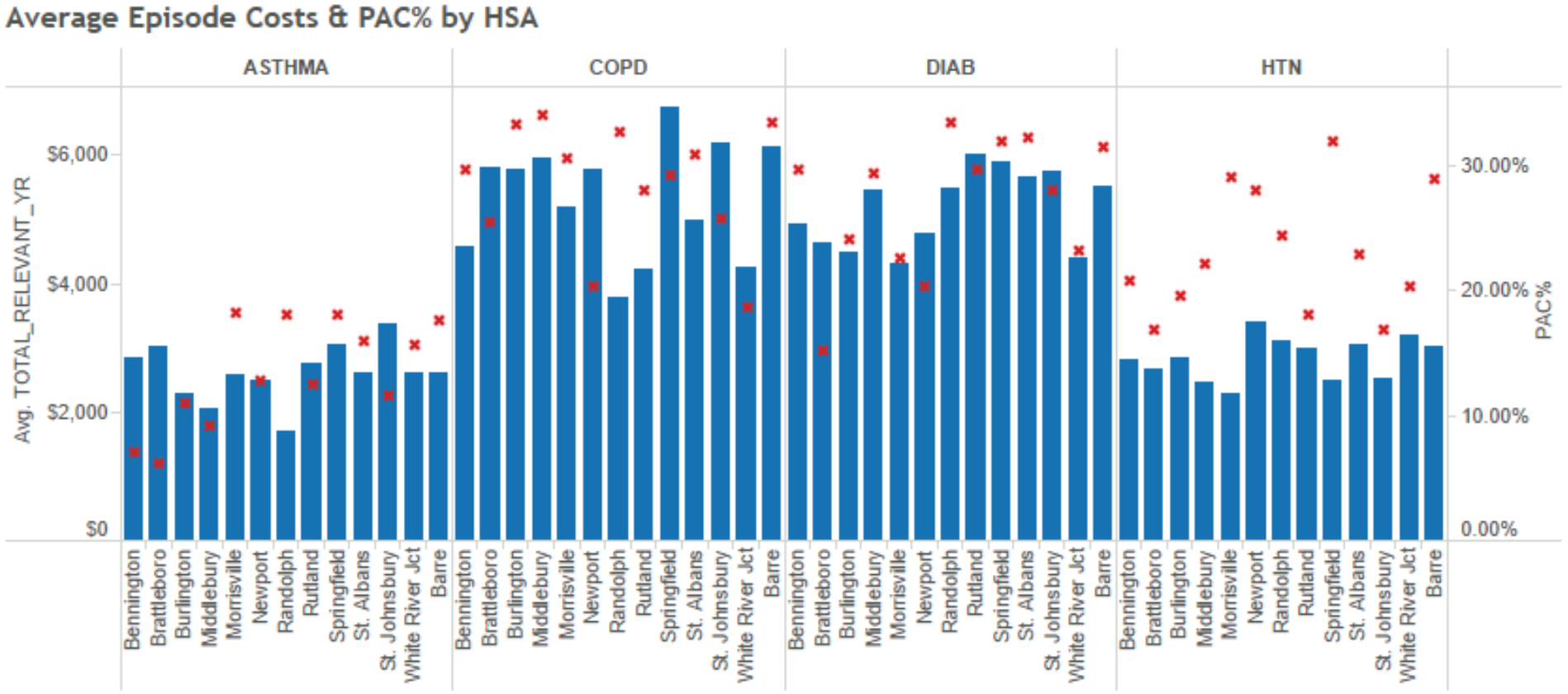
- PACs stand for Potentially Avoidable Complications
- PAC is any event that negatively impacts the patient and is potentially controllable by all the physicians and hospitals that manage and co-manage the patient.
- It is the waste within the healthcare system and could be turned into potential savings to all (divide up the pie):
  - To providers – as bonus
  - To payers – as decreased outlays
  - To patients – as better health

