Payment Models Work Group Meeting Agenda 9-16-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Tuesday, September 16, 2014 9:00 AM – 11:30 AM
BCBSVT- 445 Industrial Lane, Berlin (Presentation Room)
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	9:00 – 9:05	Welcome and Introductions Approve meeting minutes	Don George and Steve Rauh	Y – Approve minutes	Attachment 1: Meeting Minutes
2	9:05 – 9:50	Presentation– Frail and Elderly	Cyrus Jordan, Josh Plavin, Sarah Kemble and Fay Homan	N	Attachment 2A: Presenter Bios Attachment 2B: Presentation
3	9:50– 10:15	Update VMSSP Total Cost of Care Expansion Year 2	Kara Suter	N	Attachment 3: Presentation
4	10:15-10:25	Prioritizing Episodes in Vermont	Kara Suter	N	Attachment 4A: Clinical Priorities Survey Results Attachment 4B: Episode Criteria Matrix
5	10:25 – 11:20	Episodes of Care Data Q/A session	Kara Suter	N	Attachment 5: Data Presentation
6	11:20 – 11:25	Public Comment		N	
7	11:25 – 11:30	Next Steps and Action Items		N	Next Meeting: Monday, October 6, 2014 2:00 PM – 4:30 PM. DVHA Large Conference Room, 312 Hurricane Lane, Williston

Attachment 1 - Payment Models Work Group Minutes 8-04-14

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

Topic	Discussion	Next Steps
Welcome and Introductions Approve meeting minutes	Stephen Rauh called the meeting to order at 2pm. Michael Curtis made a motion to pass the minutes and Joyce Gallimore seconded. The minutes passed unanimously.	
Update on Other Work Groups	Quarter 5 report to the Federal government was just completed. Year One was extended by 3 months. Next Core team meeting will be spent working on re-budgeting. Last week the second RFP was released out to healthcare providers for sub-grants, will decide on grantees by mid October. Georgia Maheras updated the workgroup on the current status of other workgroups and pointed to the monthly status reports having just been released for any additional information.	
Follow-up Blueprint for Health discussion	Kara Suter updated the workgroup that ongoing meetings and conversations are happening with Blueprint and further plans and decisions made will be brought back to the group. More information will be brought forth at the coming workgroup meetings as issues arise.	More updates to workgroup as they surface in coming months
Review EOC Data	Kara Suter introduced François de Brantes, Executive Director of the Health Care Incentives Improvement Institute (HCI3) to the workgroup who spoke to the group two months ago, here now to give an overview of Medicaid data on bundled payments in Vermont. Commercial data is to come in a similar way next meeting. François presented attachment 4A, the following were comments on the presentation: • Paul Harrington asked about why there is variation in reimbursement to providers per episode. Francois stated a difference in pricing, frequency in the services provided per service area as well as the mix of services provided per episode. • Kara Suter asked about variation of costs when taking pricing out of the equation – and how we might be able to understand this difference better as we go forward, especially in comparison to the reference states.	

	• Paul Harrington asked for clarification on slide 9, seeing the PAC and average costs seem to be highly related. François said that this occurrence is much more common in Medicare and Medicaid and is not always true with other payers. Also commented that VT has a generally lower PAC than other states and may also account for some of this relationship • Chris Tompkins made the comment that a region with a higher PAC would therefore also have a higher average cost for a procedure. François agreed with this comment, especially in regards to chronic illnesses • Kara Suter made the comment that slide 10 around chronic care is very interesting and shows the most variability throughout the state, asked if this is what François has seen in other states as well. François confirmed that this is consistent with other states. • Abe Berman commented that there was little consistency around chronic care and average costs and performance in certain HSAs. Paul Harrington asked for a state wide average to be included on this slide in future presentations. • Conversation occurred around the scarcely populated vs more populated regions of the state and how that plays into how the data and graphs are portrayed. HSA costs are attributed to where the patient lives, not where care is provided. Out of state services were also included in this analysis • Chris Tompkins asked about complications around pregnancy and delivery. François and Stacey Eccleston said it is mostly trauma related. • Kara Suter pointed out on slide 16 that the data is not yet risk adjusted and that needs to be taken into consideration, asked how that might change the episodes. François said that risk adjustment will not change pneumonia episodes much. • Abe Berman asked if the necessary and unnecessary use of ED be taken into account. HCI3 team showed that data can drill down to this level of information – and data shows the only difference been super utilizers and utilizers is how often they visit and not the diagnosis type. Also noted that commercial data has far less super utilizers than Medicaid data. • Kara Suter asked about cross over claims – and if they are excluded from this analysis. Needs to be followed up on • Abe Berman asked about how the super utilizer conversation is tied back to the EOC discussion. François said that it is just another, broader view of the	Francois to screen shot and provide a larger view of graphs shown during presentation and not in packet Identify if dual eligibles are included/ to what extent?

	population and one that drives a lot of the costs in the state of VT. • Paul Harrington asked about the ability to see episode by payer – to potentially tease out why this might be occurring. François reported that it will be challenging but has the potential to be a great analytic tool. Kara Suter noted that we do not have Medicare data yet but Brandeis reported that it can be provided less than a few weeks out. • Conversation occurred around complications that will occur when comparing all 3 payers and plans available to consumers. • Kara Suter made the comment that this data was a first run to see what we had to work with. Confirming validity of data and getting commercial data are the immediate next steps. Plans to send out data as soon as possible as we get it in. • Chris Tompkins asked about the benefit of providing Medicare data in this capacity • Level of payment and attribution is an issue for further discussion as more data comes in and more research on what will work best for the state occurs • Showed criteria for scoring episodes, to be voted on at a later time.	
Public Comment	There was no public comment	
Next Steps and Action Items	Next meeting will be spent looking at more data from HCI3. Kara Suter requested that members send ad hoc analysis requests to Chrissy. Paul Harrington asked about a move to replicate a Maryland all payer system. Georgia Maheras reported that the administration is at a very beginning stage with this discussion but would likely leverage this workgroup. Paul Harrington moved to close the meeting, Joyce Gallimore seconded the vote. Next Meeting: Tuesday, September 16, 2014 9:00 AM – 11:30 AM at BCBSVT- 445 Industrial Lane, Berlin (Mtg Room 130s)	

VHCIP Payment Models Work Group Attendance 8-04-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

✓ via phone

	First Name	Last Name		Title	Organization	Pymt Models
1	April	Allen		Director of Policy and Planning	AHS - DCF	X
2	Carmone	Austin	✓		MVP Health Care	M
3	Ena	Backus			GMCB	X
4	Melissa	Bailey	Melissa Bailey		Otter Creek Associates and Matrix Healt	X
5	Michael	Bailit			Bailit-Health Purchasing	X
6	Susan	Barrett		Executive Director	GMCB	X
7	Anna	Bassford			GMCB	A
8	Kate	Bazinsky			Bailit-Health Purchasing	X
9	Abe	Berman		Director of Finance	OneCare Vermont	X
10	Martha	Buck			Vermont Association of Hospital and He	A
11	Heather	Bushey		CFO	Planned Parenthood of Northern New E	M
12	Gisele	Carbonneau			HealthFirst	A
13	Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
14	Ron	Cioffi		CEO	Rutland Area Visiting Nurse Association	X
15	Lori	Collins			AHS - DVHA	X
16	Amy	Coonradt		Health Policy Analyst	AHS - DVHA	X
17	Alicia	Cooper	Alicia Cooper	Quality Oversight Analyst	AHS - DVHA	S
18	Michael	Counter		Sr. Director of Finance	Visiting Nurse Association & Hospice of	X
19	Diane	Cummings		Financial Manager II	AHS - Central Office	M
20	Michael	Curtis		Director of Child, Youth & Family Se	Washington County Mental Health Serv	M
21	Danielle	Delong			AHS - DVHA	X
22	Mike	DelTrecco	here		Vermont Association of Hospital and He	M
23	Michael	Donofrio		General Council	GMCB	X
24	Audrey	Fargo		Administrative Assistant	Vermont Program for Quality in Health	A
25	Cyndy	Fischer			OneCare Vermont	A
26	Kathleen	Fish		Director actuarial Services	MVP Health Care	X
27	Katie	Fitzpatrick		VT Administrative Asst.	Bi-State Primary Care	A
28	Erin	Flynn		Health Policy Analyst	AHS - DVHA	S
29	Catherine	Fulton		Executive Director	Vermont Program for Quality in Health	M

30	Joyce	Gallimore		Director, Community Health Payme	Bi-State Primary Care/CHAC	MA/M
31	Lucie	Garand		Senior Government Relations Speci	Downs Rachlin Martin PLLC	X
32	Andrew	Garland			MVP Health Care	X
33	Christine	Geiler		Grant Manager & Stakeholder Coor	GMCB	S
34	Don	George		President and CEO	Blue Cross Blue Shield of Vermont	C
35	Carrie	Germaine	Carrie Germaine		AHS - DVHA	X
36	Jim	Giffin		CFO	AHS - Central Office	X
37	Al	Gobeille		Chair	GMCB	X
38	Bea	Grause		President	Vermont Association of Hospital and He	MA
39	Lynn	Guillett			OneCare Vermont	MA
40	Heidi	Hall		Financial Director	AHS - DMH	M
41	Janie	Hall		Corporate Assistant	OneCare Vermont	A
42	Thomas	Hall			Consumer Representative	M
43	Bryan	Hallett				X
44	Paul	Harrington	PCH	President	Vermont Medical Society	M
45	Carrie	Hathaway		Financial Director III	AHS - DVHA	X
46	Carolynn	Hatin	CL		AHS - Central Office - IFS	X
47	Selina	Hickman		Policy Director	AHS - DVHA	X
48	Bard	Hill		Director - Policy, Planning & Data U	AHS - DAIL	M
49	Churchill	Hindes		COO	OneCare Vermont	X
50	Con	Hogan		Board Member	GMCB	X
51	Nancy	Hogue		Director of Pharmacy Services	AHS - DVHA	X
52	Craig	Jones		Director	AHS - DVHA - Blueprint	MA
53	Pat	Jones			GMCB	MA
54	Kevin	Kelley		CEO	CHSLV	X
55	Melissa	Kelly			MVP Health Care	X
56	Sarah	King		CFO	Rutland Area Visiting Nurse Associatio	M
57	Nelson	Lamothe			UMASS	S
58	Kelly	Lange	Kelly Lange	Director of Provider Contracting	Blue Cross Blue Shield of Vermont	M
59	Diane	Lewis			AOA - DFR	A
60	Bill	Little		Vice President	MVP Health Care	MA
61	Georgia	Maheras			AOA	S
62	David	Martini			AOA - DFR	M
63	John	Matulis				X
64	James	Mauro			Blue Cross Blue Shield of Vermont	MA
65	Marybeth	McCaffrey		Principal Health Reform Administra	AHS - DAIL	X
66	Alexa	McGrath			Blue Cross Blue Shield of Vermont	A
67	Sandy	McGuire	✓	CFO	HowardCenter for Mental Health	M

68	Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
69	Todd	Moore		CEO	OneCare Vermont	M
70	Annie	Paumgarten	here	Eveluation Director	GMCB	X
71	Tom	Pitts		CFO	Northern Counties Health Care	M
72	Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
73	Stephen	Rauh			GMC Advisory Board	C/M
74	Lori	Real		Chief Operating Officer	Bi-State Primary Care/CHAC	MA
75	Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
76	Lila	Richardson		Attorney	VLA/Health Care Advocate Project	M
77	Howard	Schapiro		Interim President	University of Vermont Medical Group P	M
78	Rachel	Seelig		Attorney	VLA/Senior Citizens Law Project	MA
79	Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	M
80	Tom	Simpatico			AHS - DVHA	X
81	Ted	Sirotta		CFO	Northwestern Medical Center	M
82	Richard	Slusky		Payment Reform Director	GMCB	S/M
83	Kara	Suter		Reimbursement Director	AHS - DVHA	S/M
84	Beth	Tanzman		Assistant Director of Blueprint for I	AHS - DVHA - Blueprint	X
85	Anya	Wallack		Chair	SIM Core Team Chair	X
86	Marlys	Waller			Vermont Council of Developmental and	X
87	Barbara	Walters		Chief Medical Director	OneCare Vermont	X
88	Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	X
89	Spenser	Weppler			GMCB	S
90	Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
91	Sharon	Winn		Director, Vermont Public Policy	Bi-State Primary Care	M
92	Jennifer	Woodard	here	Long-Term Services and Supports I	AHS - DAIL	X
93	Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
94	Dave	Yacovone		Commissioner	AHS - DCF	X
95	Erin	Zink			MVP Health Care	X
96	Marie	Zura		Director of Developmental Services	HowardCenter for Mental Health	MA
97	Mike	Maslack				X
						97

JAMES WESTRICH — AHS - DVHA — S

✓ Bill Marder — Truven Health Analytics

Attachment 2A - Presenter Biographies

Presenter Biographies

Director - Cyrus Jordan, MD, MPH

Dr. Jordan will direct the overall operation of the project. He is the Director of the Vermont Medical Society's Foundation for Research and Education, a public-benefit corporation. His goals for the Foundation are to: 1) design solutions and recruit resources to solve problems for Vermont's practitioners and their communities; and 2) promote value and science driven health care by providing premier evaluative resources to policy makers at both the state and local levels. Dr. Jordan completed a residency in family medicine and a second in pediatrics. After an extended career in primary care, he received a Masters in Public Health and has since focused on improving the care in the state for the past two decades. He is a faculty member of the Department of Pediatrics at UVM as well as the University's Center for Clinical and Translational Sciences.

Clinician Community Champion – Josh Plavin MD MPH

The Community Champion, Josh Plavin MD MPH and Medical Director of Gifford Health Care, is an active practicing clinician and a regional opinion leader on the clinical focus area. The Champion is charged to recruit additional Community members who share his interest in the topic and are respected thoughtful clinicians in their own right. The Champion has frequent contact with the Director and improvement expert; he participates in all telecommunication events and all face to face meetings including regular meetings with the funder during the course of the project. Dr. Plavin is a clinical faculty member of the Dartmouth Medical School.

Regional Clinical Opinion Leader – Sarah Kemble MD MPH

Dr. Kemble is the medical director of Springfield Health Care Services. Her role will be to contribute her considerable knowledge of practice management and practice finances as well as her influence and professional networking with clinicians in southern Vermont and at DHMC. She is a faculty member at Dartmouth Medical School. Her role will similar to Dr. Plavin's but to a lesser extent.

Regional Clinical Opinion Leader – Fay Homan MD

Dr. Homan is a mid-career practitioner in Wells River Vermont and now a member of the Little Rivers Health Care FQHC. She has a special interest in team based care and is a recognized opinion leader in the family practice profession in the region being on the executive committee of the Vermont Academy of Family Physicians. Her role will be to contribute her considerable knowledge of practice management and models for team based care as well as her influence and professional networking with family physicians across Vermont. She is a clinical faculty

member at the UVM College of Medicine. Her role will similar to Dr. Plavin's but to a lesser extent.

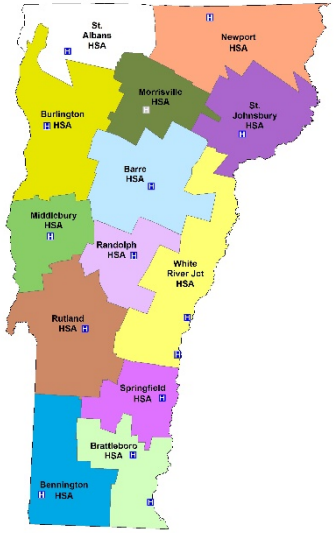
Attachment 2B - Frail and Elderly Community-Based Care Presentation

VHCIP Payment Models Work Group

Frail Elderly Community-based Care

Care Innovations, Payment Constructs and Value Measures

A Request for a Planning Grant



Actualizing reform thru clinician leadership

Better quality, Better health, Lower costs

Fay Homan MD – Little Rivers Health Care

Cyrus Jordan MD MPH – VMS Foundation

Sarah Kemble MD MPH – Springfield Medical Care Services

Josh Plavin MD MPH – Gifford Health Care

September 16, 2014

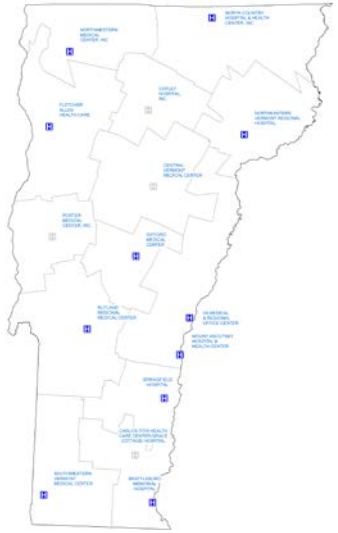
VMS Education & Research Foundation

helping physicians help patients & communities

The GMCB and VMS Education and Research Foundation

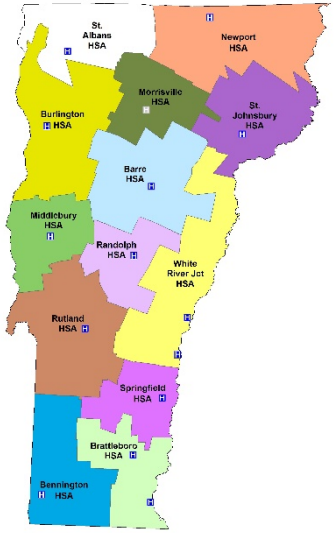
June – December 2013

Qualitative Research - Health Resource Allocation Plan

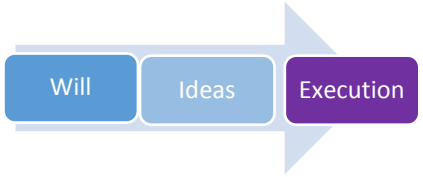


How can leaders accelerate innovation?

"You have to have the *will* to improve; You have to have *ideas* about alternatives to the status quo; and then you have to make it real through *execution*. All three have to be arranged by leaders – they are not automatic."



1. A population-based care plan
2. Coordination of care across settings
3. Anticipation of workforce needs
4. Meaningful actionable measurement
5. Transparency of payment reform



1. Actualize 3 planned levels of care
2. Make VT a magnet for the workforce
3. National benchmark for measurement
4. Reduce the gap between practice and policy

http://www.vmsfoundation.org/sites/default/files/files/Hospitalist_Report_12_5_13FINAL.pdf

http://www.vmsfoundation.org/sites/default/files/files/Rural_physicians_report.pdf

Actualizing Hospital reform thru Hospitalist Leadership

Better care, better health, lower costs

1) Pursuing High Value Health Care in VT

VHCIP Grant Program Sept 2014 – June 2016

a) **Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability**
- $5.06 billion estimated achievable annual savings - US
- $166 per admission of avoidable cost
- $9,750,342 – VT
- Hospital-acquired anemia
- Disrupted sleep
- Patient discomfort

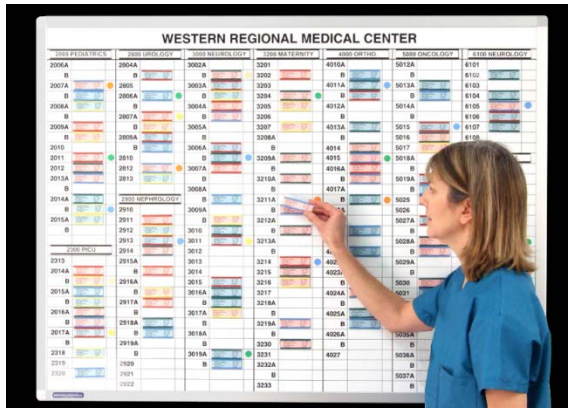
shm Society of Hospital Medicine
Hospitalists. Transforming Healthcare. Revolutionizing Patient Care.

b) **Avoid routine preoperative testing for low risk surgeries without a clinical indication**
- FAHC initially

ASCP

2) Region-wide triage system

- Hospital, rehab and SNF
- Patients located by need, not facility revenue or compliance
- **CMS waivers granted to Medicare ACOs**
  - **72 hour rule**



Actualizing Community-Based Care reform thru Core Community Practitioner Leadership

Better care, better health, lower costs

1) Regional plan for general surgery

- Foundation partnership with VT Chapter ACS
- Standing 6 member Chapter Committee May 2014
    - FAHC, DHMC, critical access practice, community hospital practice and 2 at large members
- Deliverables
    1) Current state - barriers
    2) Ideal state - reform
    3) Business plan
    4) Evaluation/measurement plan

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
100+years

2) Frail Elderly Care

- Planning effort
- Multi-site input
- Ground up informed policy
- Functional definition versus diagnostic
- Care innovation, payment reform and value measurement that make sense to patients, communities and practitioners

Frail Elderly Payment Pilot

Purpose

- Redesigning how high risk elders are cared for
- Opportunity to improve health outcomes for a high need population and decrease cost

Rationale

- Interest across several varied provider organizations
- VHCIP alternative payment model – global payment for a discreet hi-risk sub-population
- Inform infrastructure development for a high-performing health care system
- Existing peer reviewed literature on target population vulnerability and potential to avoid: expense; clinical errors; and medical complications
- Requires proactive patient identification and intervention

Deliverables:

- Recommendations for determining high risk and attributing patients to practices
  - Methodologies utilizing claims data and clinical data – validation between methods
- Suggested innovations in practice design
- Identification of regulatory barriers
- Draft payment agreements to support redesigns
- Practical, meaningful value measures –

<u>Things that matter to patients over the cost of meaningful definitions of care</u>

Frail Elderly Risk Group

Frailty in older adults: Insights and interventions

- State of vulnerability - increased risk of poor outcomes
- Common signs and symptoms are fatigue, weight loss, muscle weakness, and progressive decline in function
- Frail older adults – challenge for medical management
- Awareness and intervention - decreased risk for adverse outcomes
- Less able to tolerate stress of illness, hospitalization, and immobility
- Interdisciplinary team to monitor and manage specific issues
- Recommendations to the patient's primary care physician
- Acute Care for Elders hospital units prevent functional decline and improve functional independence if decline has occurred
    - More home-like environment
    - patient-centered medical care to prevent disability
    - comprehensive discharge planning and management.

http://www.ccjm.org/content/72/12/1105.full.pdf

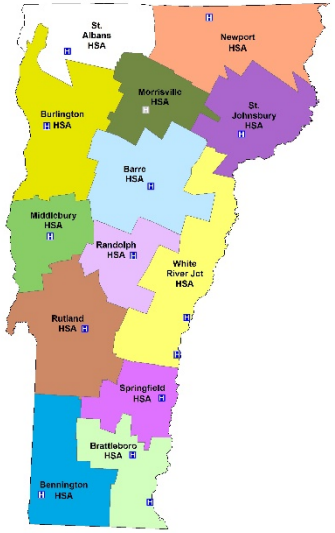
Level Of Frailty Predicts Surgical Outcomes In Older Patients

- 10-minute "frailty" test administered to older patients before they undergo surgery
- Predicts risk for complications, hospital stay and likeliness of discharge to SNF
- 5 point scale – 5 meaning "frail"
    - 10 pounds or more within the previous year
    - Weakness
    - Exhaustion
    - low physical activity
    - slowed walking
- 2.5 times as likely as those who were not to suffer a postoperative complication
- 1.5 times as likely to spend more time in the hospital
- 20 times as likely to be discharged to a nursing home or assisted living facility after previously living at home.

http://www.ncbi.nlm.nih.gov/pubmed/20510798
http://www.patientsafetysolutions.com/docs/June_2010 The_Frailty Index_and_Surgical_Outcomes.htm