High Volume Episode Costs

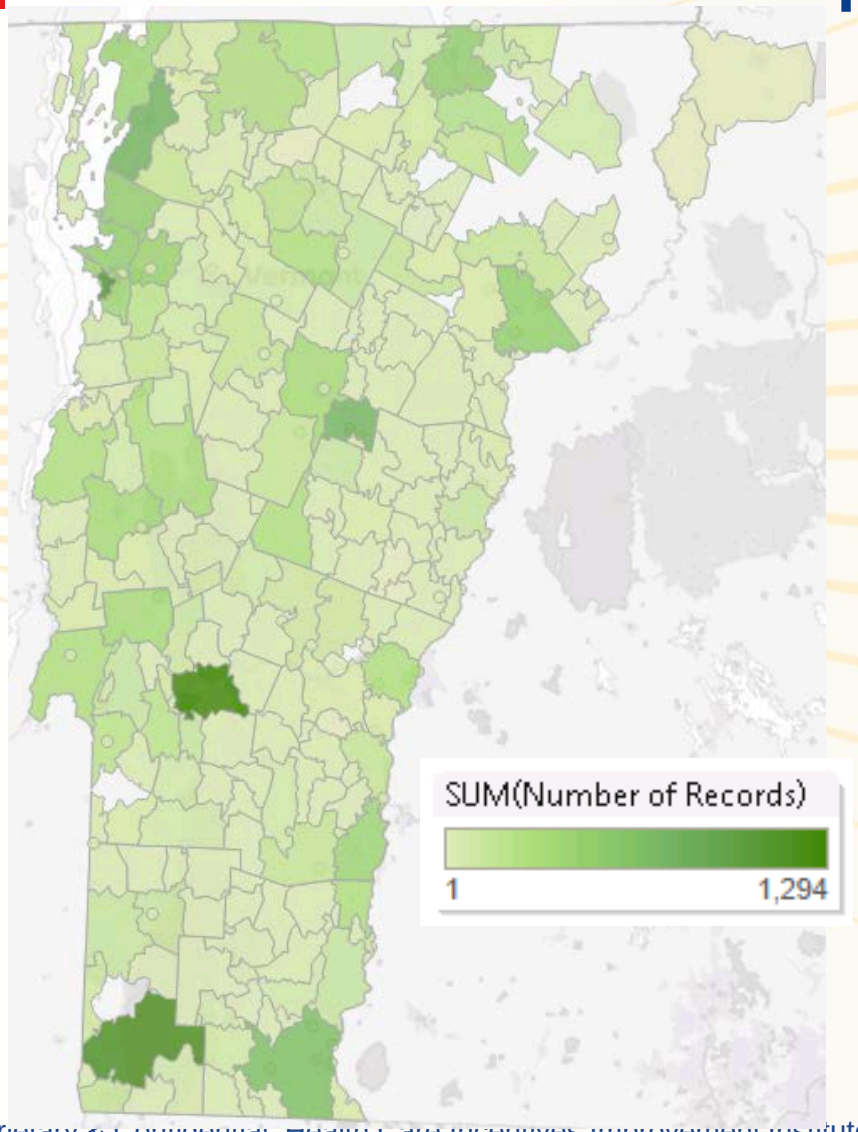


Notes:
The reference is Connecticut Medicaid.
Average episode costs are mostly lower in VT than in CT, except for deliveries and c-sections
PACs may be undercounted due to the absence of prof services and PrincDx coding on facility claims

HSA Variability In Chronic Care Is At All Levels



Volume Of Chronic Care Episodes Is Low In Most Zips

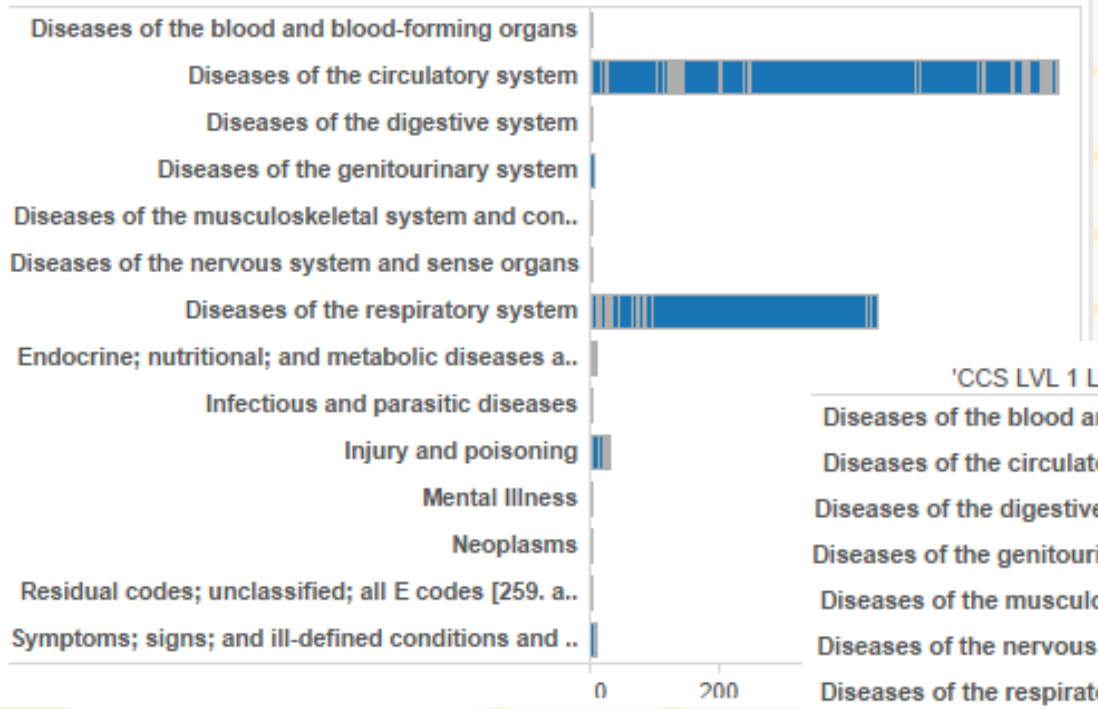


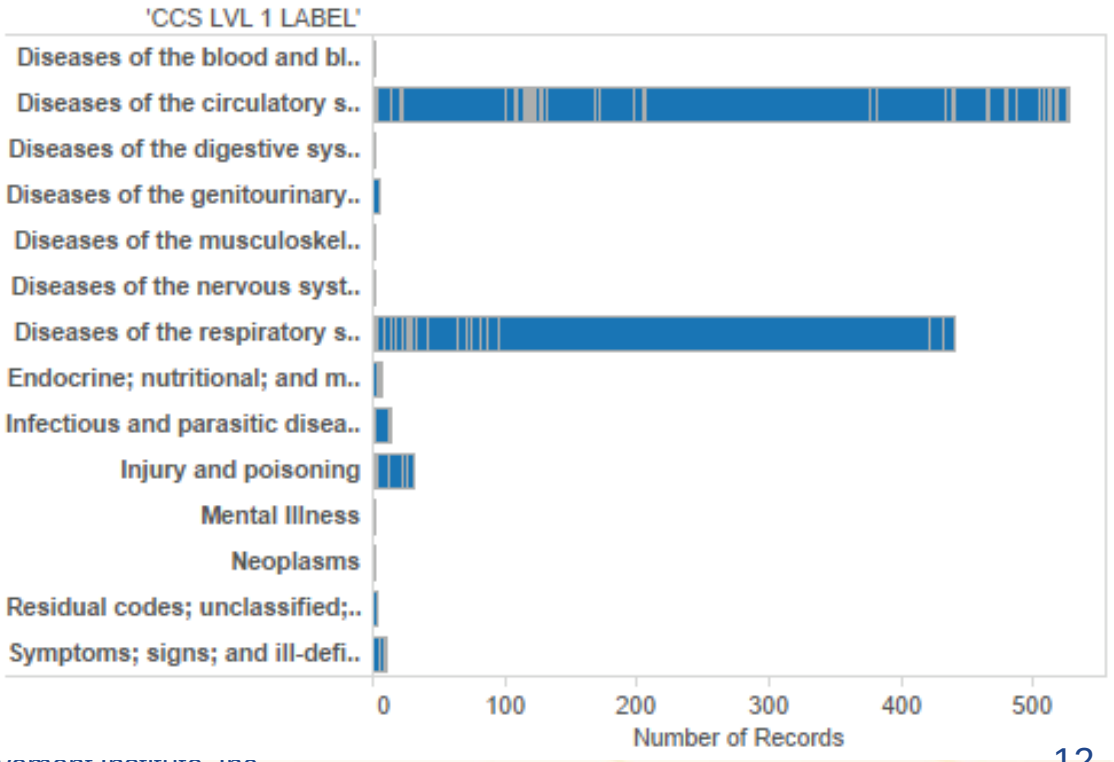
Only a few locations have more than 1000 episodes (combined for Diabetes, Hypertension, CAD, Asthma, COPD).

Most zipcode areas have fewer than 100 cases.

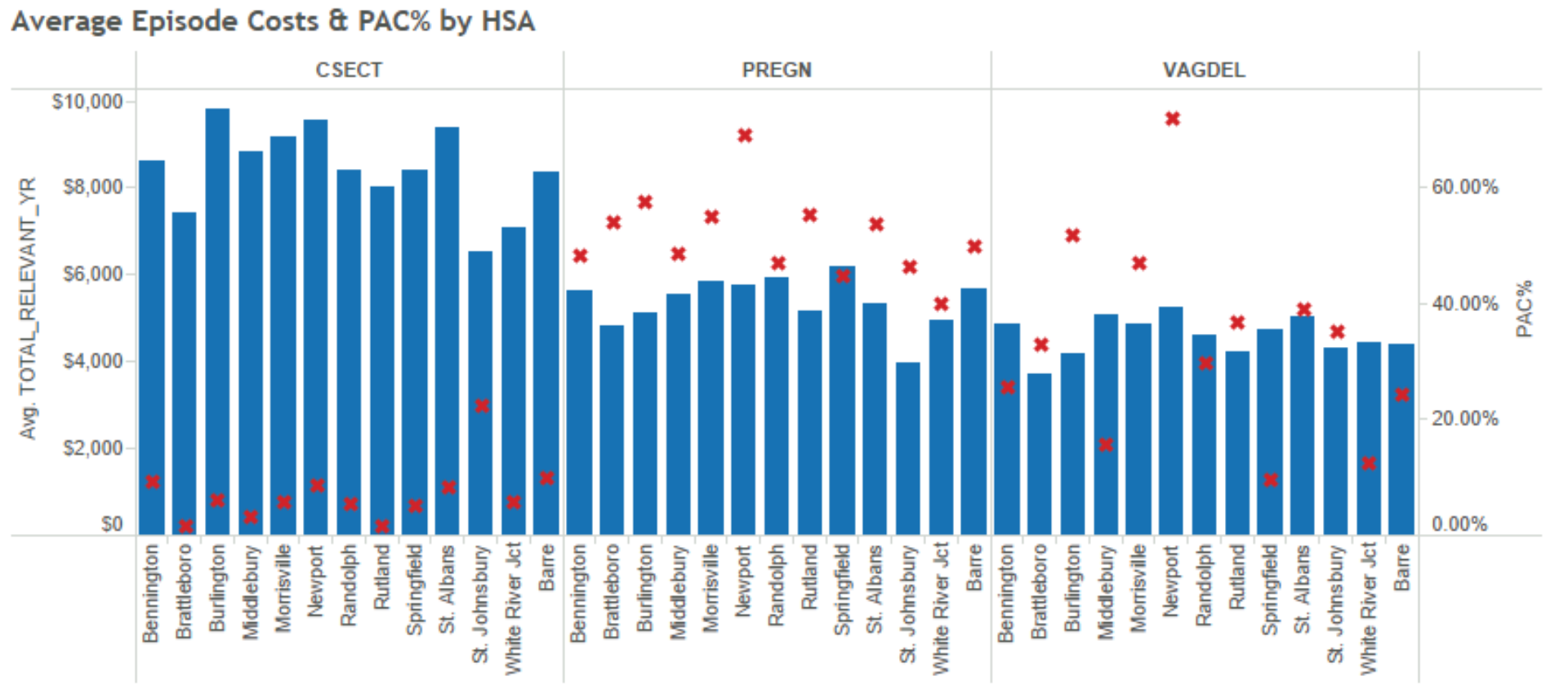
Medicaid's focus will likely be contained to a few metro areas