Commonwealth Care Alliance - Massachusetts

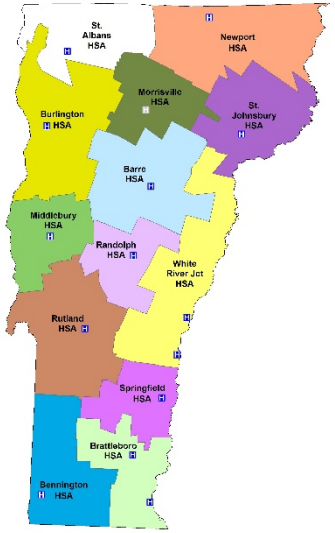
- Focuses exclusively on the care of Medicare and Medicaid's most complex and expensive beneficiaries
- Relies on Medicare and Medicaid risk adjusted premium to redesign care with a focus on investment in primary care
- Primary care multidisciplinary teams focused on empowering individuals in their care
- Replace the solo intervention of a 20 minute medically focused physician office visit with care coordination and elastic nurse practitioner home response capability to assess and manage new problems, replaces physician/MD office telephone management, the Ambulance and the emergency room
- 46% fewer NH admissions (1.7 vs 3.3)
- 50% lower hospital admissions per1000/yr (332 vs 671)



http://www.commonwealthcarealliance.org/

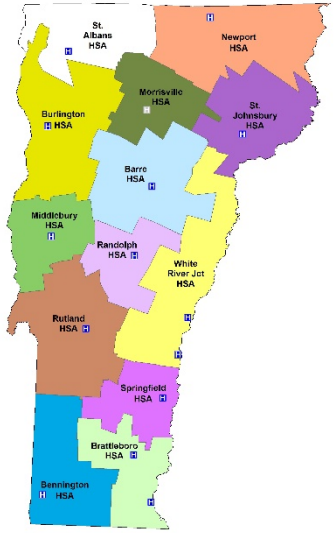
Key Concepts in Care for the Frail Elderly

- **Health care moves out of the office and into the home**
- **Coordination and decision-making rests with Primary Care Provider/Medical Home**
- **Avoid health care that is unwanted, unnecessary**



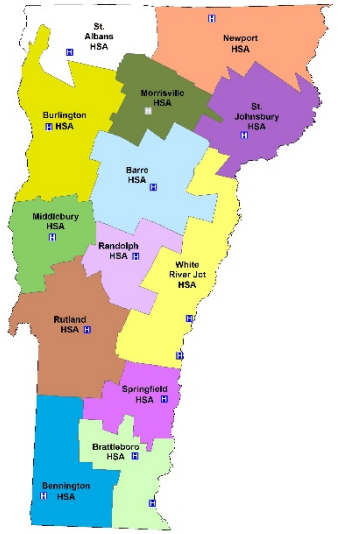
Coordination and Decision-making Rests with Primary Care Provider/Medical Home

- Stranger involvement will be met with suspicion
- Access to providers who know the patient best
- Current system is fragmented
- The right care in the right setting



Move Health Care Out of the Office and Into the Home

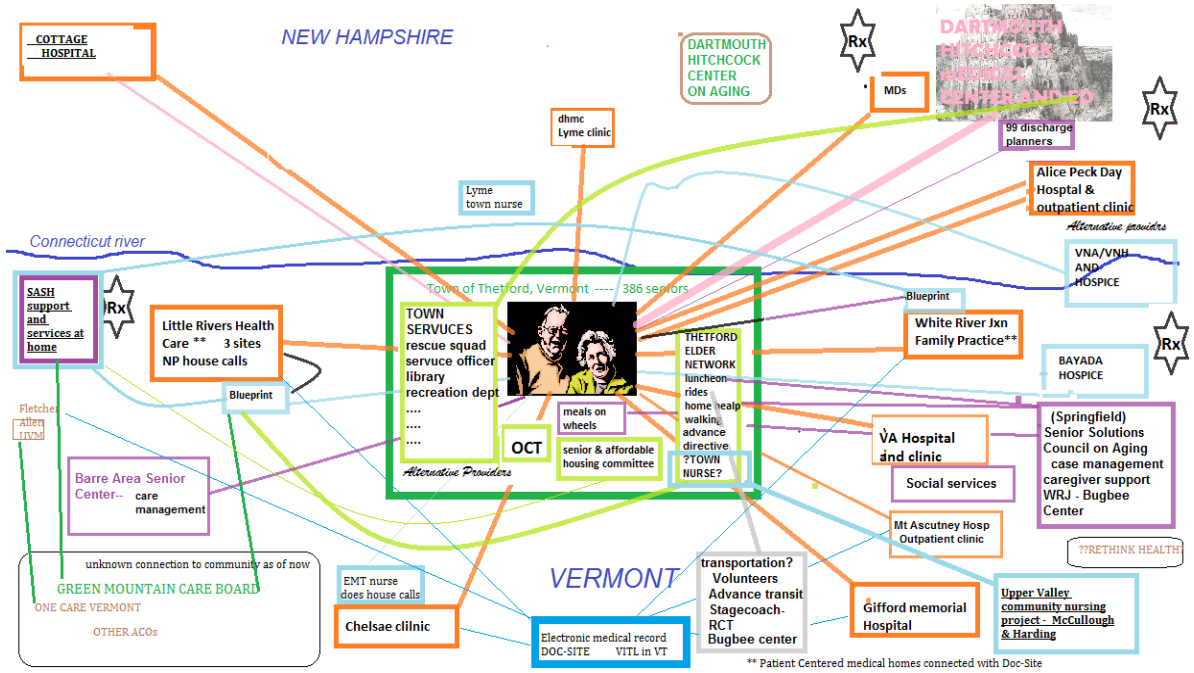
- Home visits by primary care provider
- Integration of VNA and office nursing
- Current payment system is an obstacle
- “It takes a village”



It Takes a Village

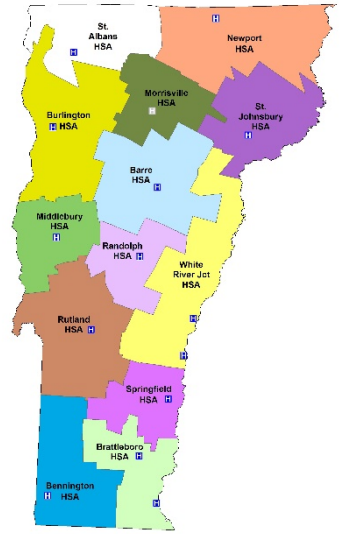
- Family
- Paid caregivers
- Volunteers
- Established programs
- Church community
- Frail elders supporting each other
- Blueprint

MAP OF HEALTH CARE FOR SENIORS IN THETFORD
The Aging Maze



Avoiding Unnecessary, Unwanted Health Care

- 24 hour access to PCP/Medical Home team
- Family/caregiver meetings re Advanced Directive, COLST, code status
- Anticipatory guidance for patient and caregivers
- If hospitalized, consultation with PCP/team
- Phone support for PCPs by specialists
- Focus on comfort at home



Continuity Equals Quality

Innovative payment pilot would be constructed to -

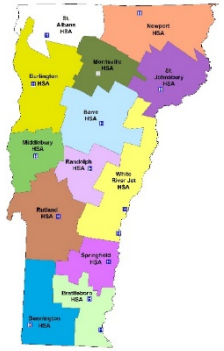
- **Allow PCP's to redistribute their time**
- **Less hurried face-to-face visits**
- **Incentive to take on patients with complex, changing clinical status - patients who will be costly to care for in any case**
- **Frail elderly - PCP time increases exponentially at the end of life**
- **Comprehensive knowledge of medical and psychosocial situation is vital to distinctions between emergencies, disease progression vs. flares of expected symptoms**
- **No algorithm or cookbook protocols**
- **Accessible primary care can decrease suffering and futile medicalization of end-of-life events**

Younger, generally healthy patients can be managed by with other care team members and clerical office staff following evidence-based guidelines and algorithms

Patients with one or two well controlled chronic diseases can also be prompted when routine monitoring, such as blood sugar, blood pressure and cholesterol checks are due, with fewer office visits than is now customary.

If 7% of the population >age 65 meets the criteria of frailty, this is the group of patients primary care practices should be incentivized for extra time and attention, including home visits

Continuity Equals Quality



“We're going to look at the whole panel of patients and try and make that panel healthy, not just concentrate on the 15-minute visit. the primary care physician of the future should probably see about 10 patients a day, should spend real time with those patients. Those should be patients that are complicated, that really need a physician to take care of them."

New England Journal of Medicine
Perspective Roundtable: Redesigning Primary Care
Lee T; H.Bodenheimer T; Goroll A.H.Starfield; B.Treadway K. N Engl J Med 2008; 359:e24

Transitional Care Model

Nursing and primary care coordinate with community partners in a team-based longitudinal setting

Demonstrated significant reductions in re-hospitalization at 6 weeks, 26 weeks and 52 weeks

Mary D. Naylor, PhD, RN, FAAN, Marian S. Ware Professor in Gerontology, Director, New Courtland Center for Transitions and Health, University of pennsylvania School of Nursing
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2753.2011.01659.x/abstract

Proposed Budget
6 Months Duration

Budget Narrative

- The budget is built around the principal activities of the Committee anticipated to occur over the span of six months.
- Four Committee meetings
- Distance telecommunications/Project website
- 10% FTE contribution from the Core Community Practices Community Champion
- 5% FTE contribution from two other clinical opinion leaders representing different regions of the state, different practice constructs and broad professional networks
- 30% FTE project management and support for clinical champions from the VMS Foundation
- A final presentation and report to the funder recommending specific care redesign initiatives, supporting payment constructs and outcome monitoring moving the state towards sensible allocation of health resources for one of its highest risk costly populations

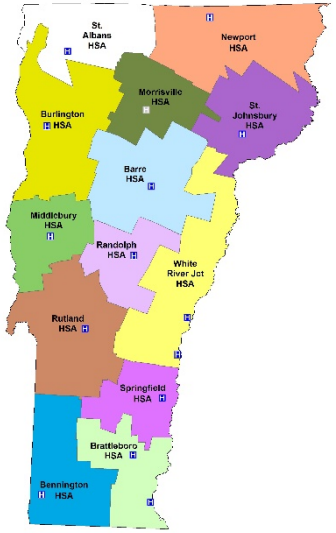
Vermont Medical Society Education and Research Foundation		
Frail Elderly		
November 1, 2014 thru May 30, 2015		
Personnel		
Personnel subtotal	$	27,225
Fringe		
	$	6,806
Travel		
Mileage	$	1,017
Equipment		
	$	-
Supplies, meetings		
Supplies subtotal	$	3,050
Indirect		
	$	3,810
Contracts		
Clinician Community Champion	$	9,075
Regional Clinical expert	$	4,537.50
Regional Clinical expert	$	4,537.50
PI/Measurement	$	3,240
Health economist	$	-
Contracts subtotal	$	21,390
Total		
	$	63,298

VHCIP Payment Models Work Group

Frail Elderly Community-based Care

Care Innovations, Payment Constructs and Value Measures

A Request for a Planning Grant



Actualizing reform thru clinician leadership

Better quality, Better health, Lower costs

Fay Homan MD – Little Rivers Health Care

Cyrus Jordan MD MPH – VMS Foundation

Sarah Kemble MD MPH – Springfield Medical Care Services

Josh Plavin MD MPH – Gifford Health Care

September 16, 2014

VMS Education & Research Foundation

helping physicians help patients & communities

Attachment 4A - Clinical Priorities Survey Results

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

St. Joseph's 7, UHC Campus, 1 South Prospect Street, Burlington, Vermont 05401
802 656 8210 TEL 802 656 8368 FAX

www.vchip.org

Table 2. Top 20 Important Health Conditions[6] Identified by Patient-Centered Medical Homes (PCMH's) in Vermont During Their Most Recent Survey

Rank	Condition	# of Practices
1	Diabetes	93
2	Hypertension	74
3	Tobacco Use	34
4	Asthma	33
5	Obesity	26
6	Depression	26
7	ADHD	18
8	Well-Child (2 year old)	15
9	Hyperlipidemia	13
10	Well Child (age not specified)	6
11	Pharyngitis	6
12	Chronic Obstructive Pulmonary Disease (COPD)	4
13	Chronic Pain	3
14	Opiate abuse	3
15	Congestive Heart Failure (CHF)	3
16	Well child (9 mo)	2
17	Coronary Heart Disease (CAD)	2
18	Anxiety	2
19	Well-Child (12 mo)	1
20	Pregnancy (prenatal care)	1

Table 3. Top 25 Preventative Services[7] Identified by Patient-Centered Medical Homes (PCMH's) in Vermont During Their Most Recent Survey

Rank	Preventative Services	# of Practices
1	Breast cancer screening (Mammogram)	44
2	Colorectal cancer screening (Colonoscopy)	40
3	Cervical cancer screening (Pap smear)	26
4	Pneumococcal vaccine (Pneumovax)	22
5	Influenza vaccine	19
6	Lead screening	18
7	MMR vaccine	15
8	DTAP vaccine	13
9	Well child visit	8
10	Physical exam	7
11	HPV vaccine	5
12	Zoster vaccine (Zostavax)	5
13	Hemoglobin	5
14	Annual Medicare Wellness visit	5
15	Smoking Cessation Intervention	4
16	Bone Density Screen	4
17	IPV vaccine (Polio)	3
18	Cholesterol screening	3
19	Hearing screening	2
20	Developmental screening	2
21	Immunizations (2 year)	1
22	Oral Risk Assessment	1
23	Blood sugar reading	1
24	Abdominal Aortic Screen	1
25	MCHAT Screening	1

[6]Practices can choose up to 3 important health conditions. Includes practices VCHIP scored but have not been officially recognized by NCQA (at the time the dashboard was updated). Excludes closed practices.

[7]Practices can choose up to 3 preventative services. Includes practices VCHIP scored but have not been officially recognized by NCQA (at the time the dashboard was updated). Excludes closed practices.

Attachment 3 - TCOC Expansion in VMSSP

TCOC Expansion in VMSSP

Year Two Discussion

Background

- VMSSP Year 2 includes an optional track for ACOs willing to expand the core services for which they will be accountable;
- In exchange, the ACOs will receive an "enhanced" sharing rate of 60%;
- This rate would continue through Year 3 when ACOs will be required to expand the base of core services.

Background

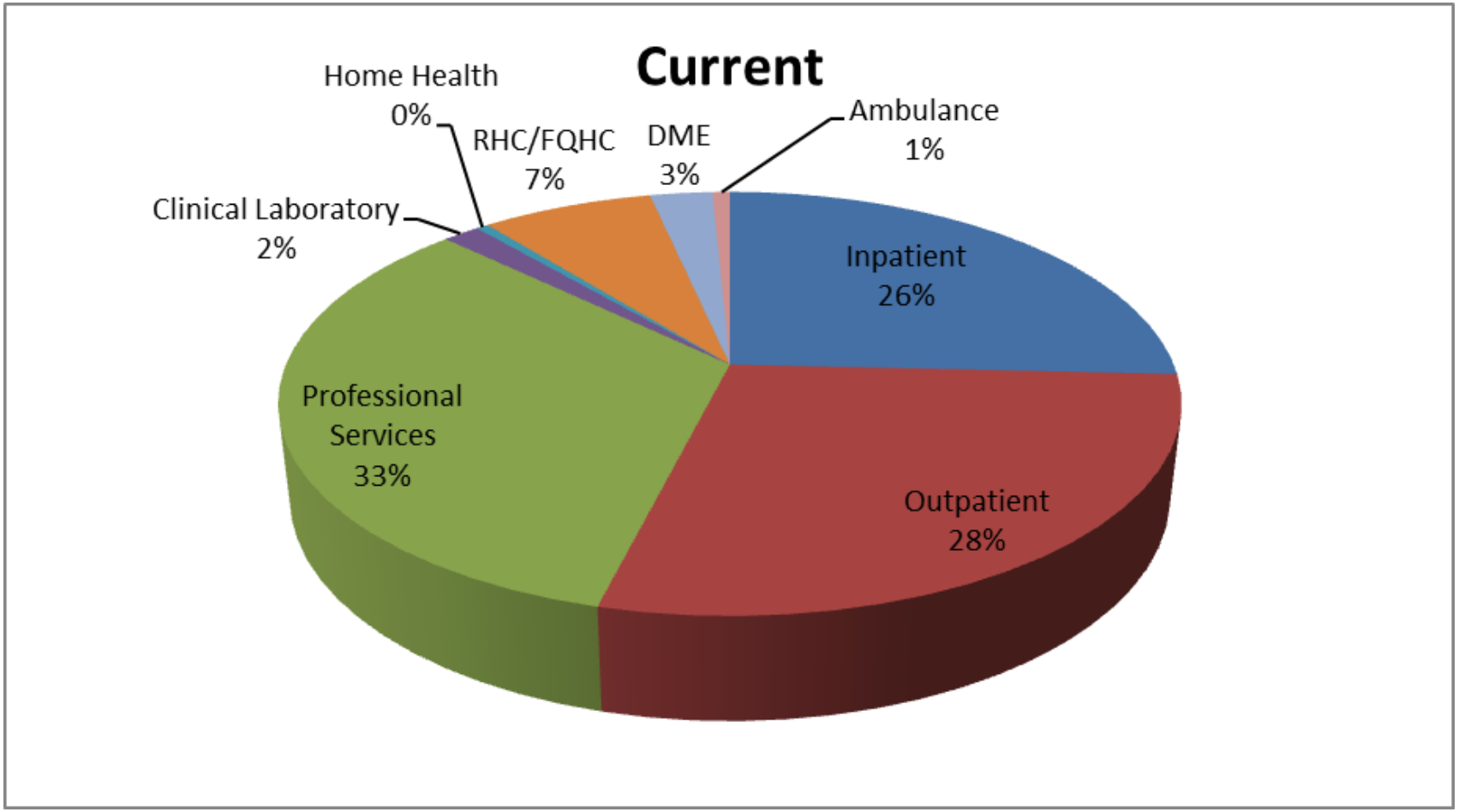
- Process for consideration of inclusion of additional core service costs:
  - What are the advantages and disadvantages for including these costs in the base?
  - What is the operational feasibility of including these costs?

Background

- Year Two Focus
  - Pharmacy
  - Pediatric Dental
  - Adult Dental
  - Non-emergency Transportation (NEMT)
  - Medically-necessary personal care services
  - Primary Care Case Management (PCCM) and Community Health Team (CHT) payments

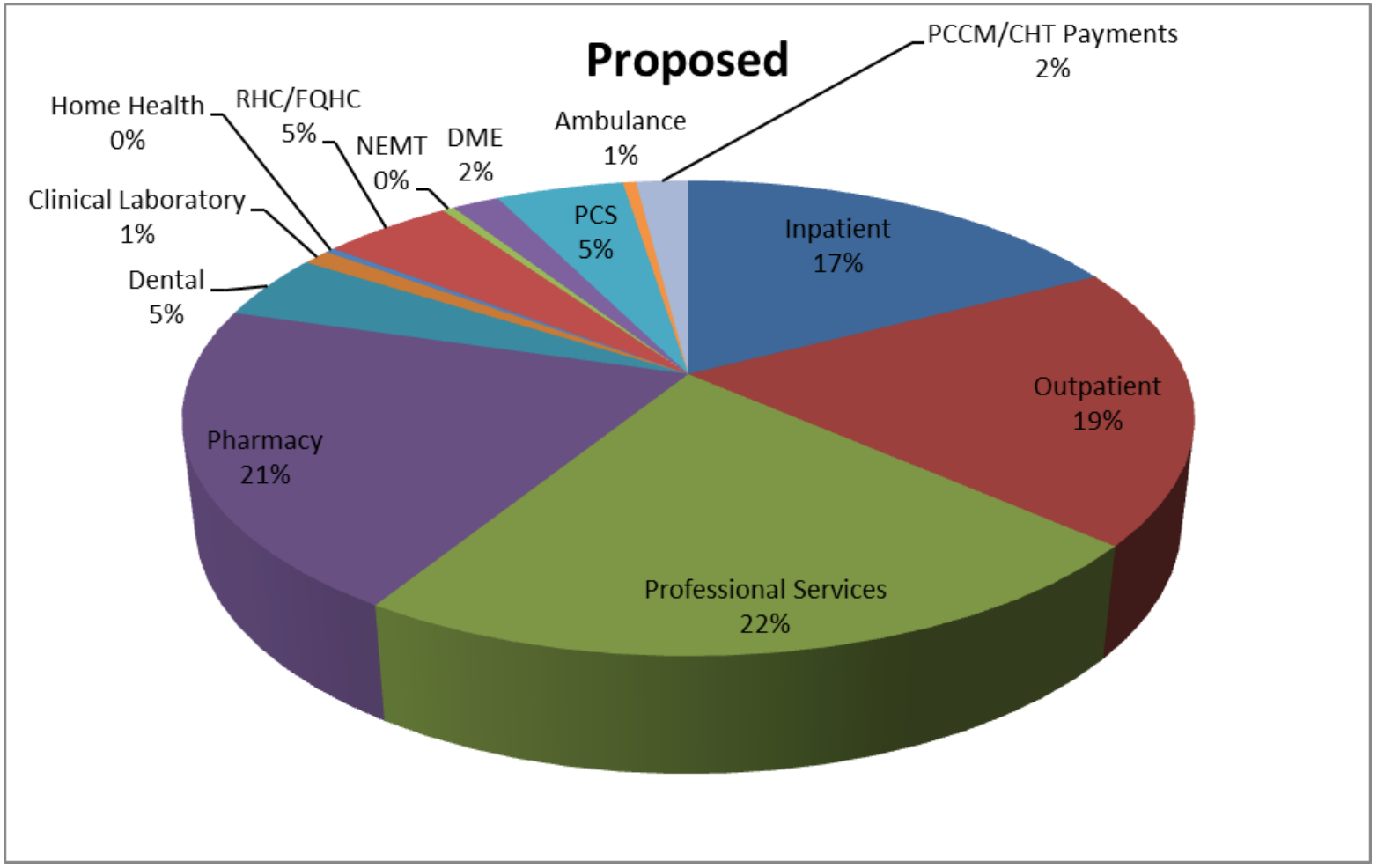
- Year Three Focus
  - Specialized service programs
    - Mental Health Programs
    - DLTSS/CFC Programs
    - Public Health Programs
    - School-based Programs
    - Substance Abuse Programs

Breakdown of Core Service Spend*



*Figures are estimated and subject to change

Breakdown of Core Service Spend*



*Figures are estimated and subject to change

Approximate Increase in $$'s Under Program with New TCOC

- ~$200 million in spending in VMSSP Year 1 TCOC for attributed beneficiaries
- Adding all proposed categories would increasing spending by ~50% to $300 million
- Pharmacy is the largest new category, followed by personal care services and dental

NOTE THESE ARE ROUGH ESTIMATES BASED ON ESTIMATED ATTRIBUTED POPULATION AND SPEND, SUBJECT TO CHANGE

Year Two Expansion of TCOC

CORE SERVICES UNDER CONSIDERATION

Pharmacy

Advantages

- Pharmacy costs are a large component of total spend
- Research supports that effective management of prescription drugs could drive savings and improve outcomes

Pharmacy

Disadvantages

- Other SSPs have not yet included pharmacy
- ACOs uncertain about their ability to control these costs as benefit administered under a PBM
  - However, given physicians are primary prescribers, they will have some control over the frequency, length, and number of medications prescribed
  - ACOs can look across all providers and help ensure coordination among primary care and specialists
  - ACOs can also help drive best practices related to prescribing

Pharmacy

Operational Feasibility

- Non-claims based 340b reconciliation was a hurdle when considering adding pharmacy for Year 1
- We have identified an approach that would allow for adjustment due to 340b
- Will require an update to the methodology described in the contracts, current standards and pending SPA

Dental

Advantages

- Encourages more active coordination between medical and dental providers
  - Anecdotal evidence suggests that many patients use ER for dental services that could otherwise be seen in dentist offices
  - May promote ED diversion programs trend
  - Well established that good preventative dental care has long term positive impact on health outcomes
- Annual dental visits is currently a M&E measure

Dental

Disadvantages

- Other SSPs have not included dental costs
- ACOs uncertain about their ability to control these costs
- There are different benefit designs between adults and pediatric populations
  - Adult benefit is capped
  - Pediatric is not

Dental

Operational Feasibility

- FQHC-based dental services include a retrospective reconciliation
- Would require additional adjustment to costs represented in claims
- Will require an update to the methodology described in the contracts, current standards and pending SPA

Non-emergency Transportation (NEMT)

Advantages

- Encourages more active coordination and cost-effective use of NEMT benefit
  - Well established that transportation is barrier to seeking care among Medicaid population
  - Some examples nationally of innovative use of NEMT to improve costs and quality of care

Non-emergency Transportation (NEMT)

Disadvantages

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

Non-emergency Transportation (NEMT)

Operational Feasibility

- A major change in payment methodology occurred in the benchmark years; thus,
- Comparing costs to the performance years would require additional adjustment in both expected and actual cost calculations; and,
- Would require an update to the methodology described in the contracts, current standards and pending SPA

Personal Care Services (PCS)

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

Advantages

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

Personal Care Services (PCS)

Disadvantages

- ACOs uncertain about their ability to control these costs and/or whether using more PCS may help reduce spending for other services
- Some spending for these type of services are not under the medical benefit

Personal Care Services (PCS)

Operational Feasibility

- A change in payment methodology occurred in the benchmark years; thus,
- Comparing costs to the performance years would require additional adjustment in both expected and actual cost calculations; and,
- Will require an update to the methodology described in the contracts, current standards and pending SPA

Primary Care Case Management (PCCM) and CHT Costs

NOTE: Excludes NCQA P4P Payments

Advantages

- More accurately accounts for costs of services to support beneficiaries
- May improve use or expansion of these services to control costs and improve quality
- Currently included in commercial SSP

Primary Care Case Management (PCCM) and CHT Costs

Disadvantages

- Population-based payments, so not inherently possible to “save on these costs”;
- Said another way, including would grow the base from which to calculate savings, but there is no savings possible from these dollars specifically

Primary Care Case Management (PCCM) and CHT Costs

Operational Feasibility

- These are not paid via claims and historic trends may not match actual
- Would require additional adjustment to costs represented in claims and in both expected and actual cost calculations
- Will require an update to the methodology described in the contracts, current standards and pending SPA

Summary

Specific input is requested on the following:

- Overall approach to inclusion of new core services in the Year 2 TCOC
  - Pharmacy
  - Dental
    - Given the adult dental cap, is it appropriate to include both adult and pediatric costs or just pediatric?
  - NEMT
  - Medically-necessary/Acute PCS Services
  - Case Management and CHT Costs

Request for Input

- Please submit feedback on the inclusion of those services by **Friday, September 26, 2014**

- Please email to Amanda Ciecior at amanda.ciecior@state.vt.us

Attachment 4B - Episode Criteria Matrix

EOC	EOC is of interest to Providers	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	Raw Score
DIAB	3	3	3	3	3	3	3	21
ASTHMA	3	3	3	2	3	3	3	20
PNE	3	1	3	3	3	3	3	19
COPD	2	3	3	3	2	3	3	19
HTN	3	3	1	2	3	3	3	18
CHF	**2**	**2**	1	3	3	3	2	16
VAGDEL	2	2	3	3	1	3	2	16
CAD	1	1	3	2	2	3	3	15
GERD	1	1	3	3	2	2	3	15
STR	2	2	1	2	2	2	3	14
PREGN	1	2	3	1	2	3	2	14
COLOS	3	1	3	1	1	1	2	12
AMI	1	2	1	2	1	2	2	11
EGD	1	1	3	2	1	1	2	11
COLON	3	1	1	3	1	1	1	11
GBSURG	1	1	3	2	1	1	2	11
CSECT	1	1	3	1	1	2	2	11
CxCABG	1	1	1	3	2	1	1	10
PCI	1	1	2	2	2	1	1	10
HYST	1	1	2	1	1	2	2	10
KNARTH	1	1	2	1	1	1	1	8
HIPRPL	1	2	1	1	1	1	1	8
KNRPL	1	1	1	1	1	1	1	7

Attachment 5 - EOC Payer Compare Presentation

Vermont Episodes – A Comparison of Commercial and Medicaid Payers

September 16, 2014

Payment Models Work Group

Vermont Episodes – A Comparison of Commercial and Medicaid Payers

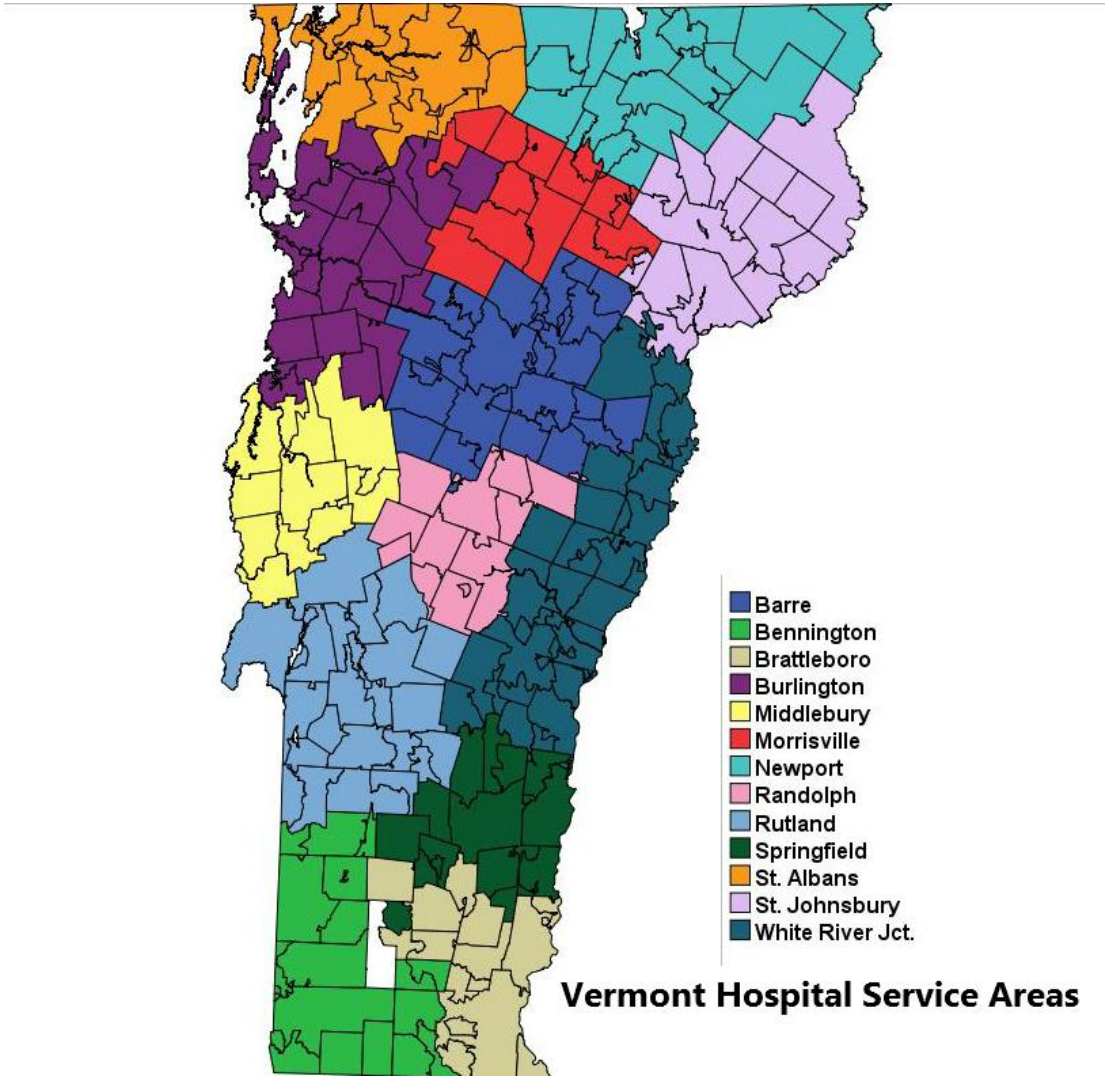
BACKGROUND INFORMATION

Episode List

Coronary artery disease - CAD
Congestive heart failure - CHF
Acute myocardial infarction - AMI
Pneumonia - PNE
Chronic obstructive pulmonary disease - COPD
Asthma - ASTHMA
Complex coronary artery bypass graft - CxCABG
Percutaneous coronary intervention (Angioplasty) - PCI
Diabetes - DIAB
Knee replacement and knee revision - KNRPL
Knee arthroscopy – KNARTH
Hip replacement and hip revision - HIPRPL

Gastro-esophageal reflux disease - GERD
Esophagogastroduodenoscopy upper GI (Endoscopy) - EGD
Colon resection - COLON
Colonoscopy - COLOS
Gall bladder surgery - GBSURG
Hysterectomy - HYST
Vaginal delivery - VAGDEL
Cesarean section - CSECT
Hypertension - HTN
Stroke - STR
Low risk and high risk pregnancy – PREGN

Health Service Area Map



**Null refers to services provided outside of Vermont*

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

Important Notes

- If an average is provided, the total has been annualized. If a total is provided, the total includes costs summed from 2008-2012
- Savings from CSECT and VAGDEL are rolled into a single PREGN episode
- The graphic scales on the Medicaid and Commercial charts may not be the same; please be aware if doing visual comparisons

Vermont Episodes – A Comparison of Commercial and Medicaid Payers

DATA BOOK

Explanation of Data

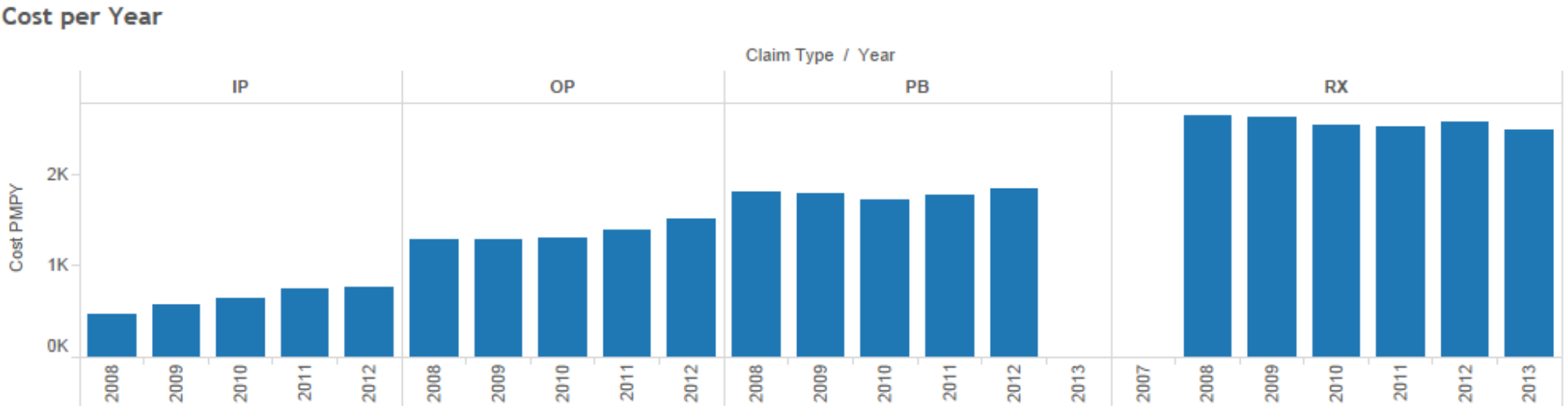
- Total Costs include claims that are assigned to multiple episodes to give an accurate measure of cost of each category of episode in isolation. However, this also means that some costs are double counted and episode costs for each category should not be summed together to a grand total.
- Average episode costs reflect the average costs of each episode after trimming outliers and are presented for the level at which they are complete. Costs for chronic conditions reflect annual costs. Costs for all others episodes are for the length of the episode as defined by episode duration limits
- PAC % is the total costs attributed to potentially avoidable complications divided by the total costs in each episode type
- Provider comparison data is only available when there is a provider who had 50 or more patients per episode. If it is noted the top 26 providers are illustrated, there are significantly more than could be shown.
- The percent contribution chart shows the variation of price, service mix and volume in the overall episode cost – the higher percentage the greater the influence of that factor on cost variation
- Potential savings are derived by determining the 80th percentile of episode costs and reducing episodes above that amount down to that amount. Episodes above the 98th percentile are excluded from the calculation to avoid factoring in outliers that might be covered to stop loss provisions

Data Book Slide 10

TOTAL EPISODE COSTS

Total Episode Costs

Medicaid



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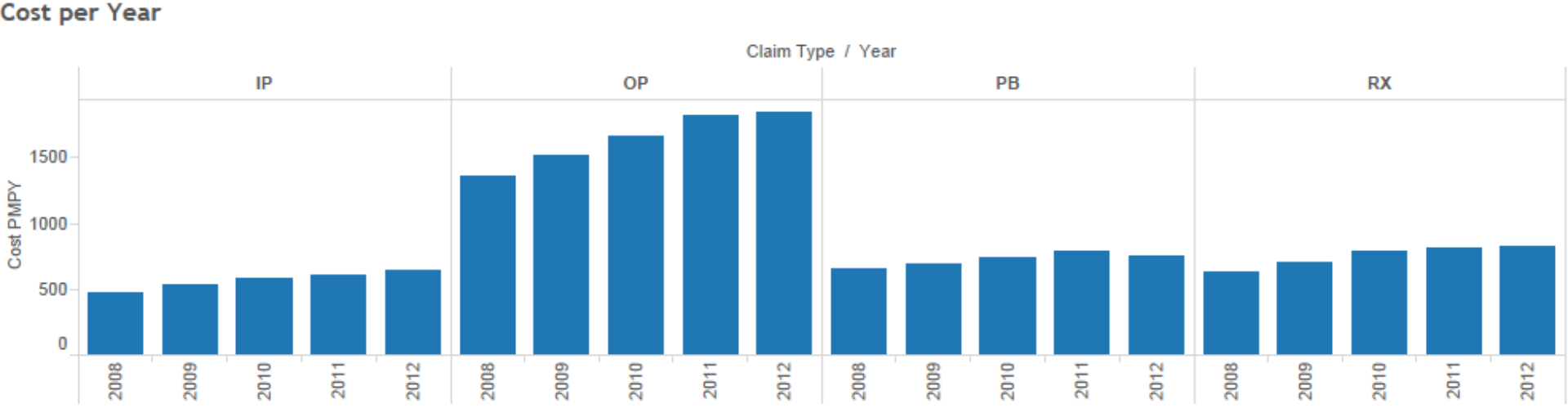
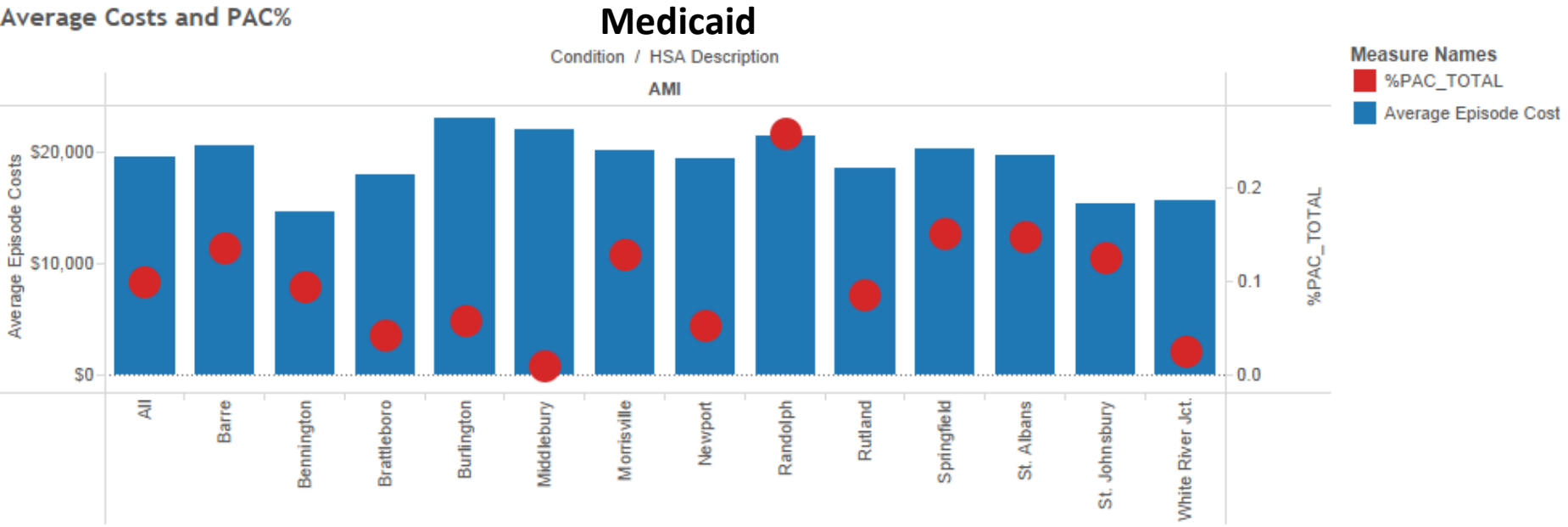
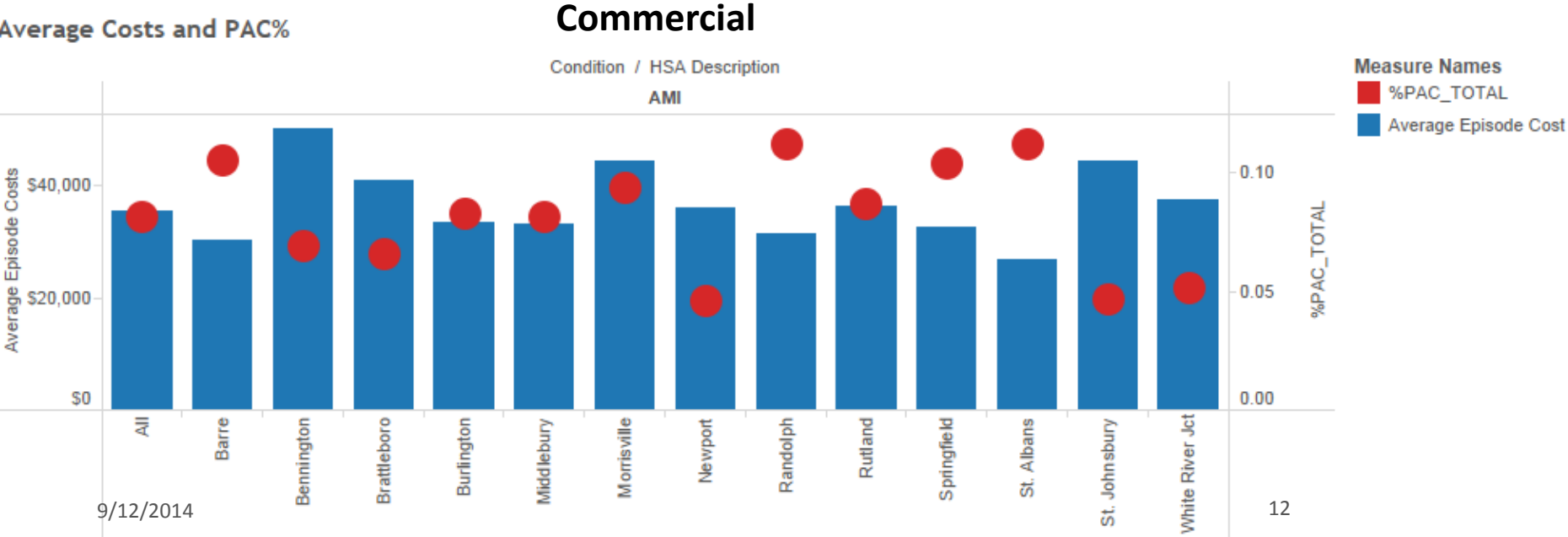


Data Book Slides 12-34

AVERAGE COST AND PAC %

Average Cost and PAC % by Episode





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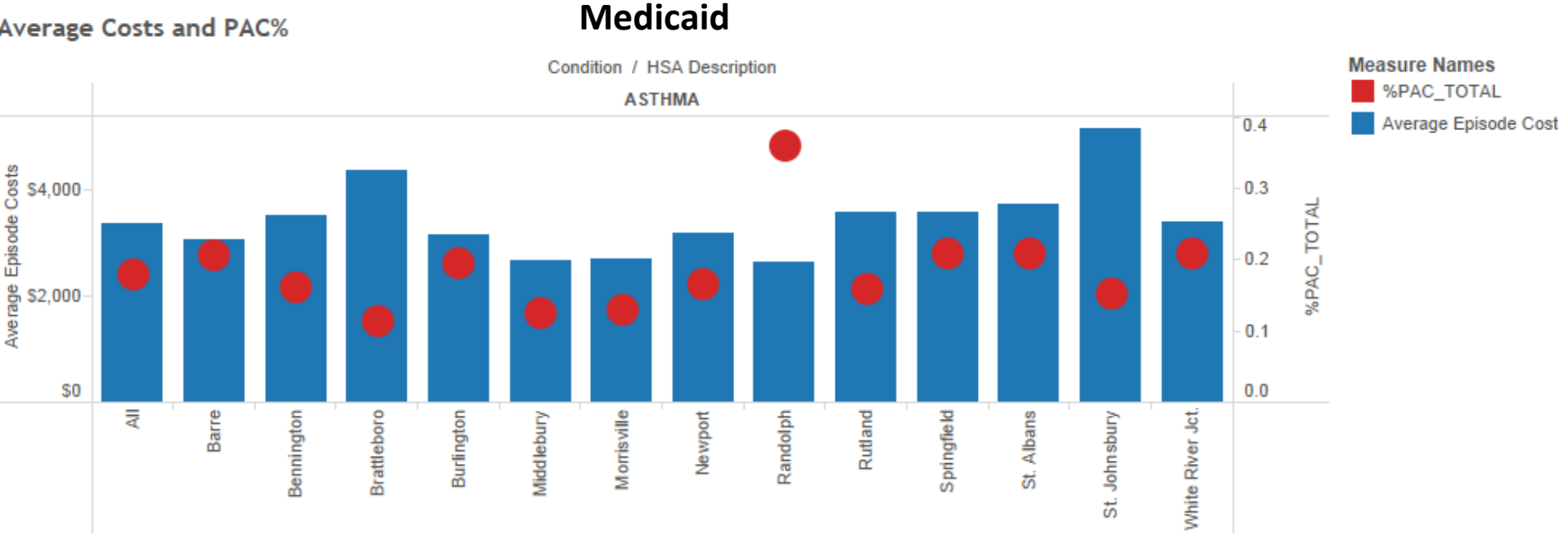

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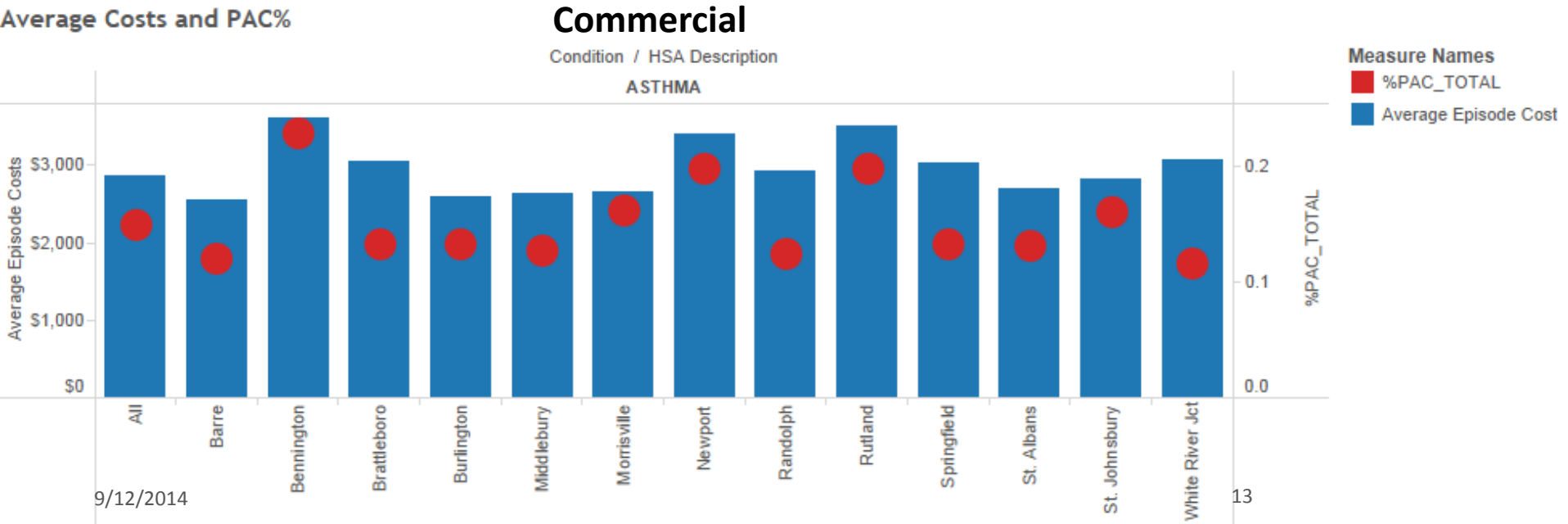