Most Of The IP Stays Are Related To Acute Exacerbations

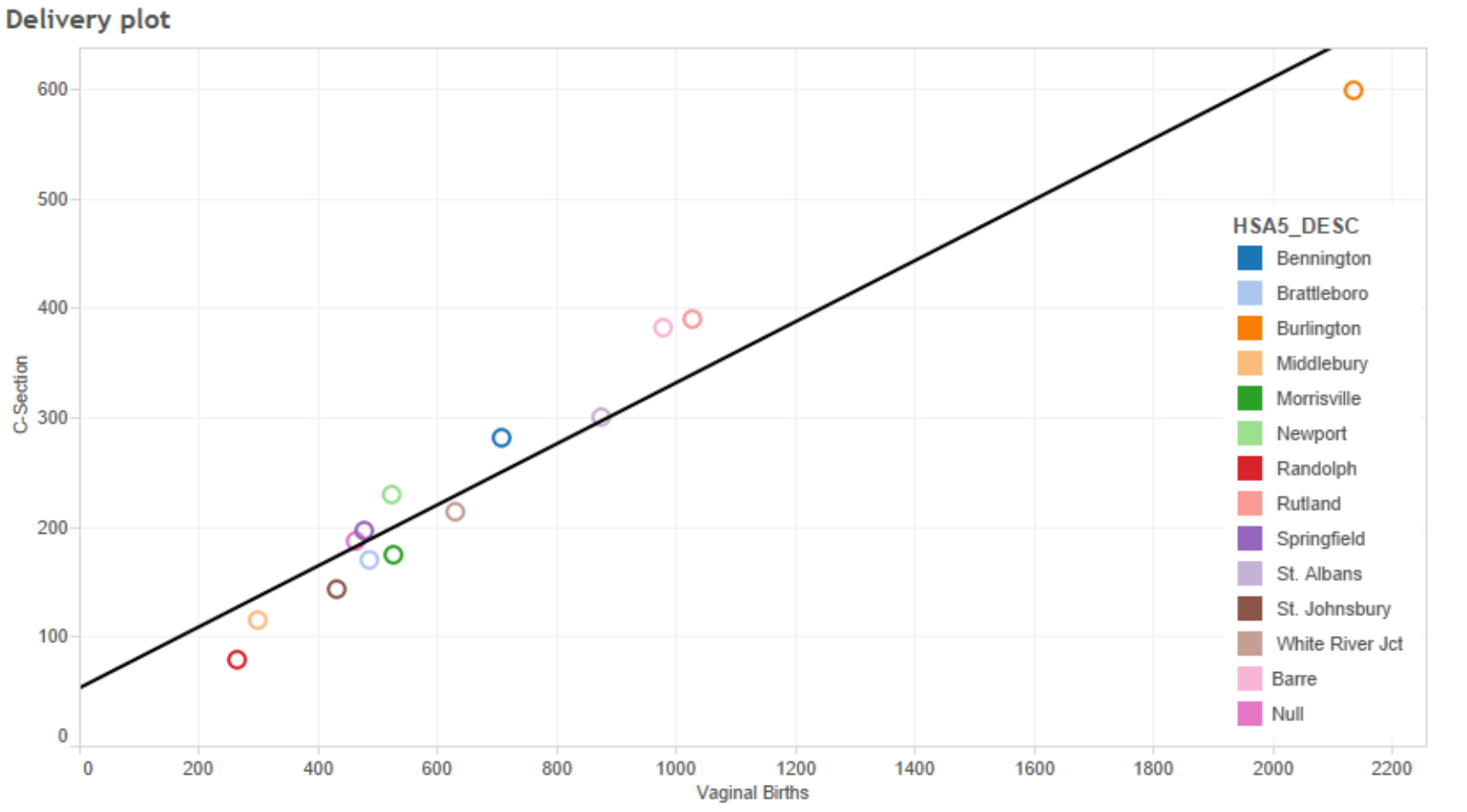




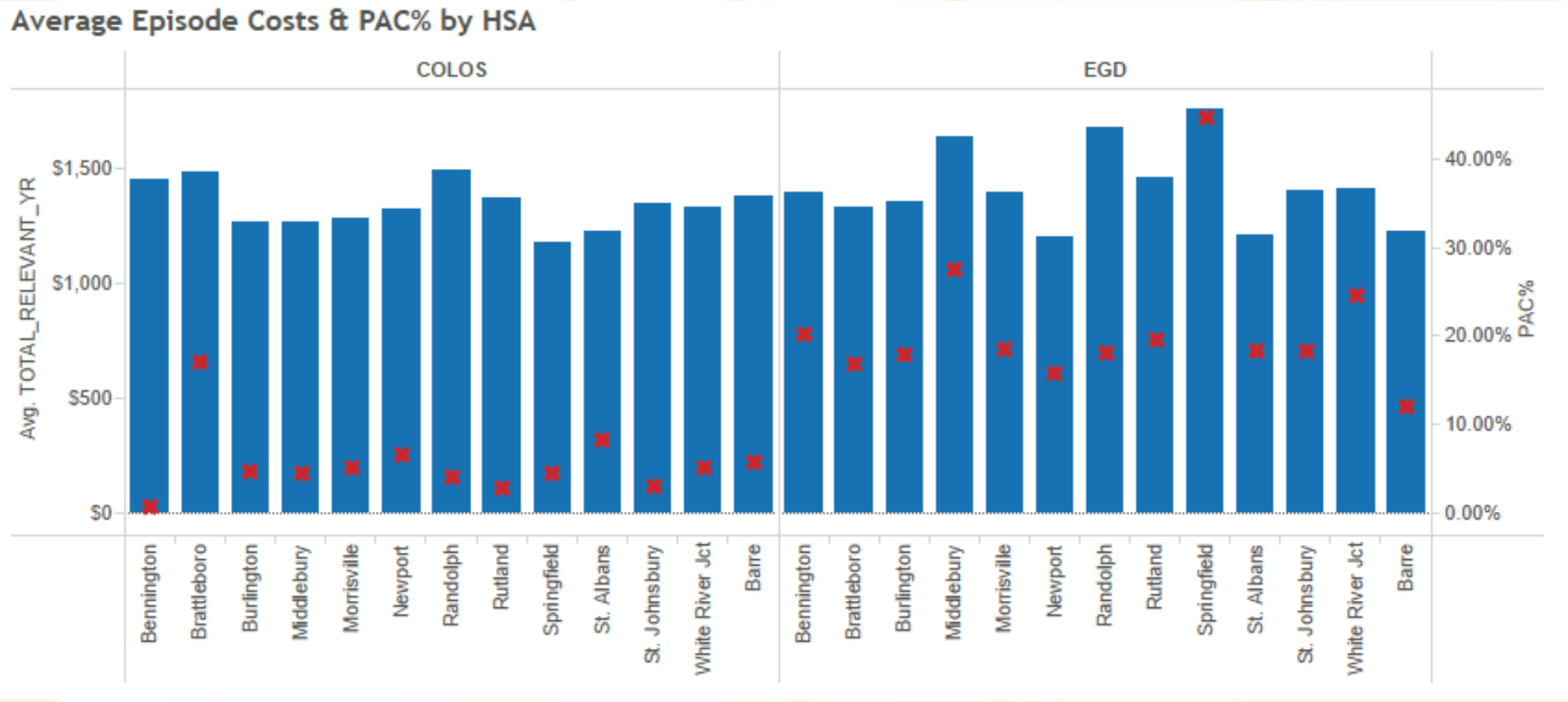
There Is Much Less Variability In Pregnancies & Deliveries



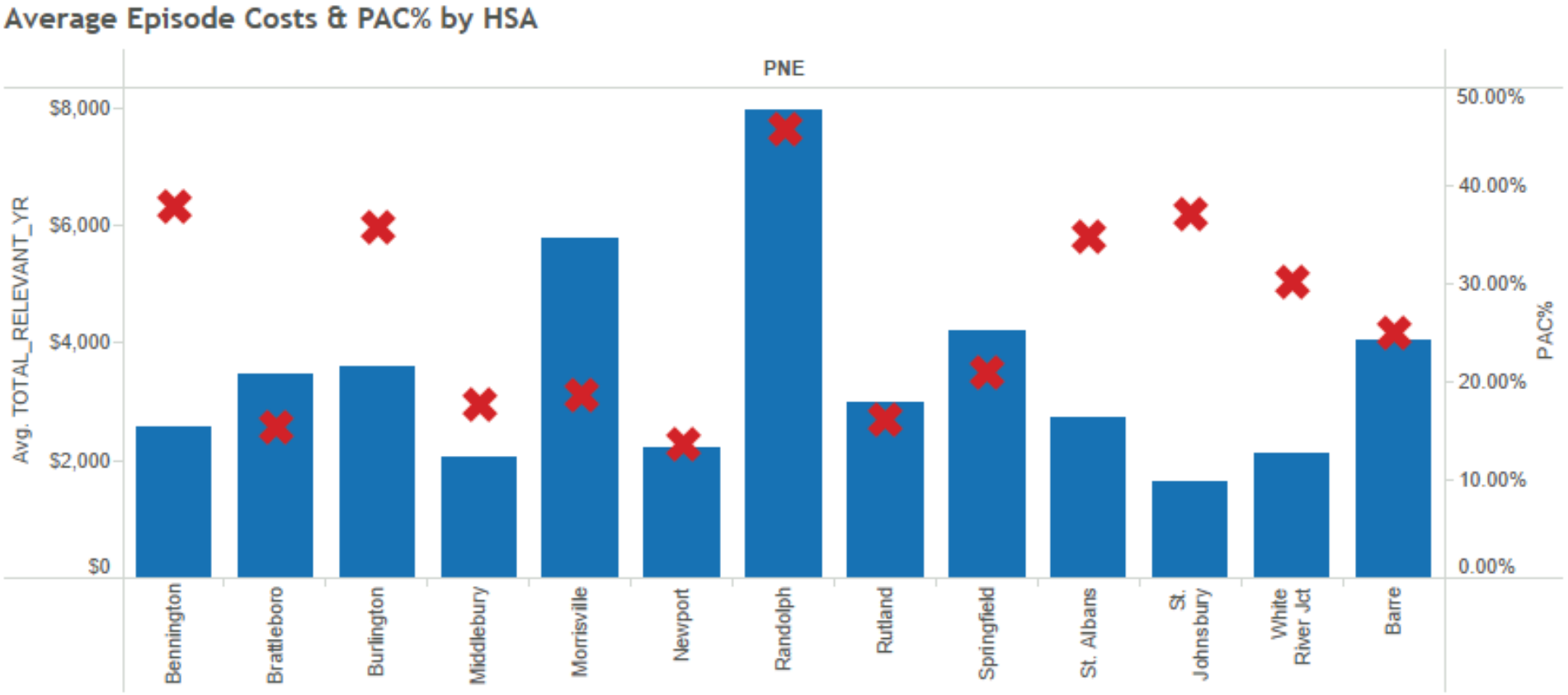
The Rate Of C-Sections To Vaginal Deliveries Is Consistent