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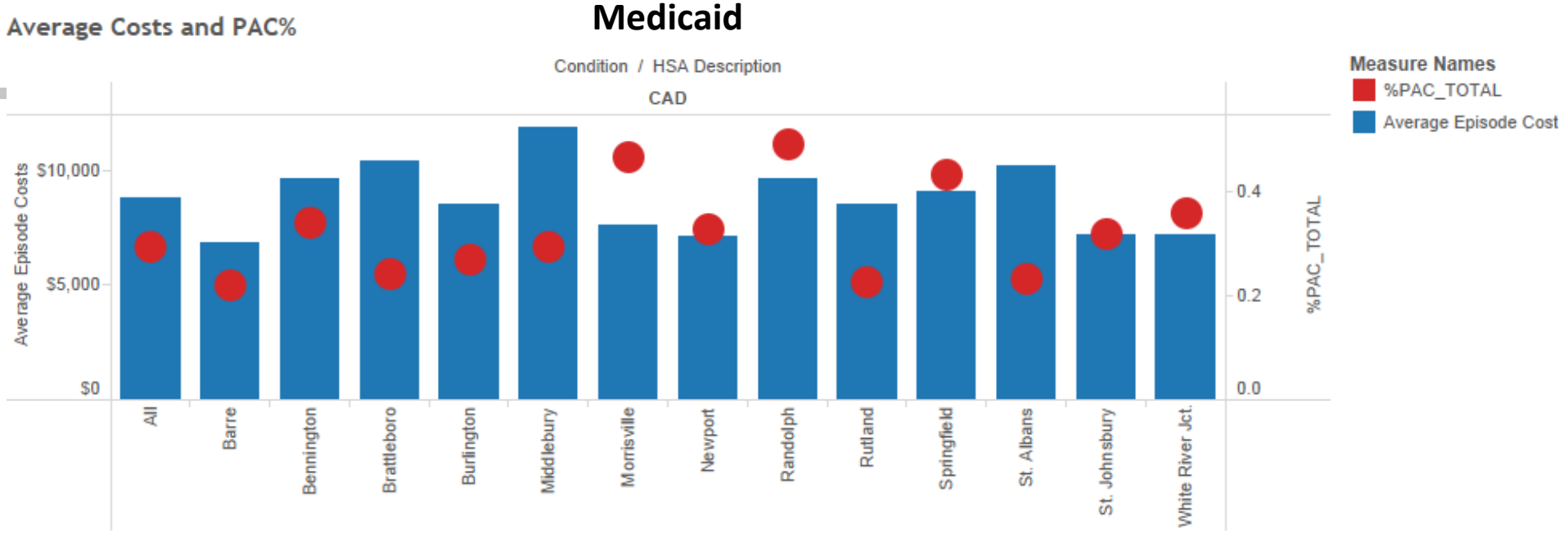

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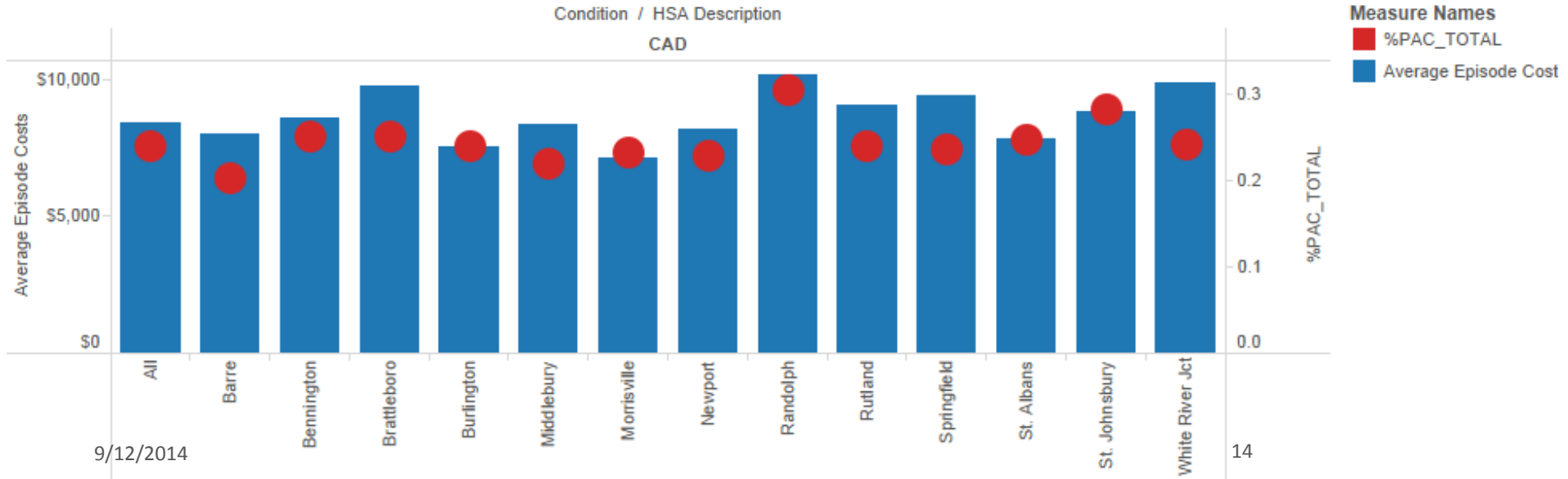

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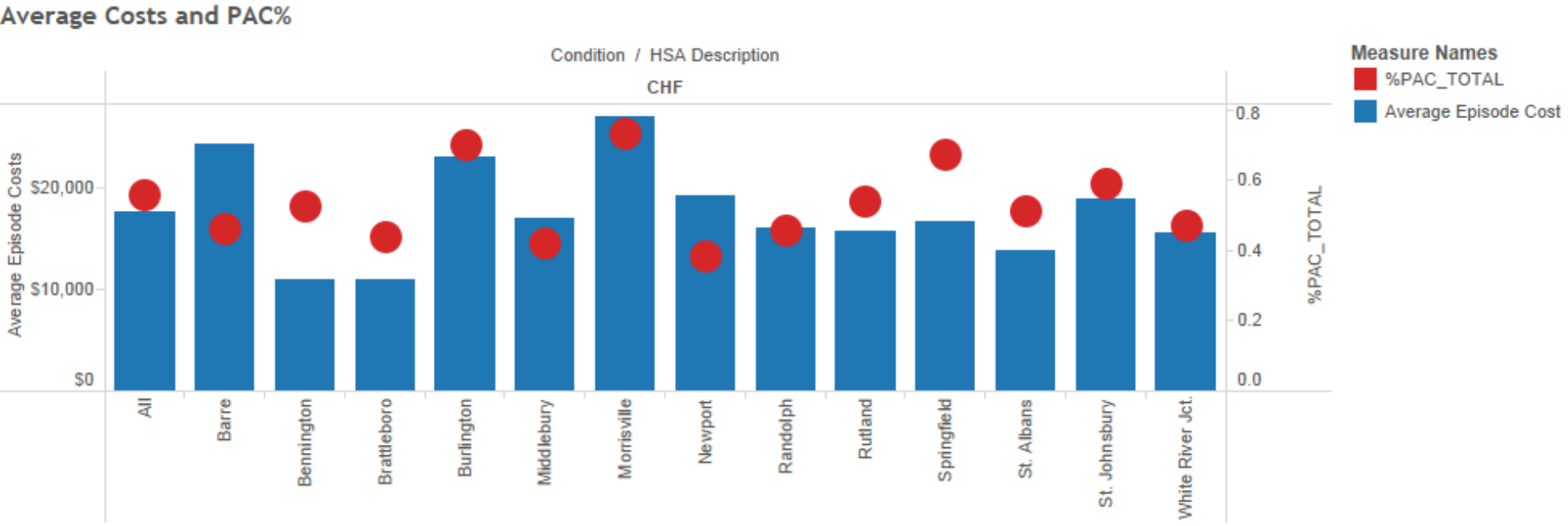

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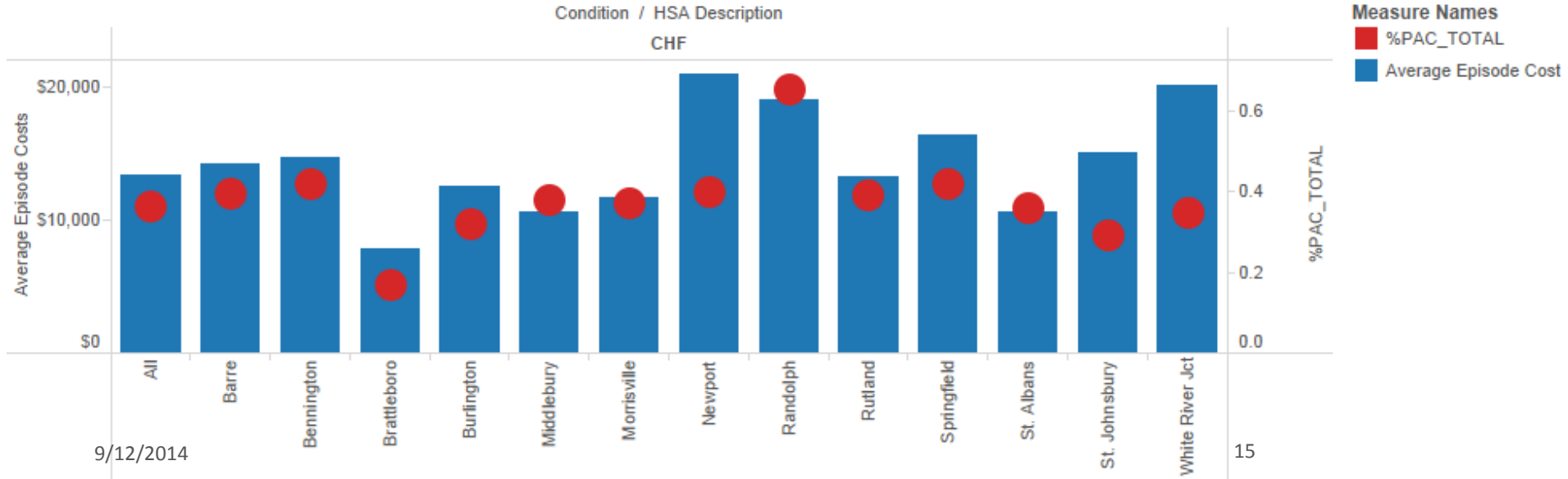

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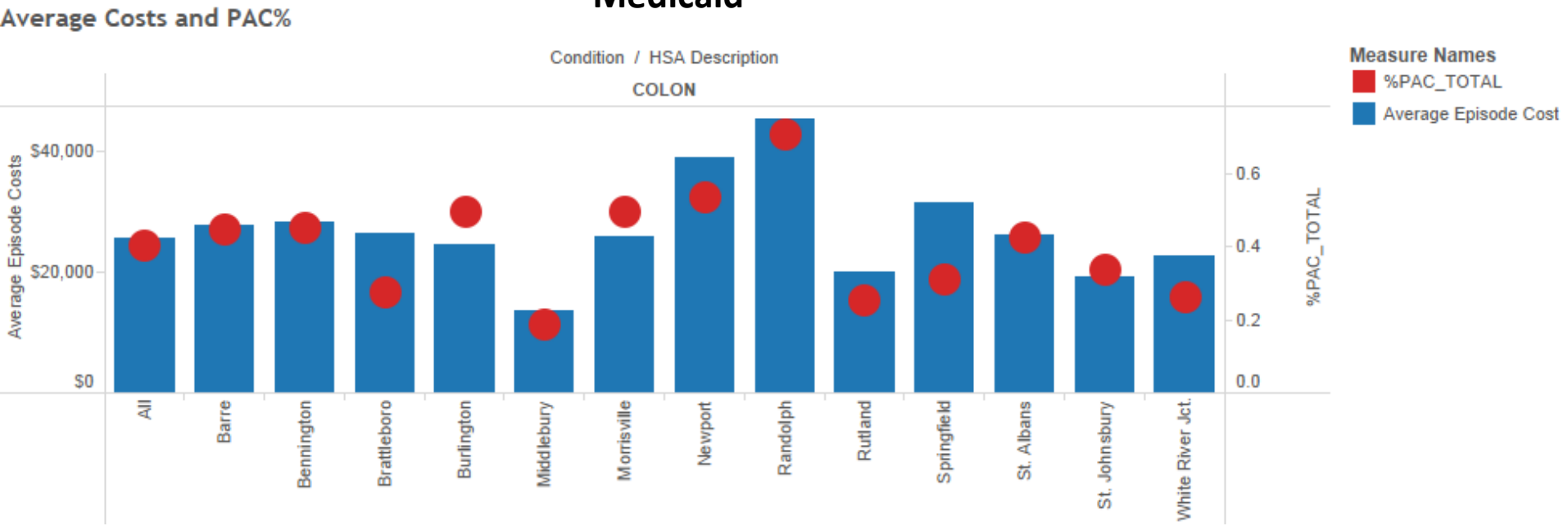

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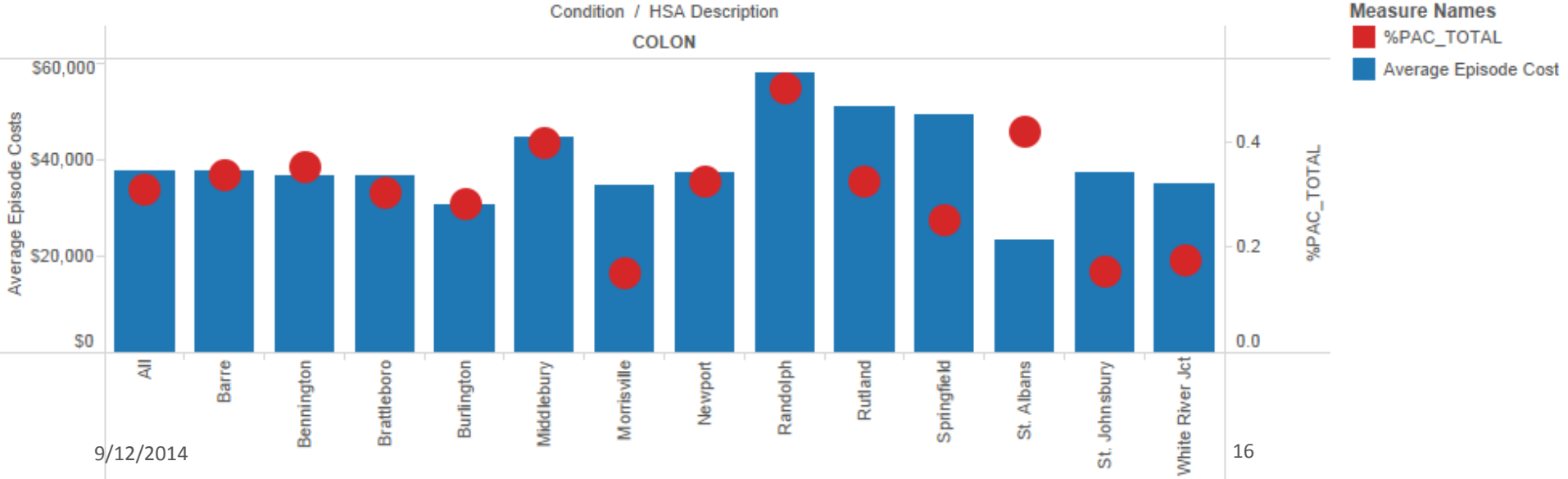

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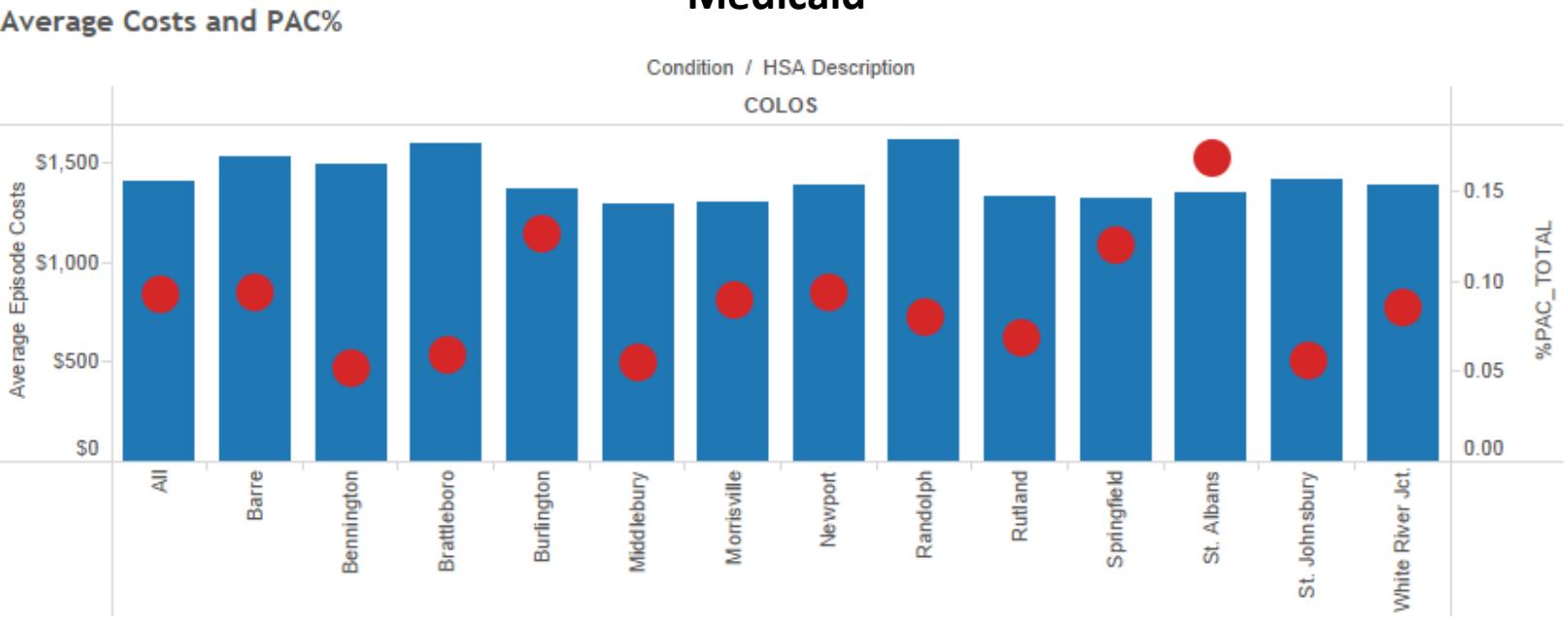

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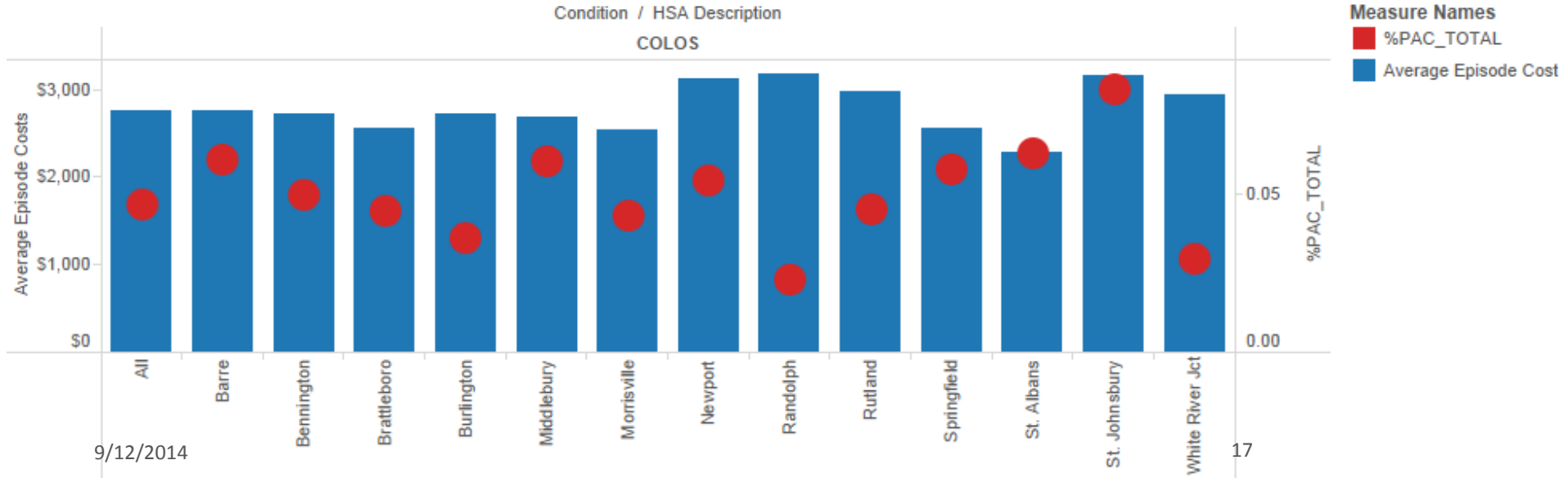

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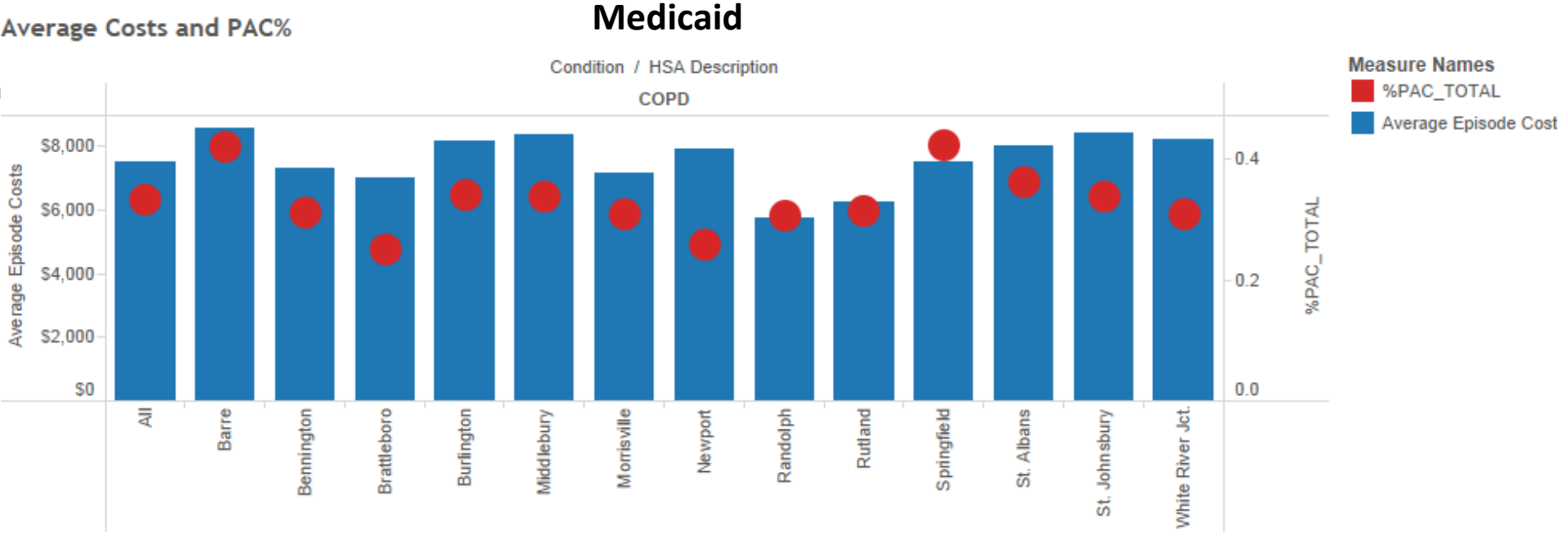

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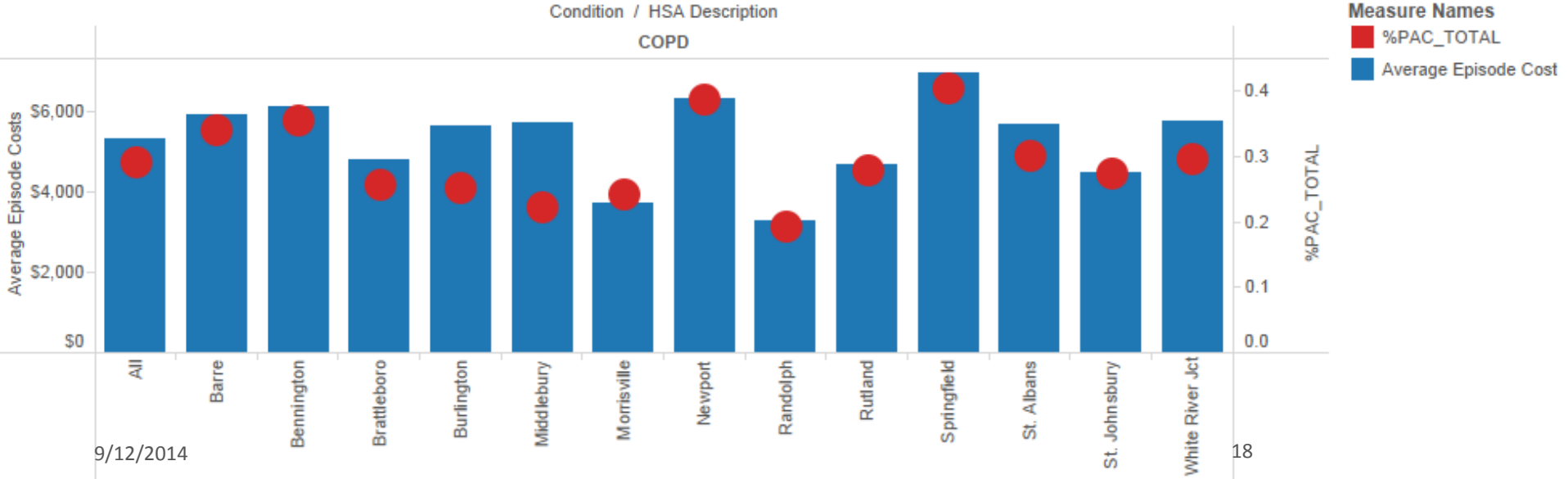

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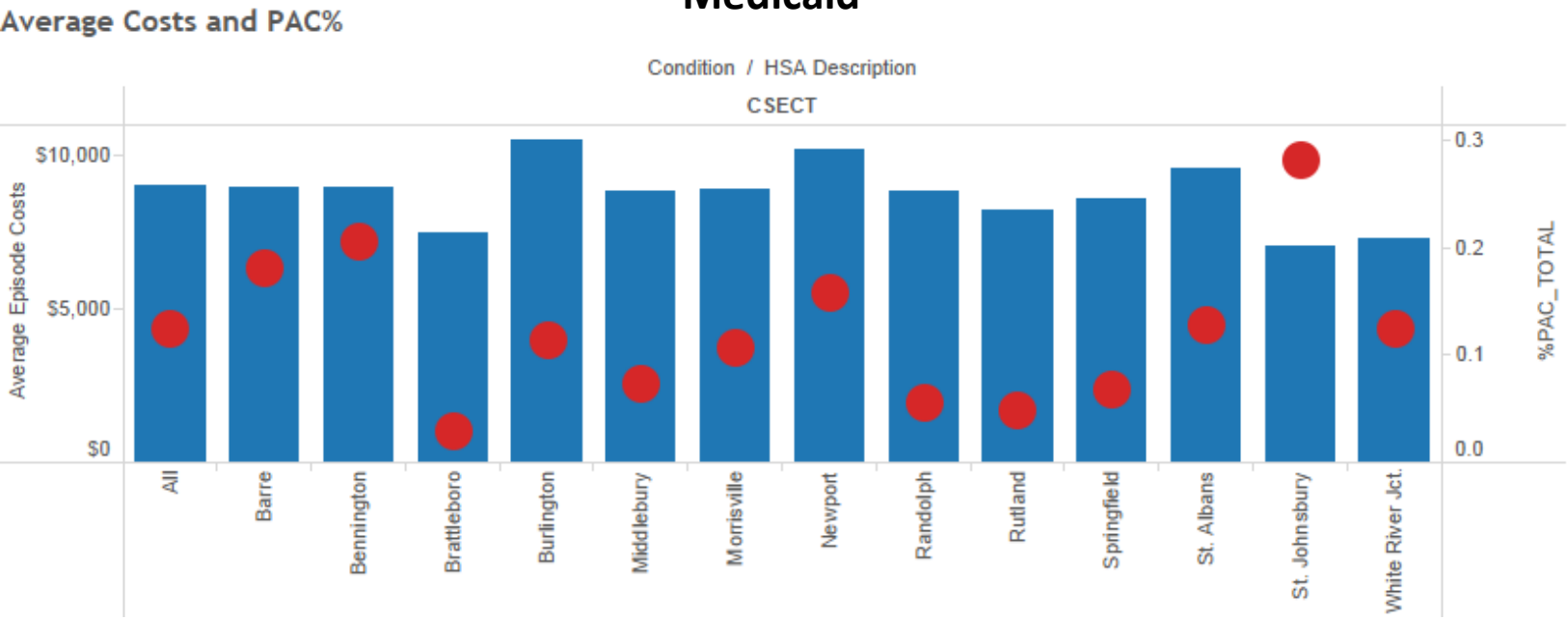

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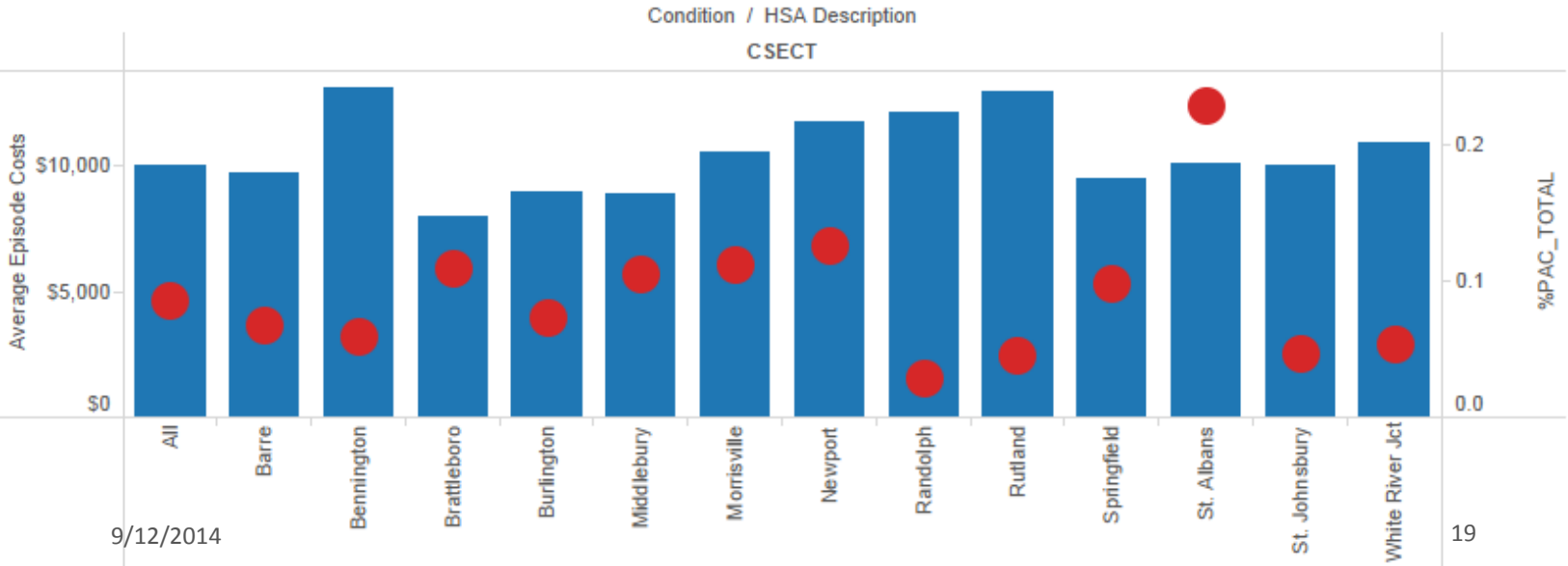
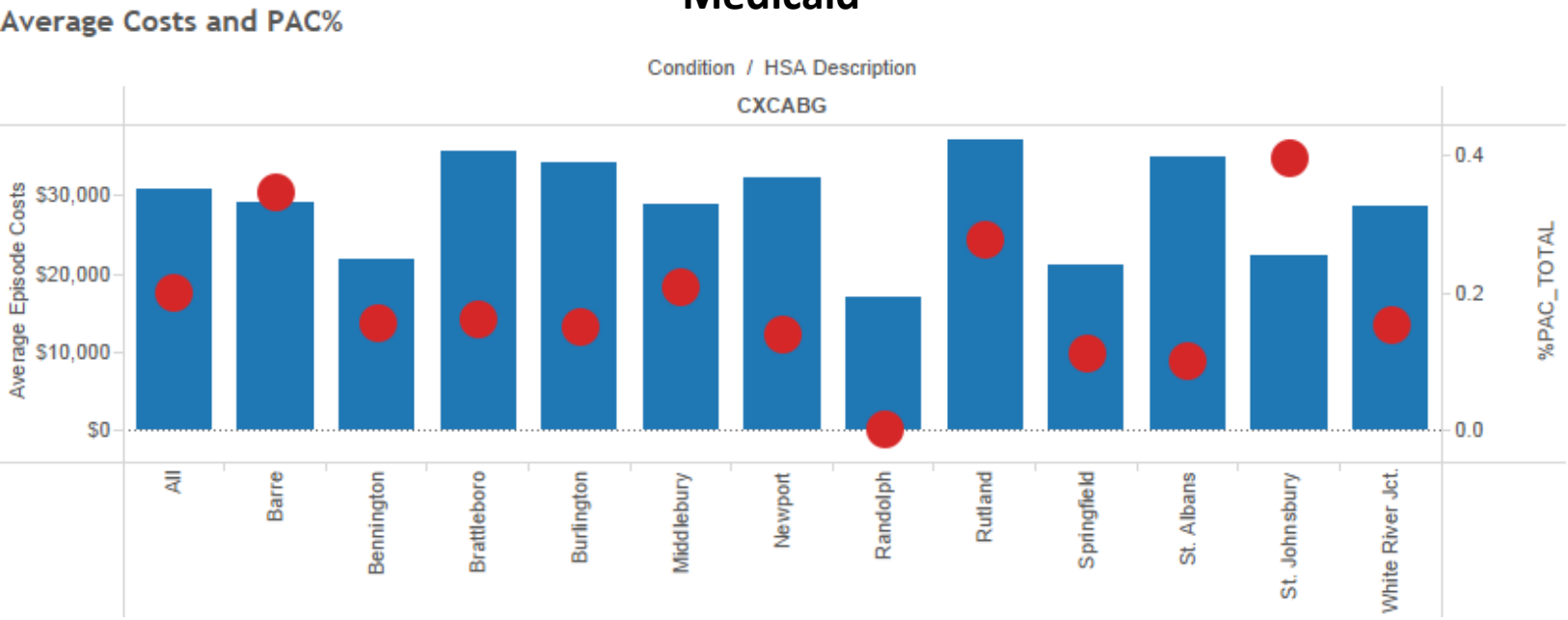


Medicaid



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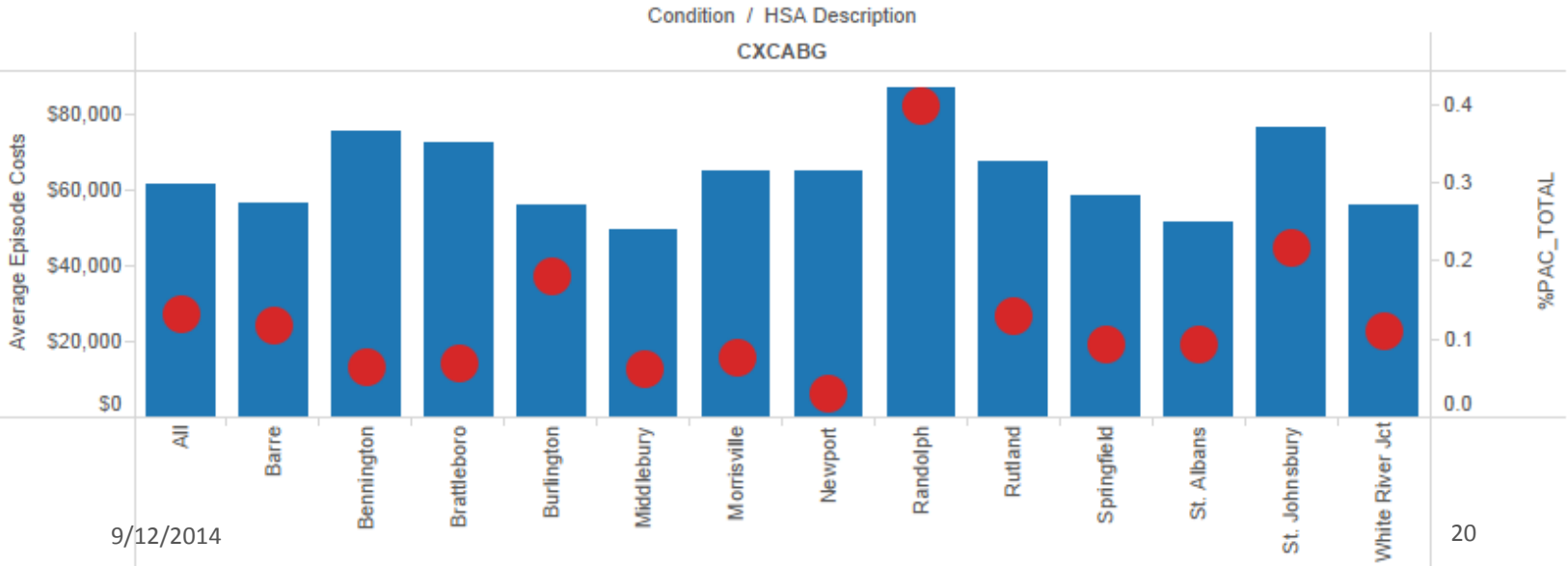
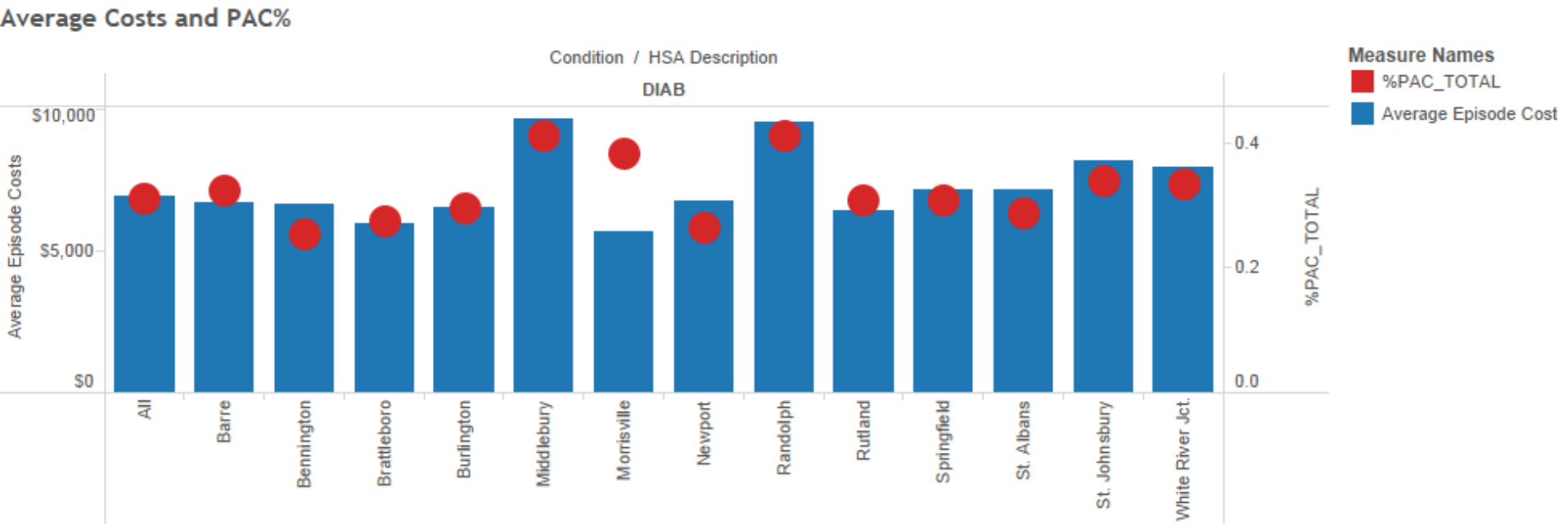


Medicaid



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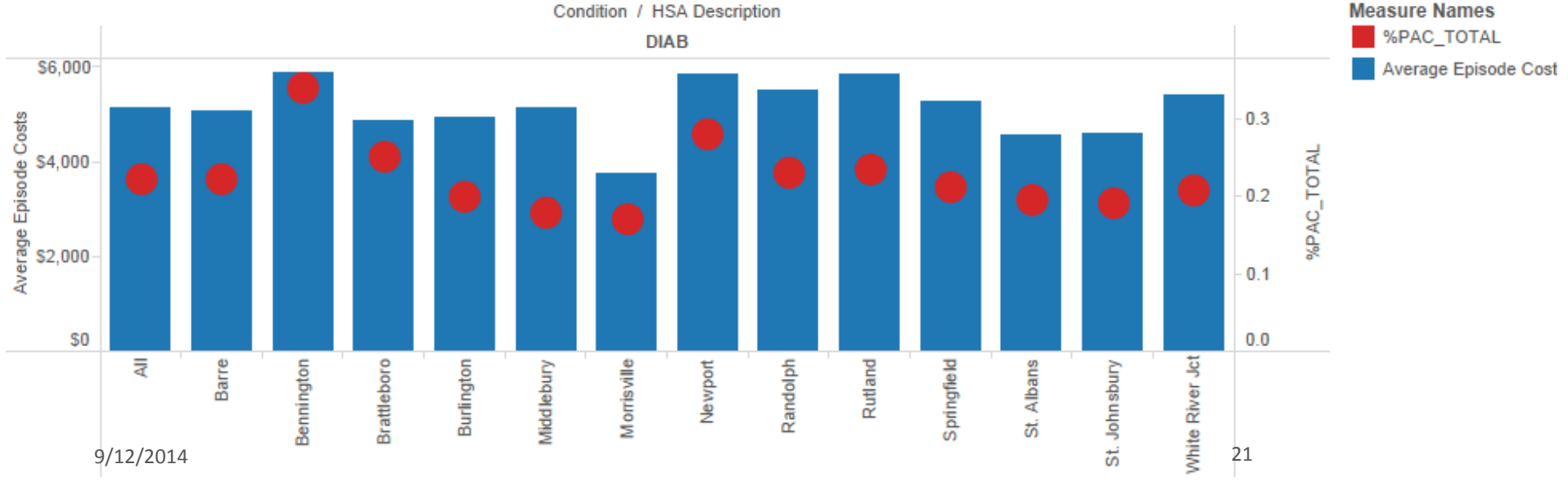

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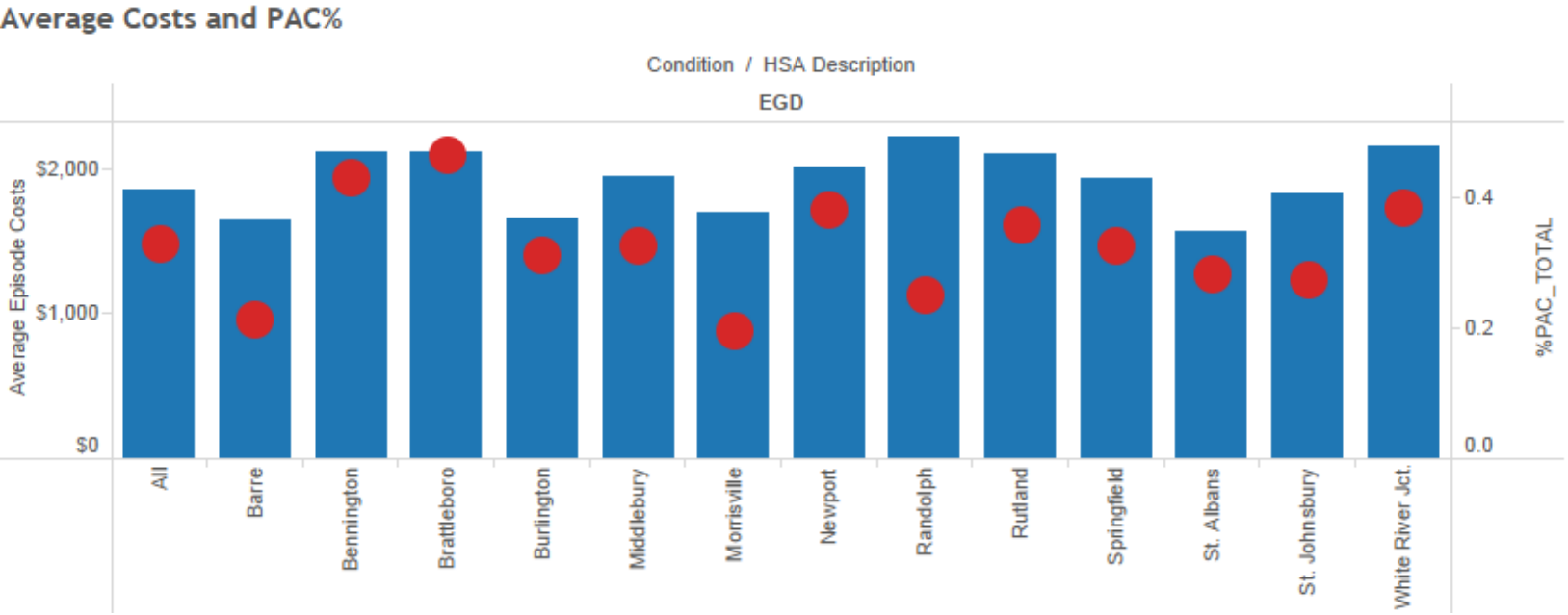