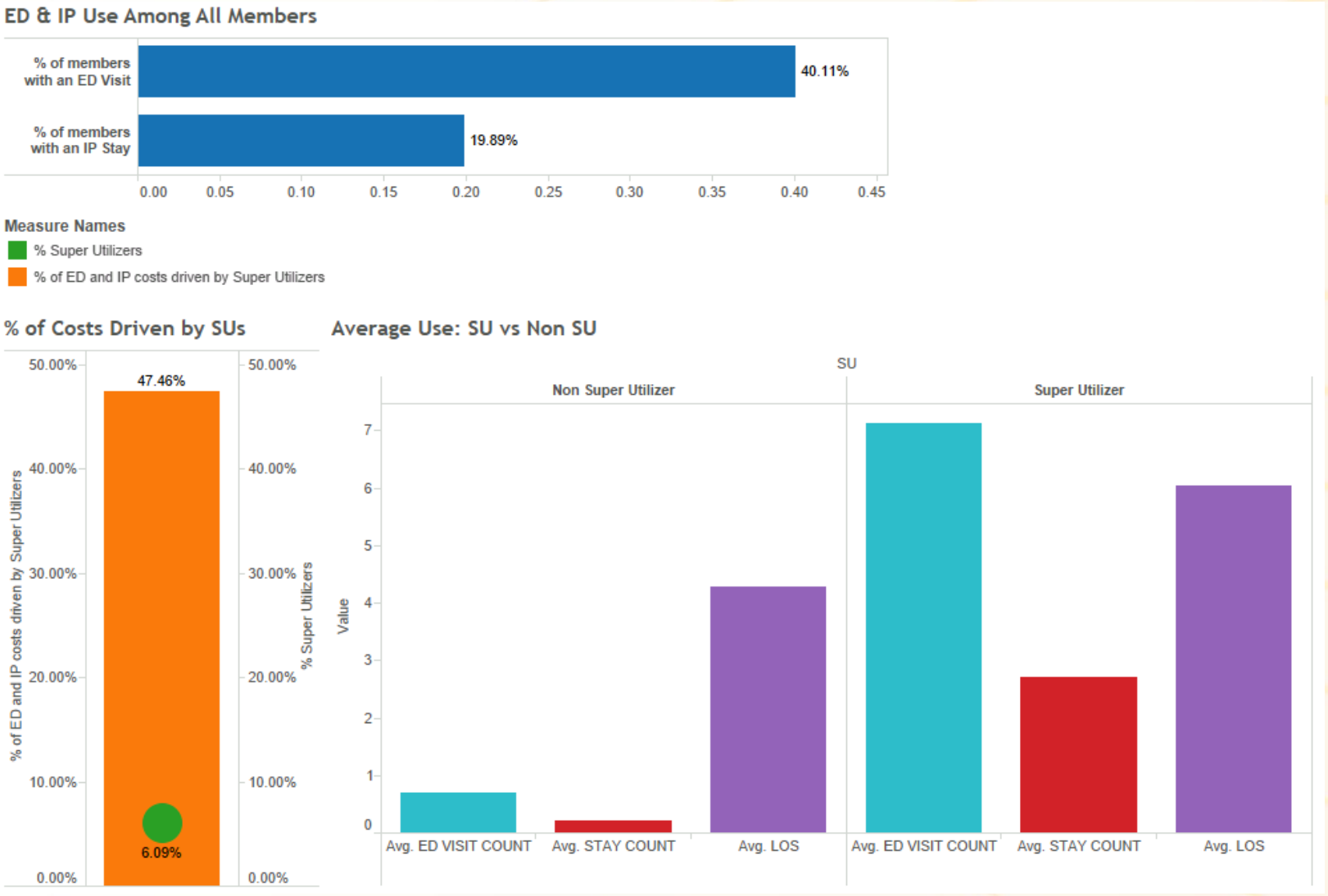
Procedural Episodes Have Less Variability By HSA