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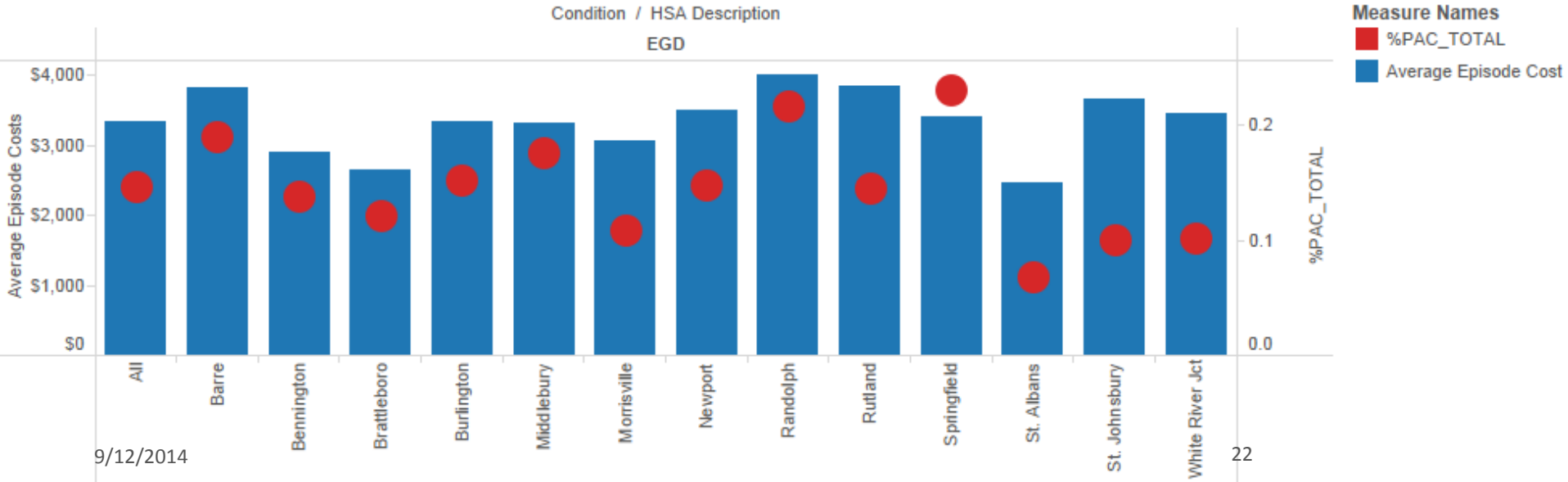

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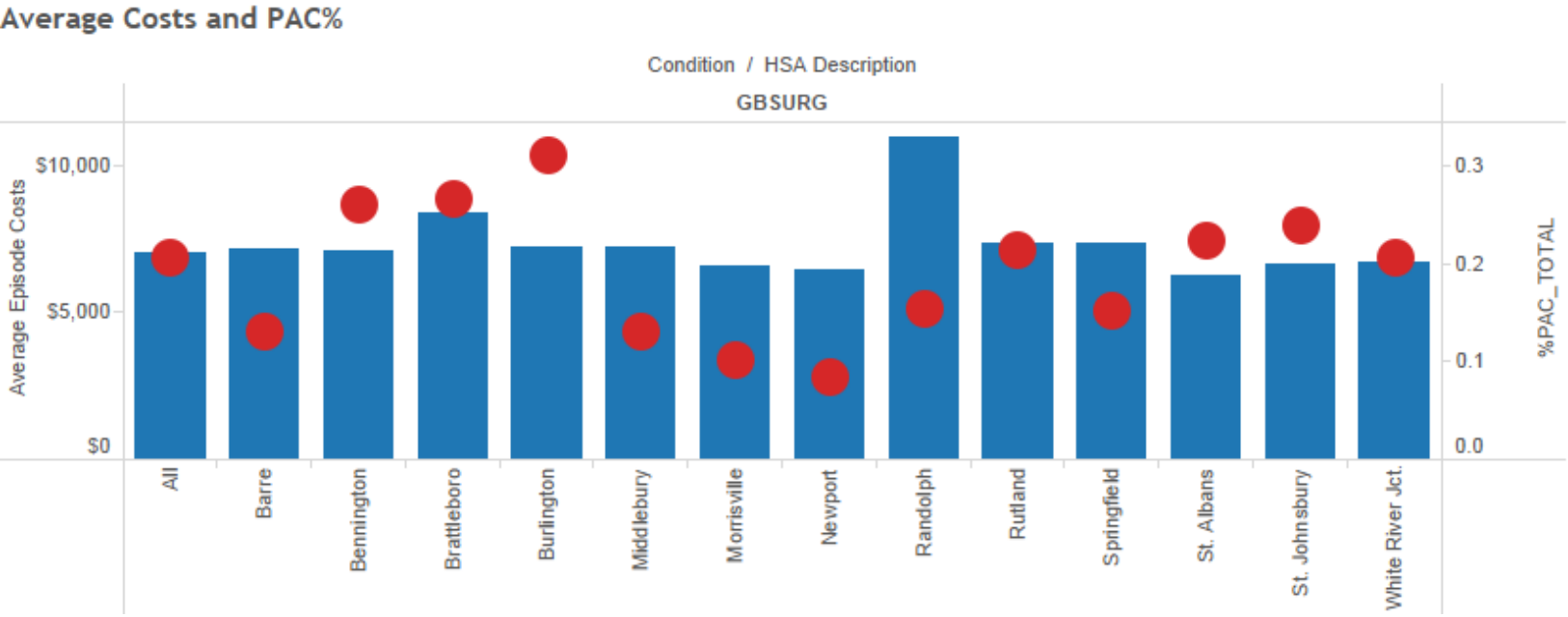

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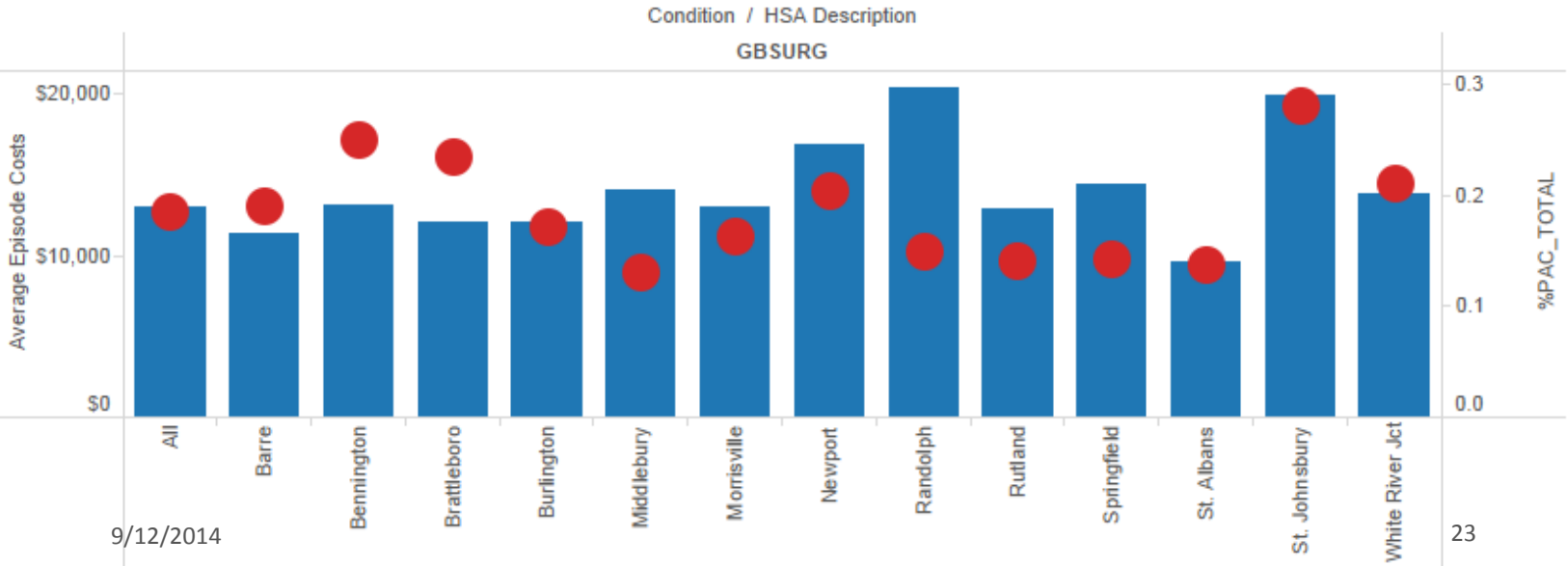

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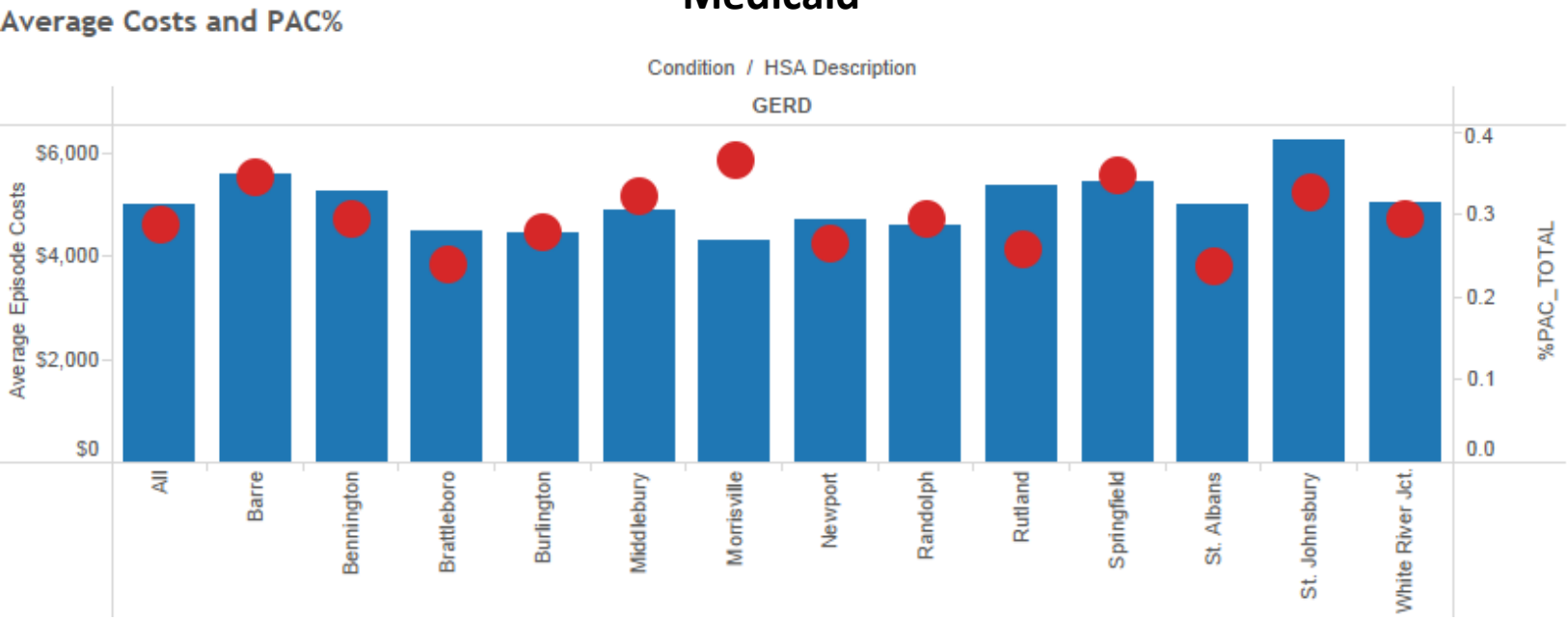

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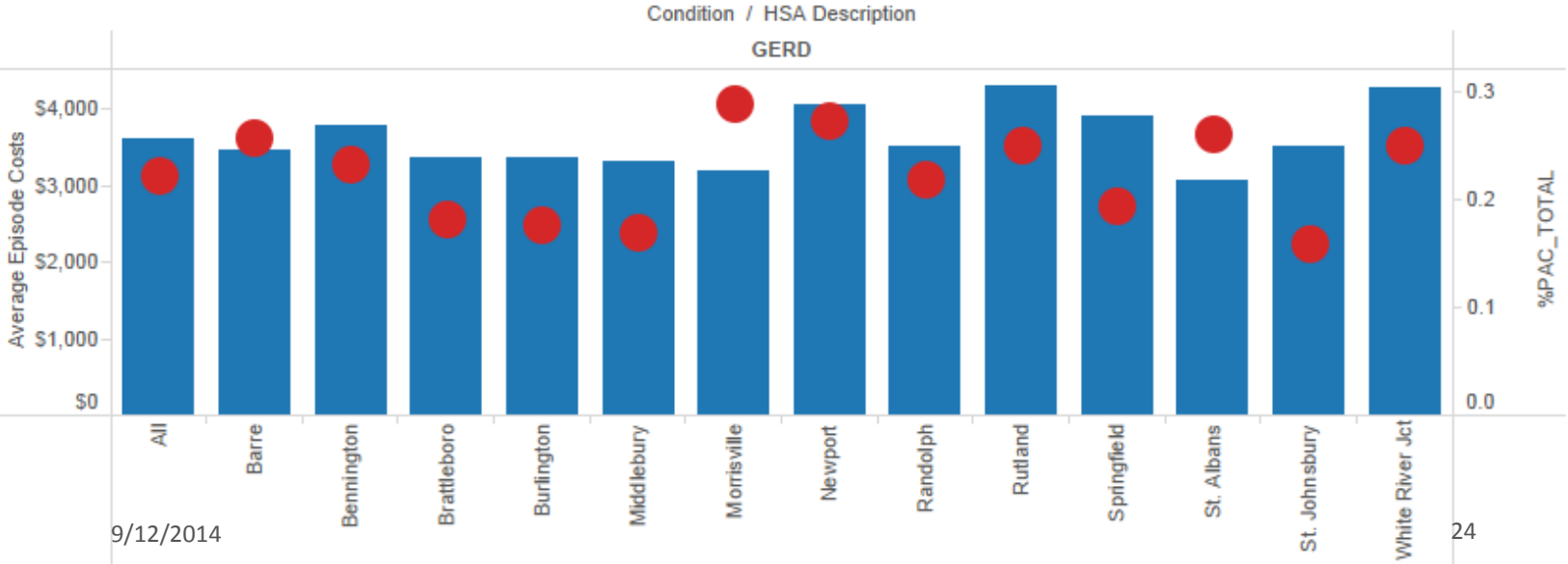

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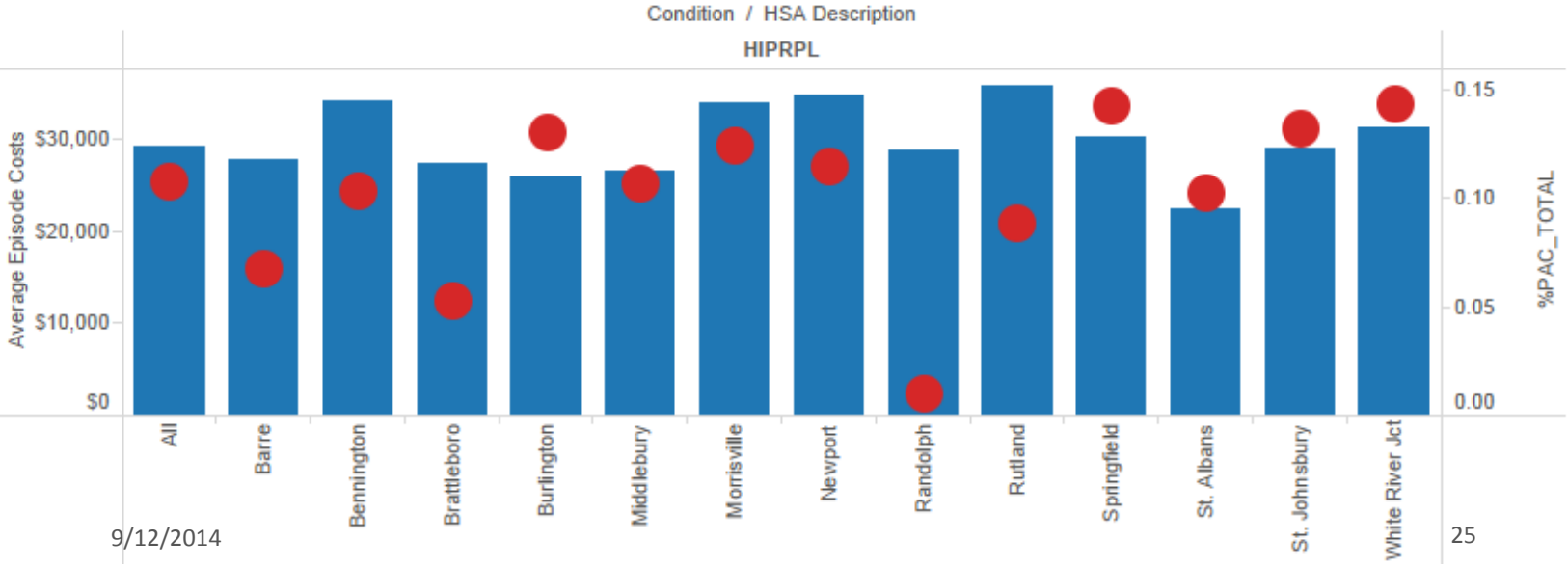

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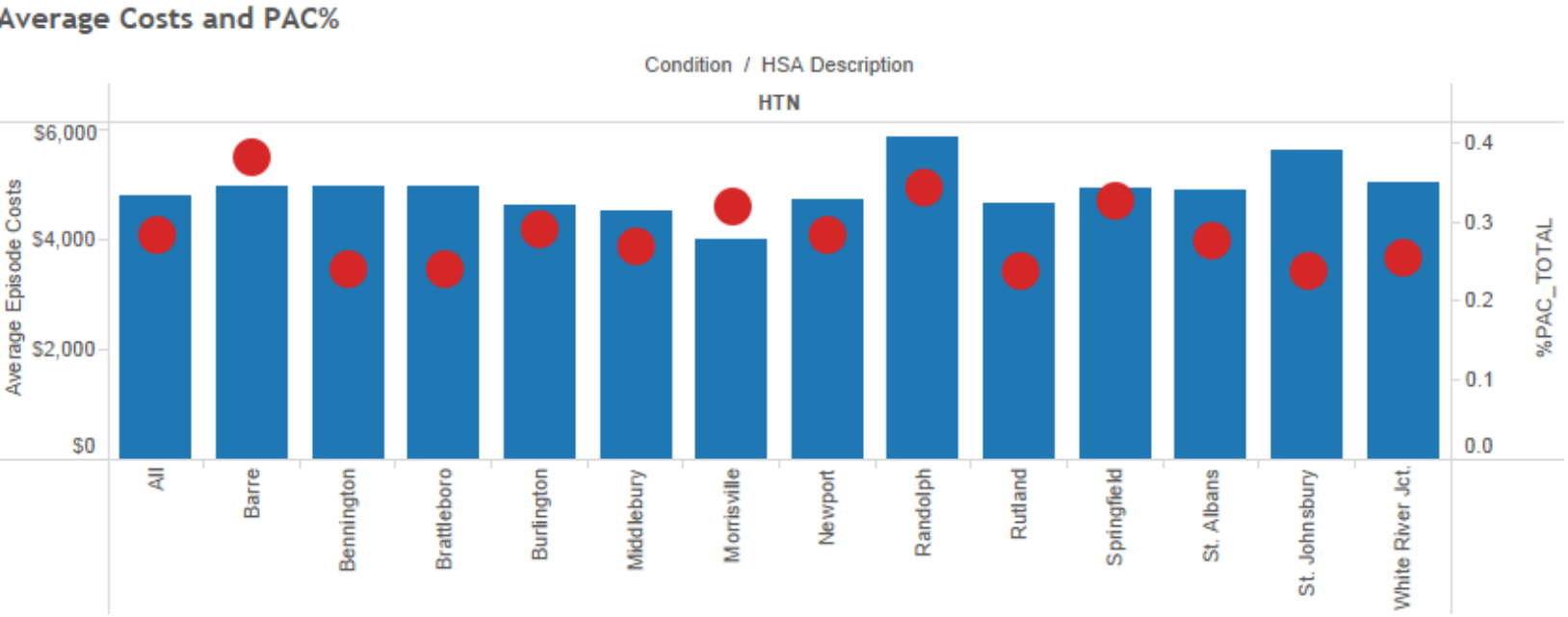

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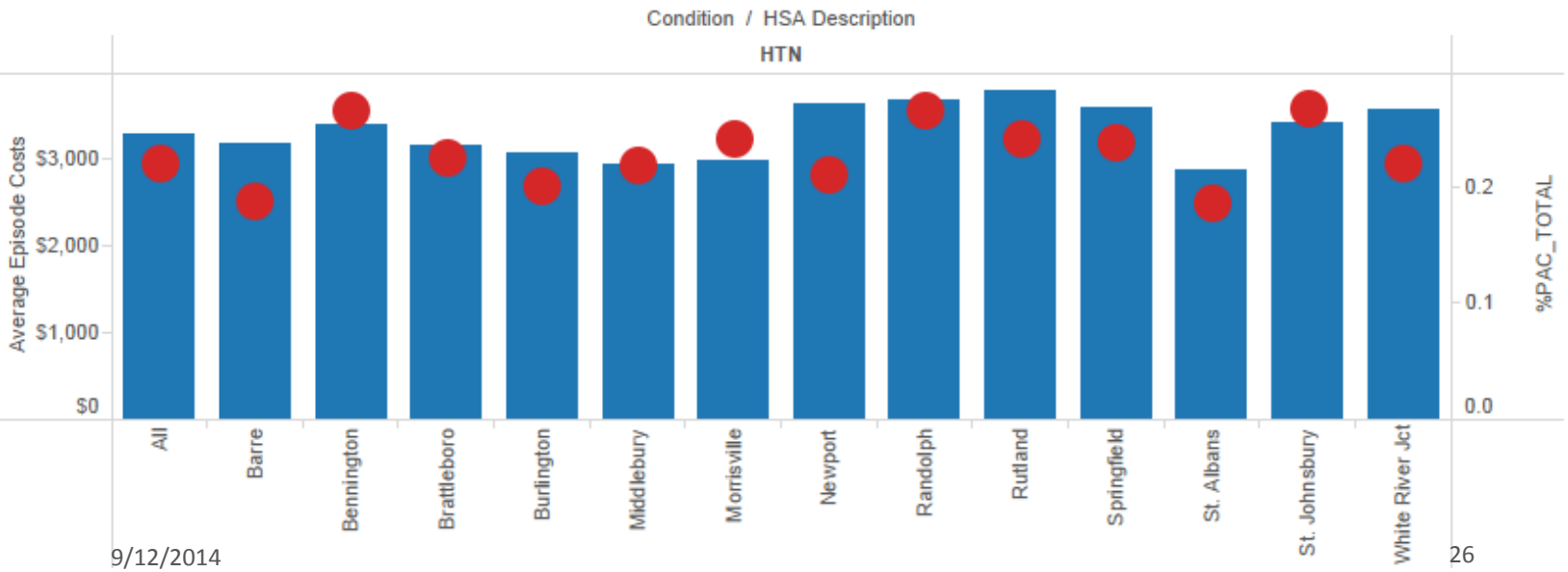

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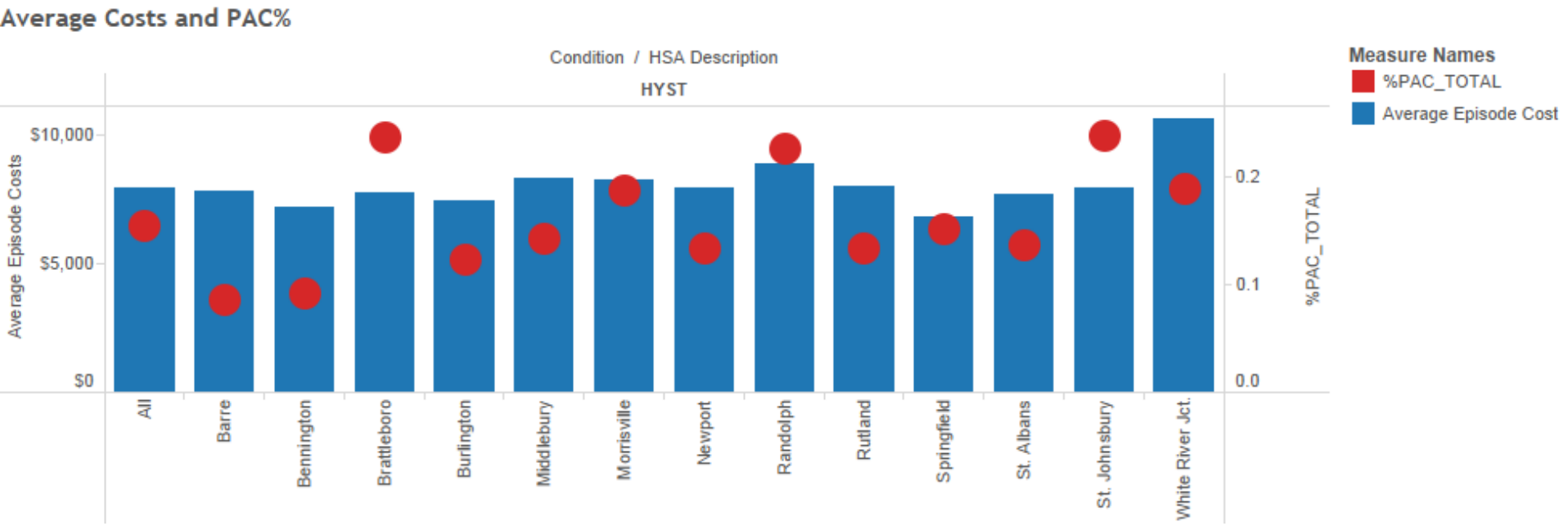

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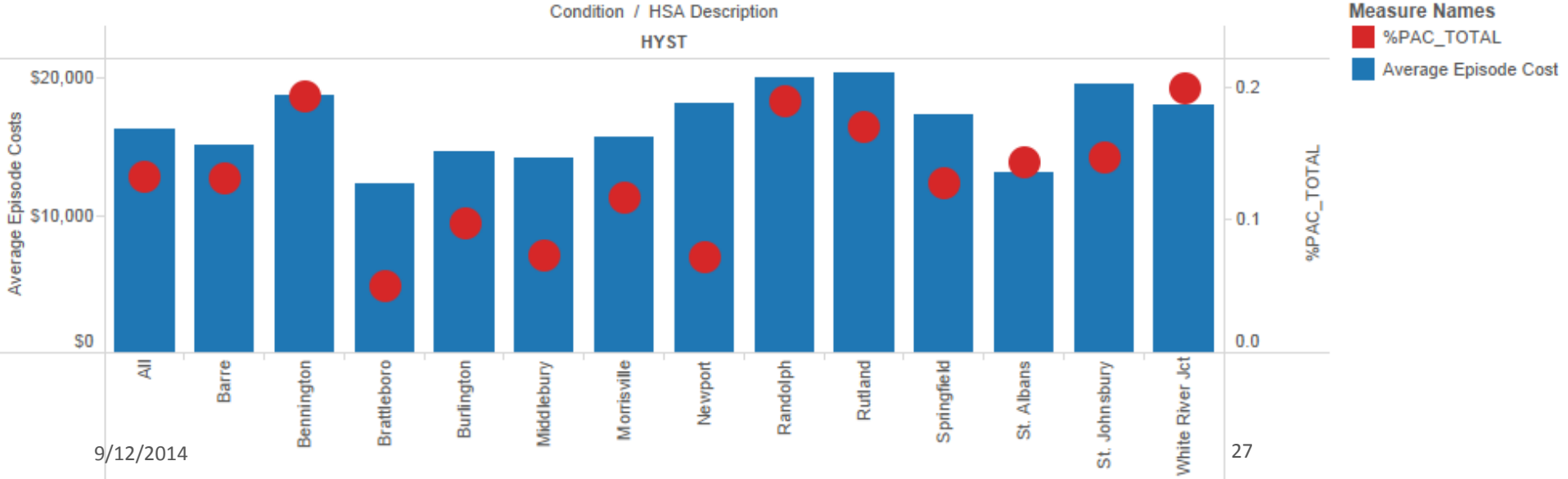

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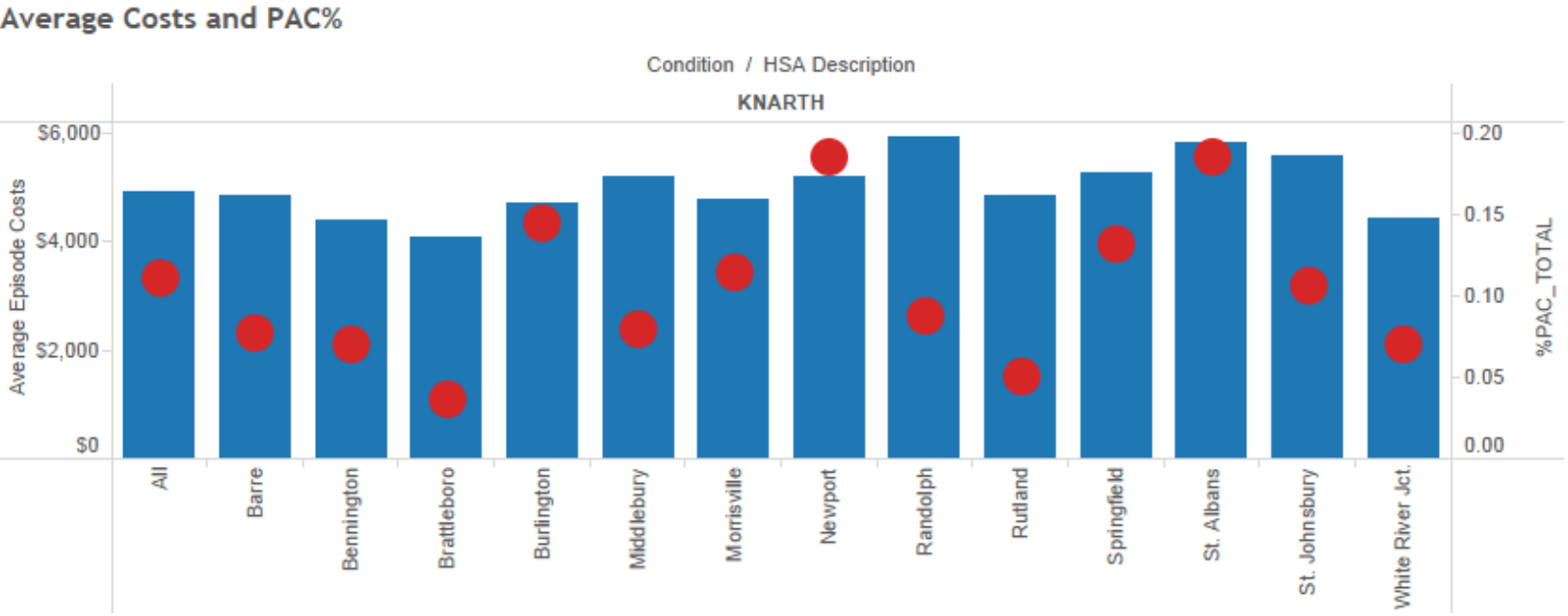

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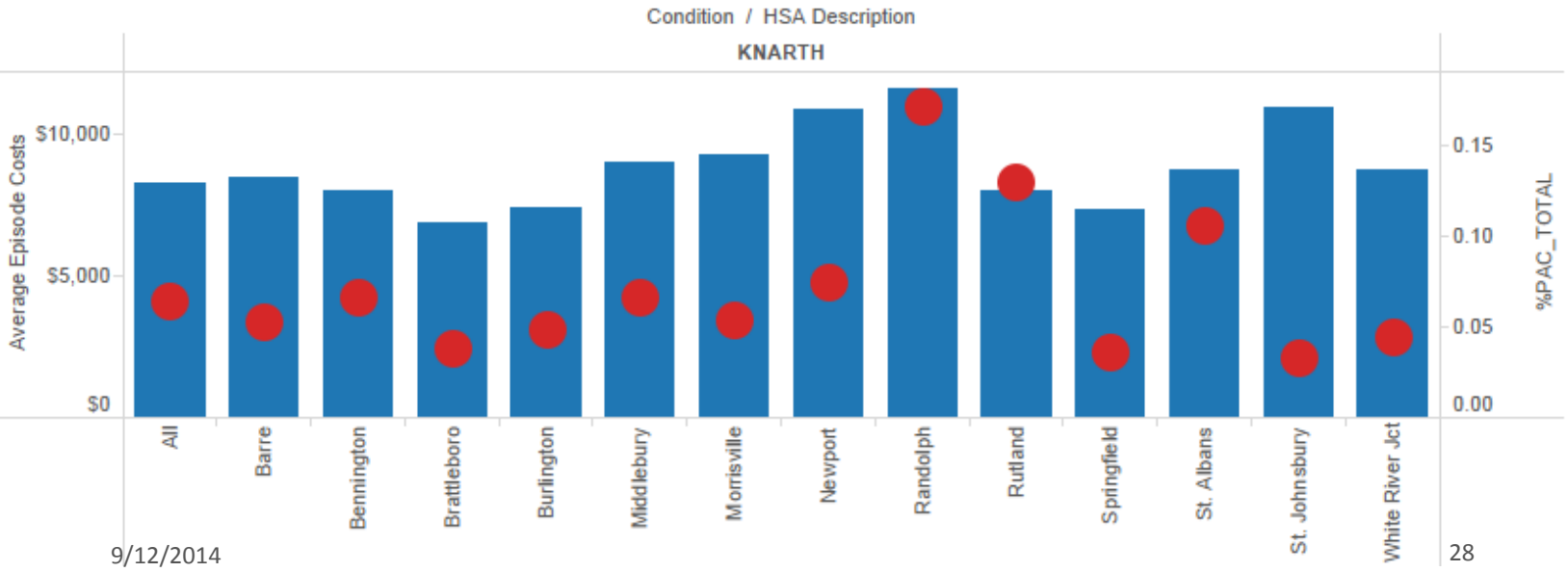

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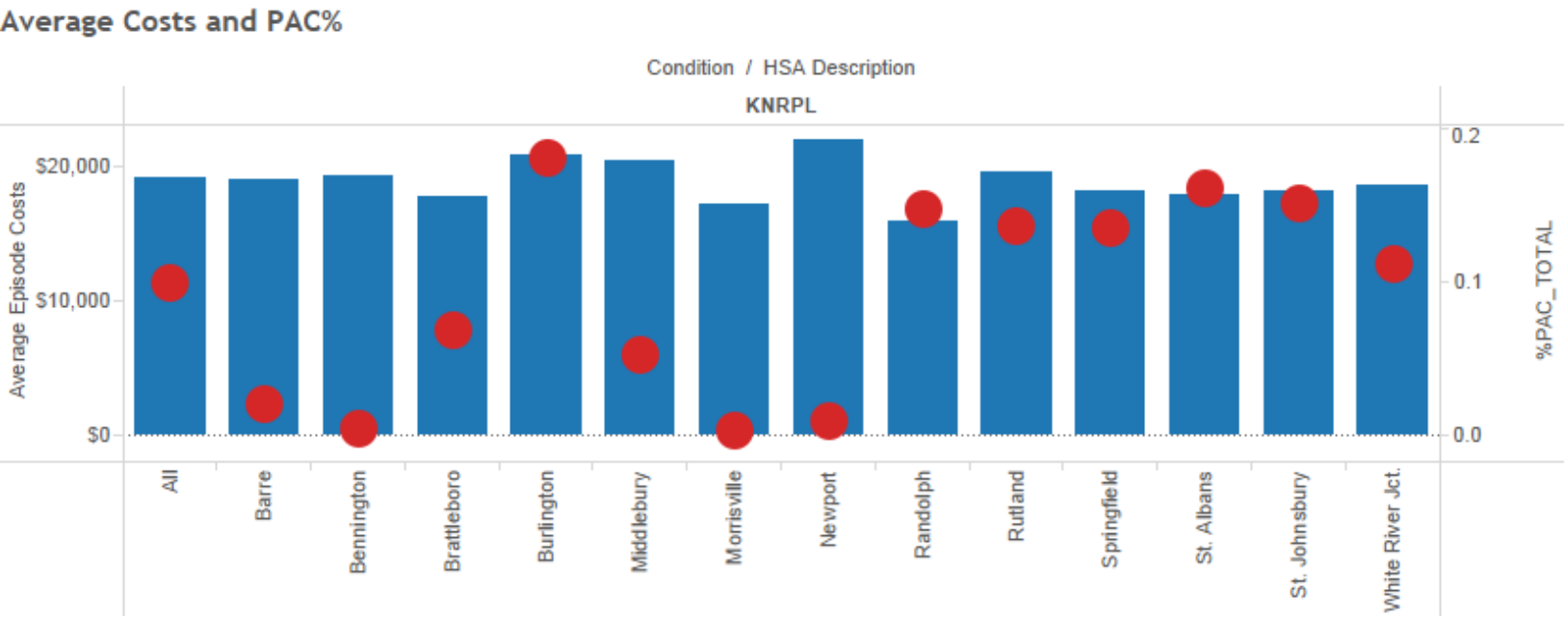

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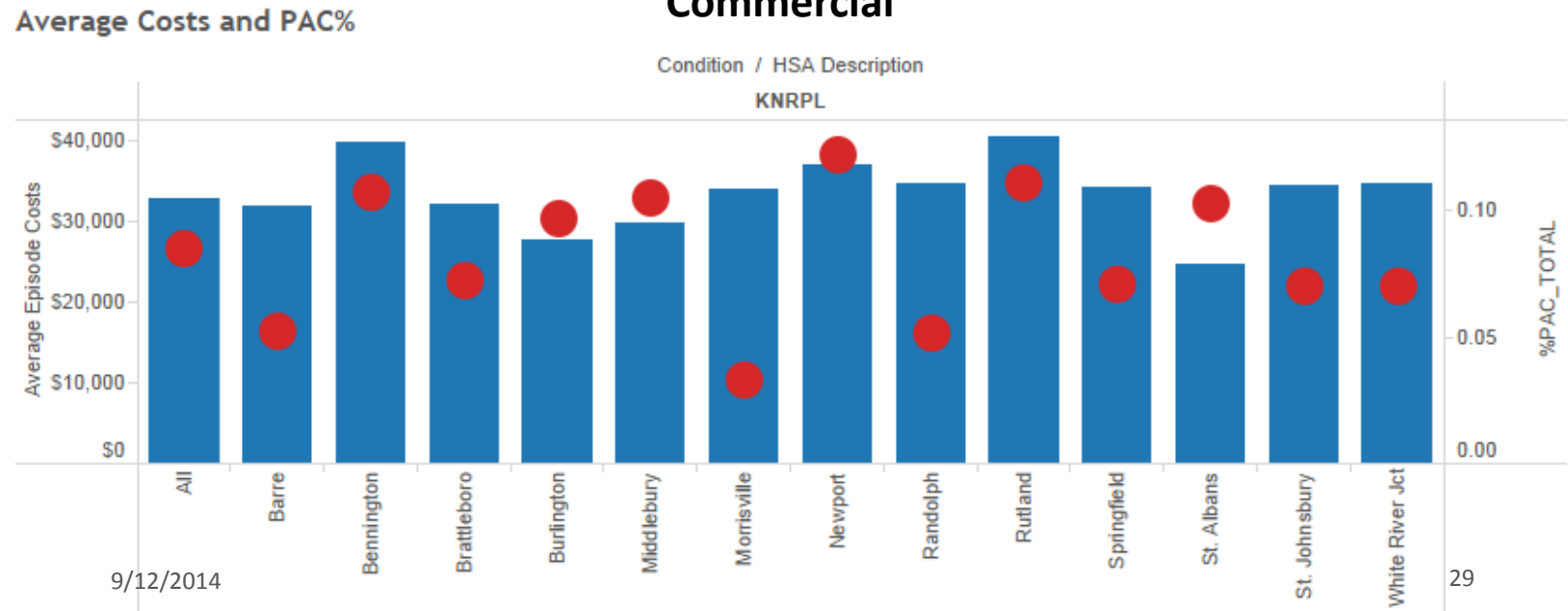

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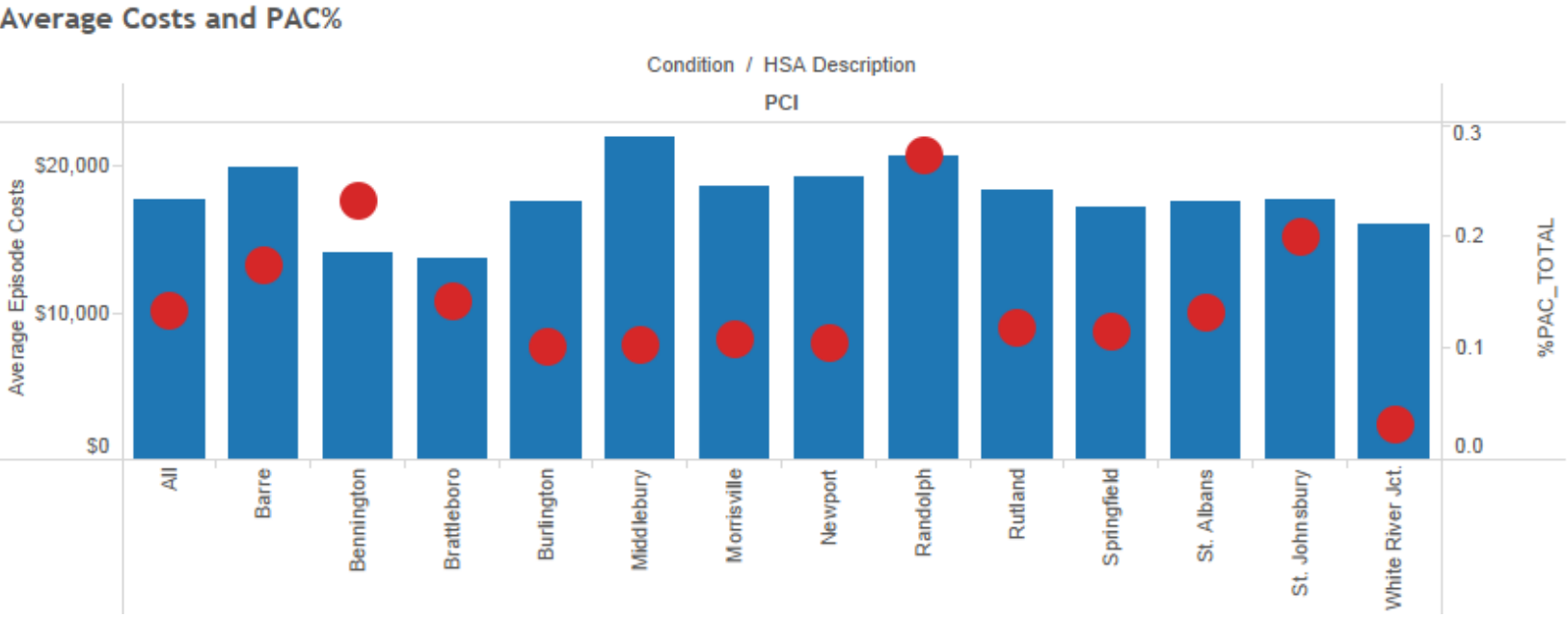

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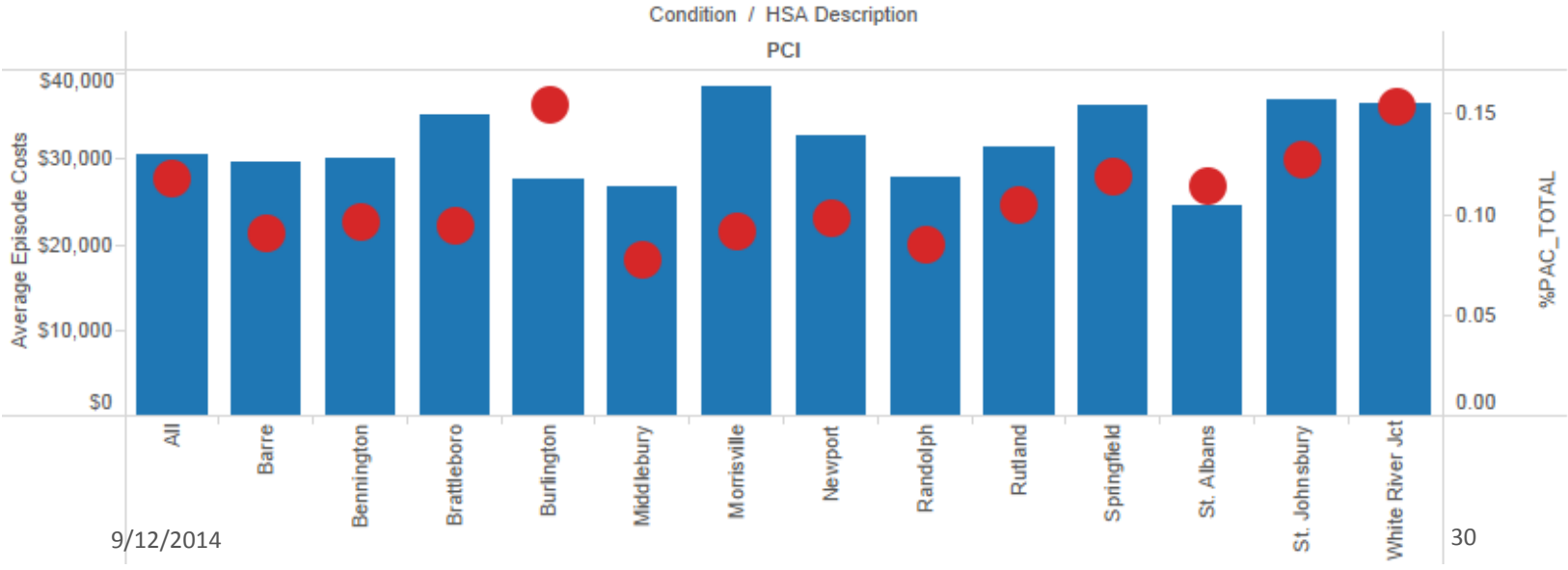

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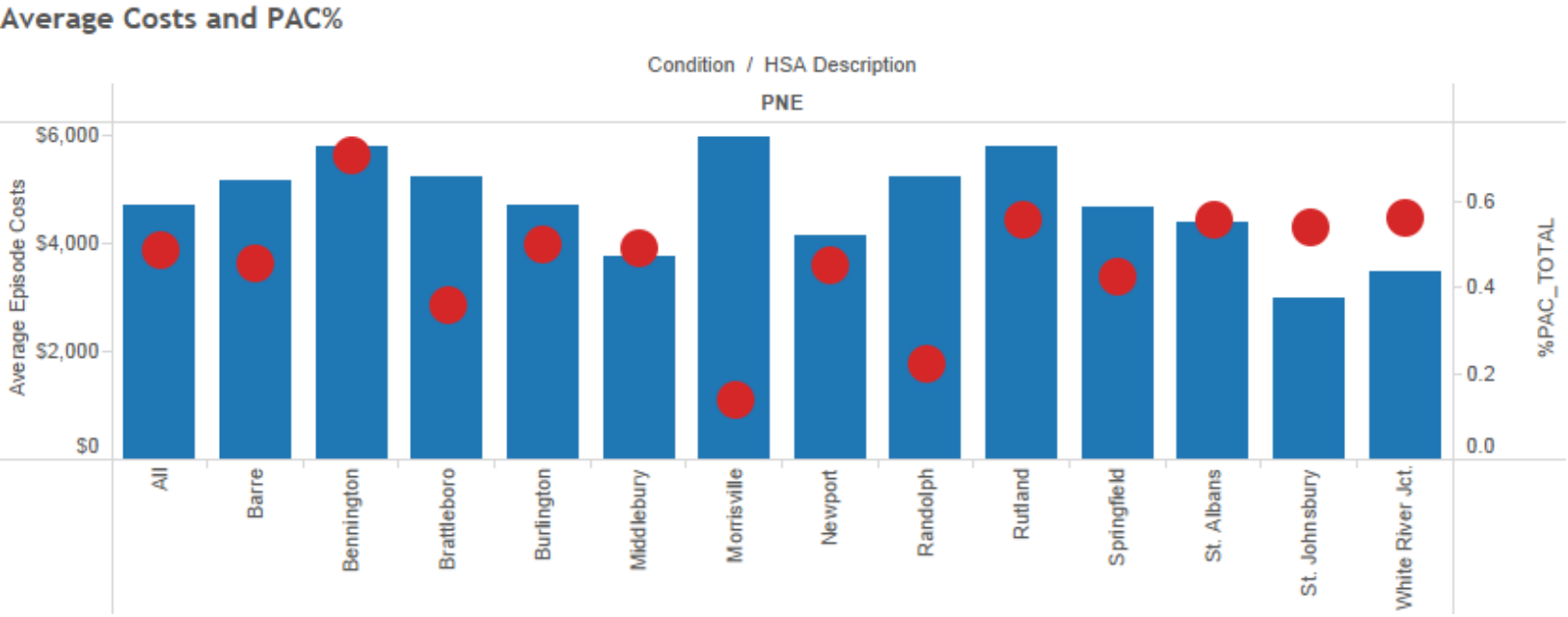