Acute Episodes Have More Variability



Super-Utilizer Analysis



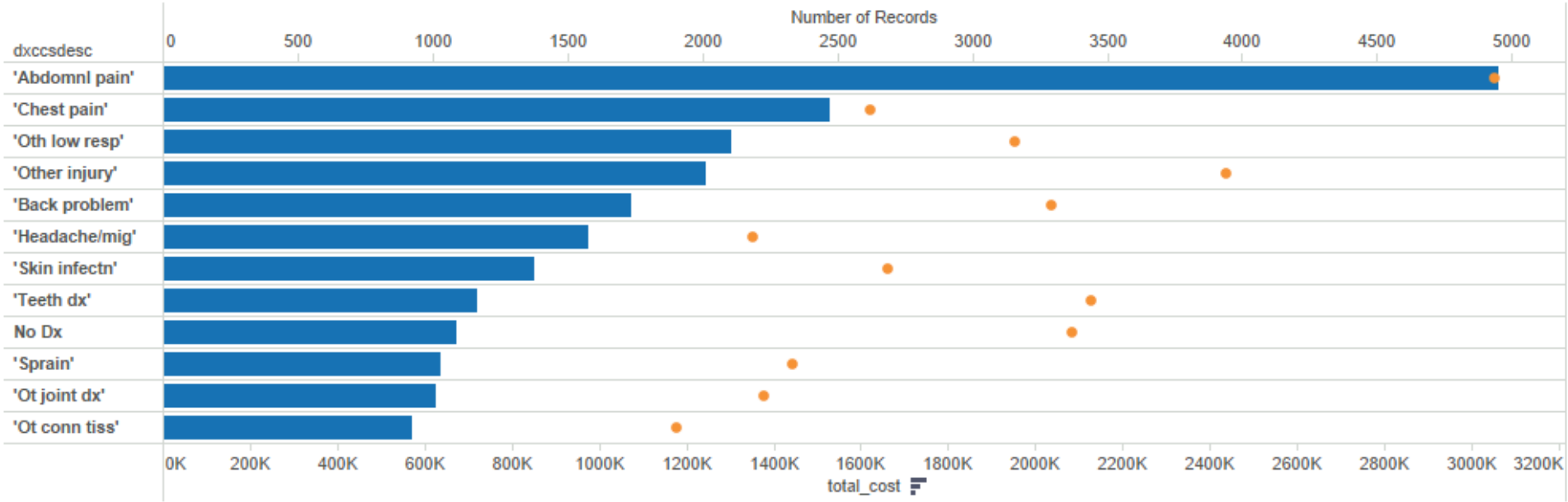
Volume of Sus By Type

Reasons For SU ED Visits

ED Freq & Cost by SU Type

SU TYPE	Number of Records	ED VISIT COUNT	Total ED Visit Cost
ED and IP SU	1,514	18,557	$8,259,517
ED SU	5,229	49,251	$18,137,049
IP SU	3,731	6,748	$2,446,482
NON SU	161,550	110,916	$39,087,238
Grand Total	172,024	185,472	$67,930,287

ED SU visit Diagnoses: Top 12 PDx

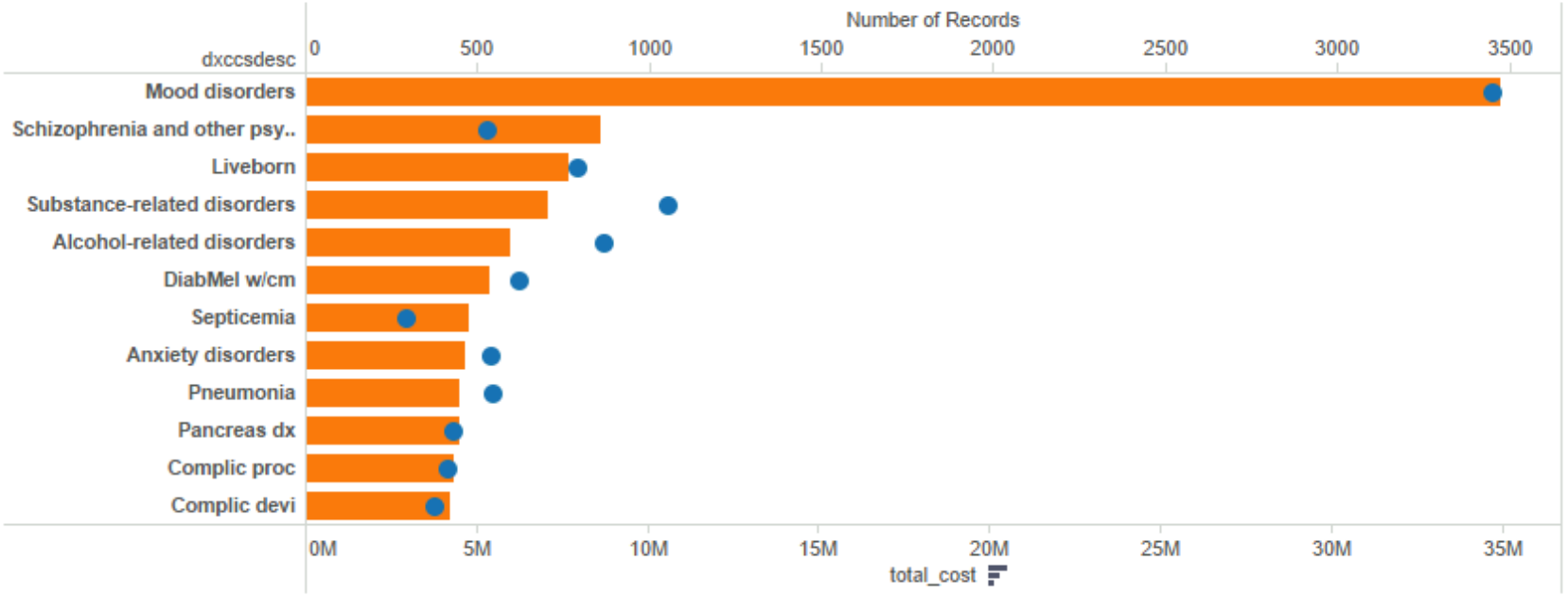


Reasons For SU IP Stay

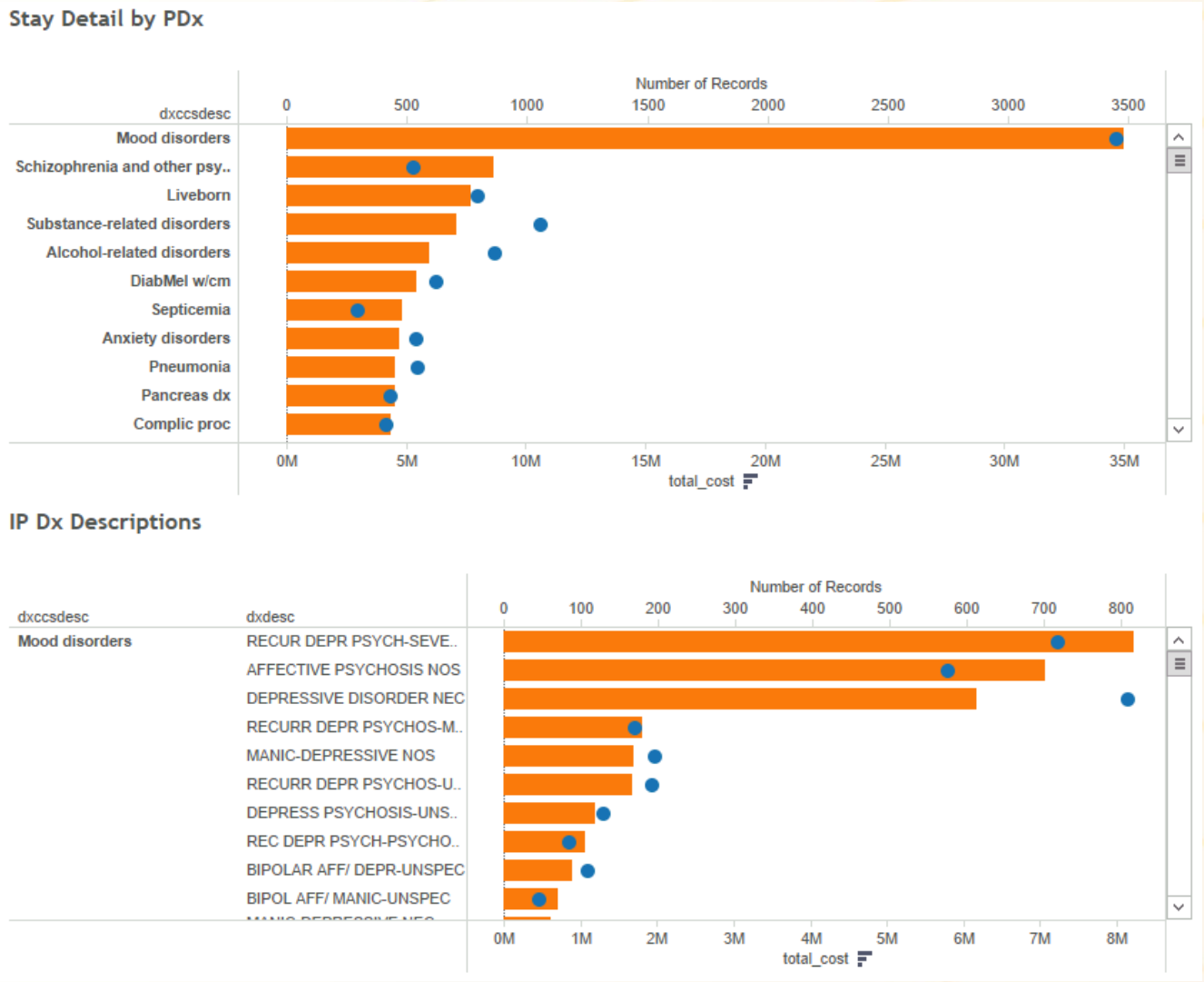
Stay Freq & Cost by SU Type

SU TYPE	Number of Records	STAY COUNT	Total Stay Cost
ED and IP SU	1,514	9,276	$84,775,397
ED SU	5,229	3,140	$26,316,063
IP SU	3,731	15,869	$154,179,054
NON SU	161,550	32,616	$286,483,148
Grand Total	172,024	60,901	$551,753,662

IP Stay Diagnoses: Top 12 PDx



Principal Diagnosis Code Detail



Next Steps

- Run commercial data
- Compare frequency and costs of Medicaid and Commercial episodes by HSA
- Other ad hoc analyses

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Attachment 4B - Criteria for Evaluating Episodes of Care Data

Payment Models Work Group
Criteria for Evaluating Episodes of Care Data

EOC	EOC is of interest to Physicians	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							
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