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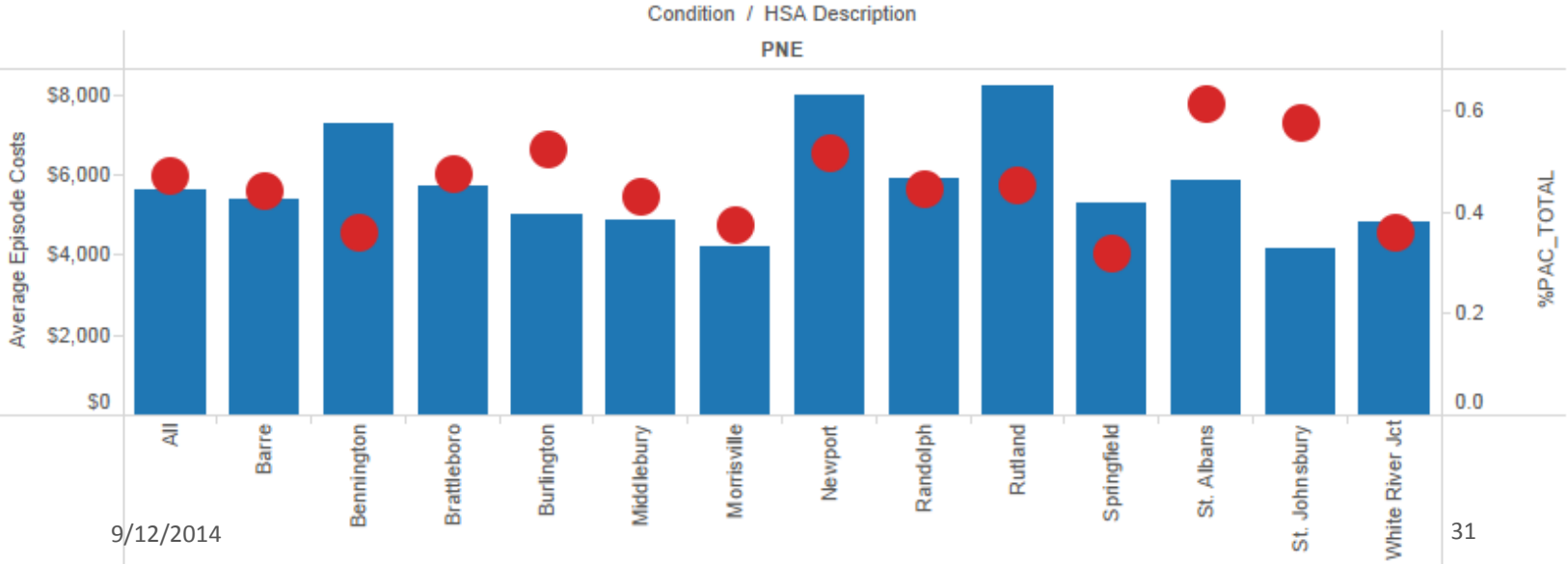

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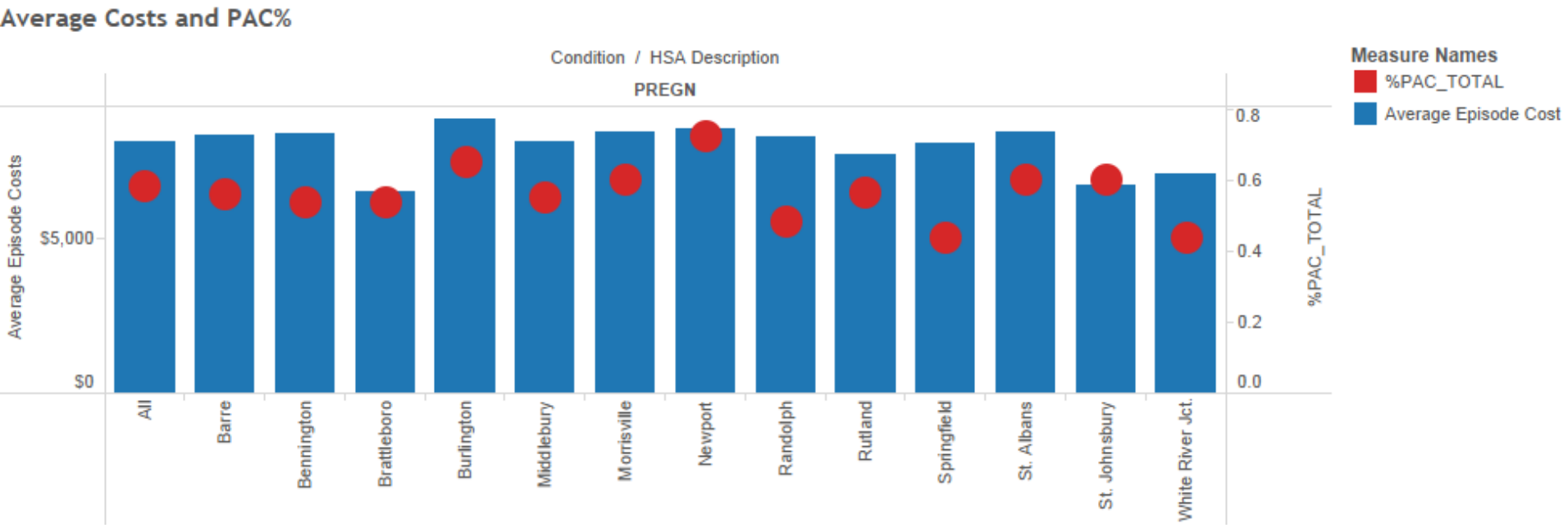

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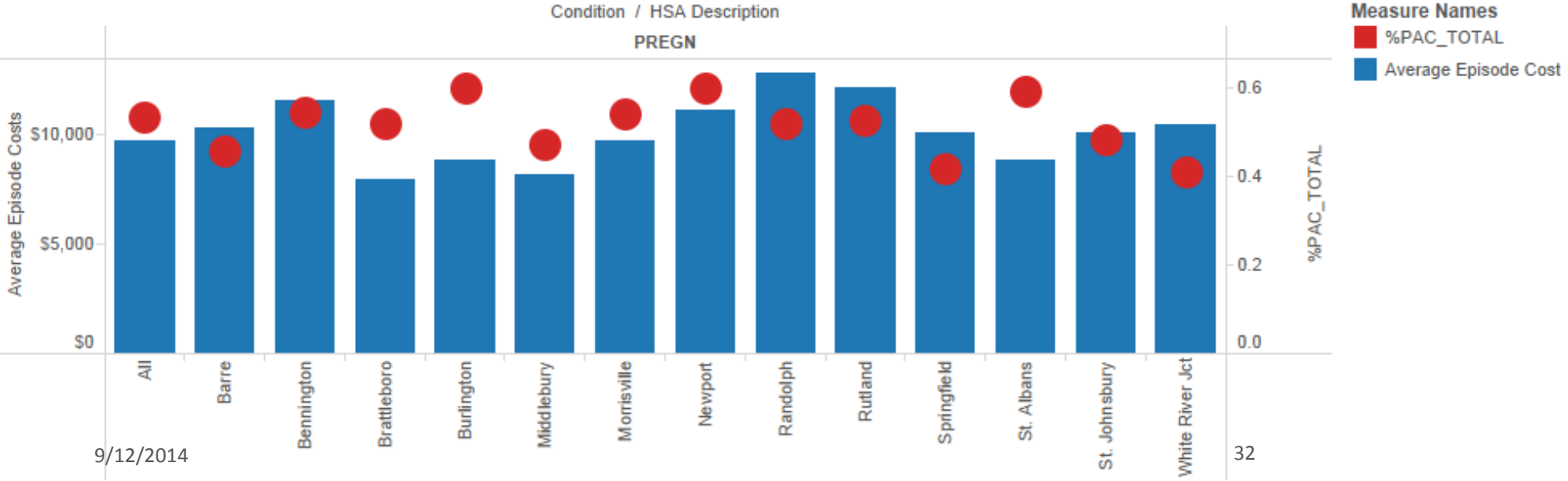

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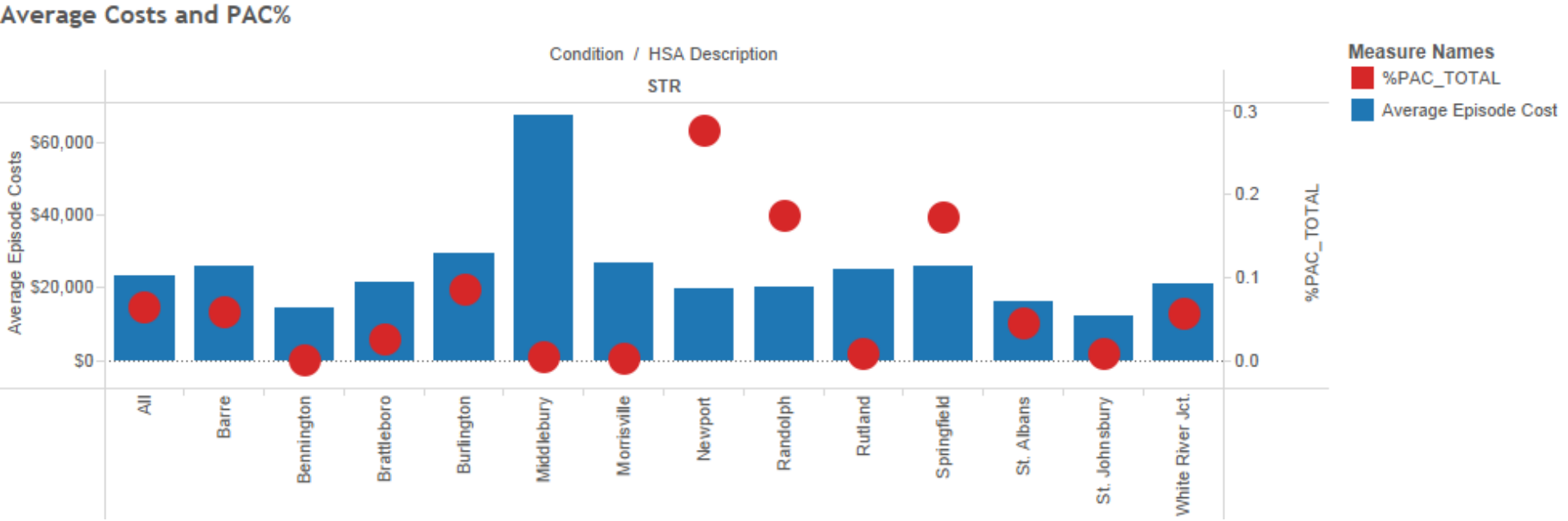

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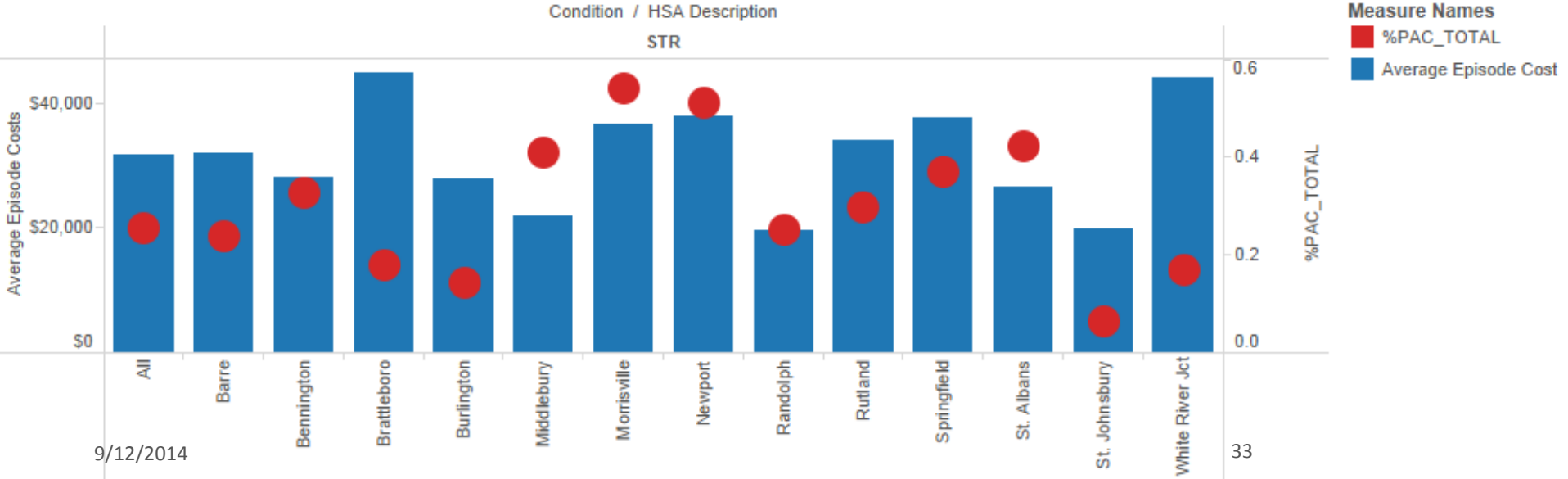

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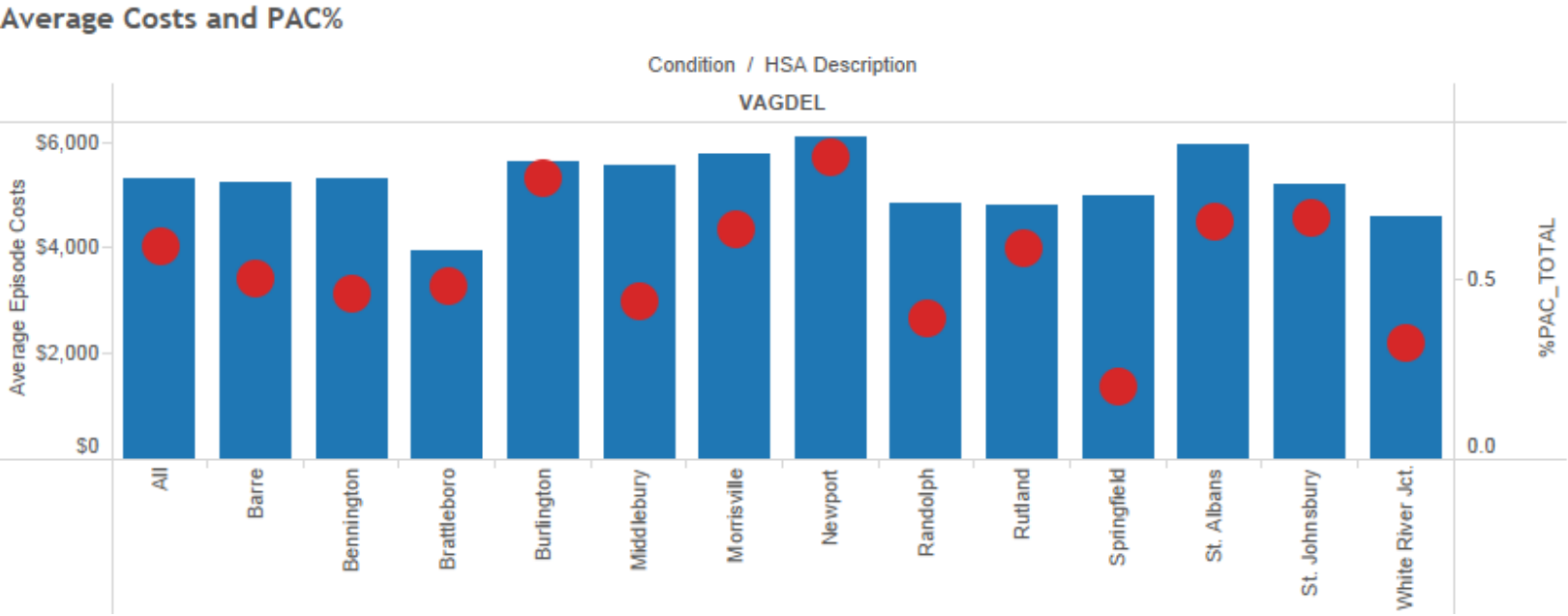

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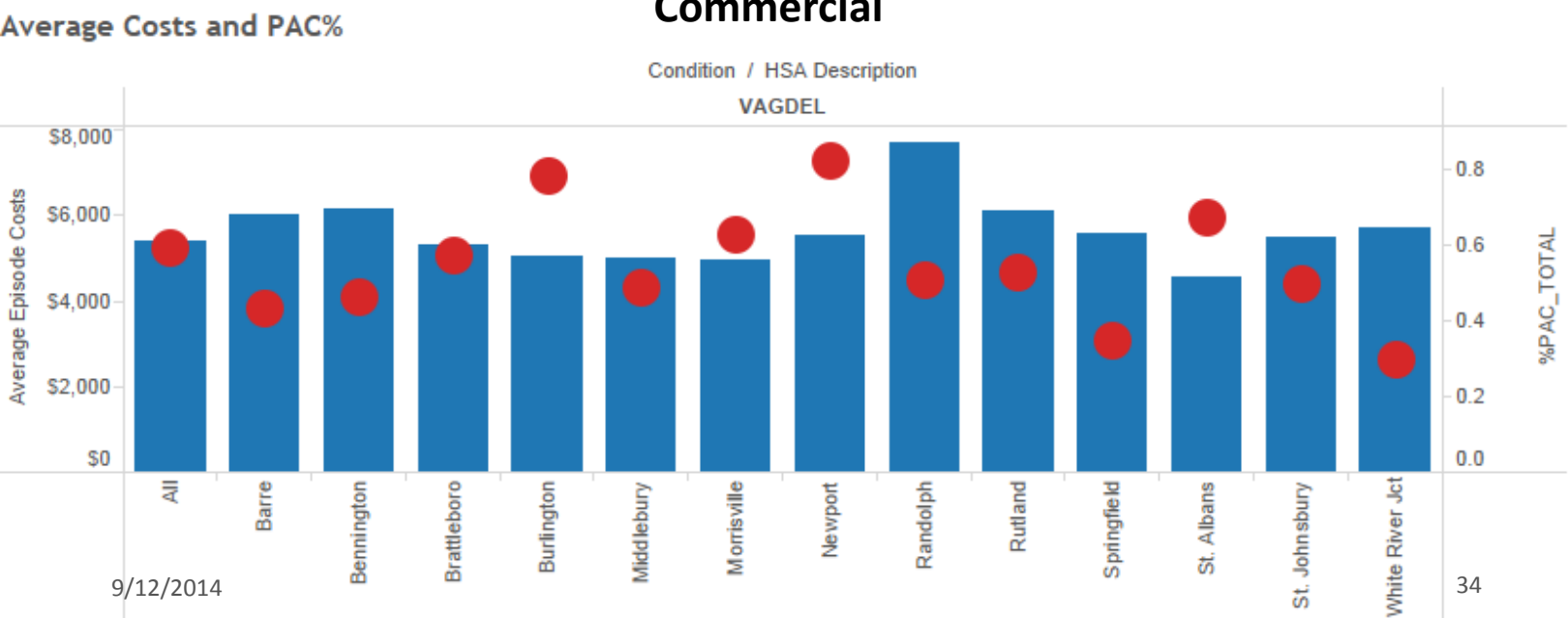
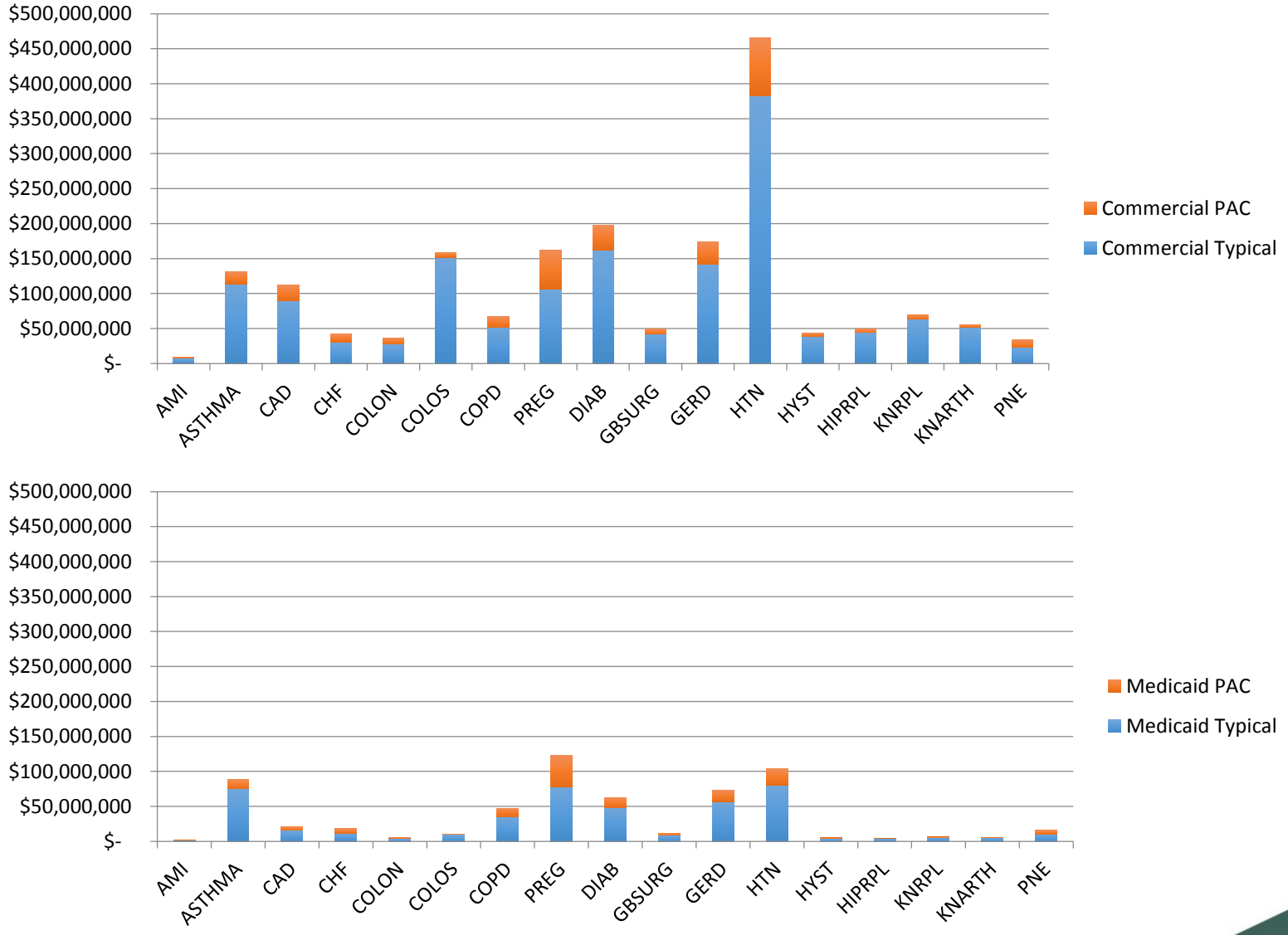


Data Book Slide 36

PAC COSTS

Total Typical And PAC Costs

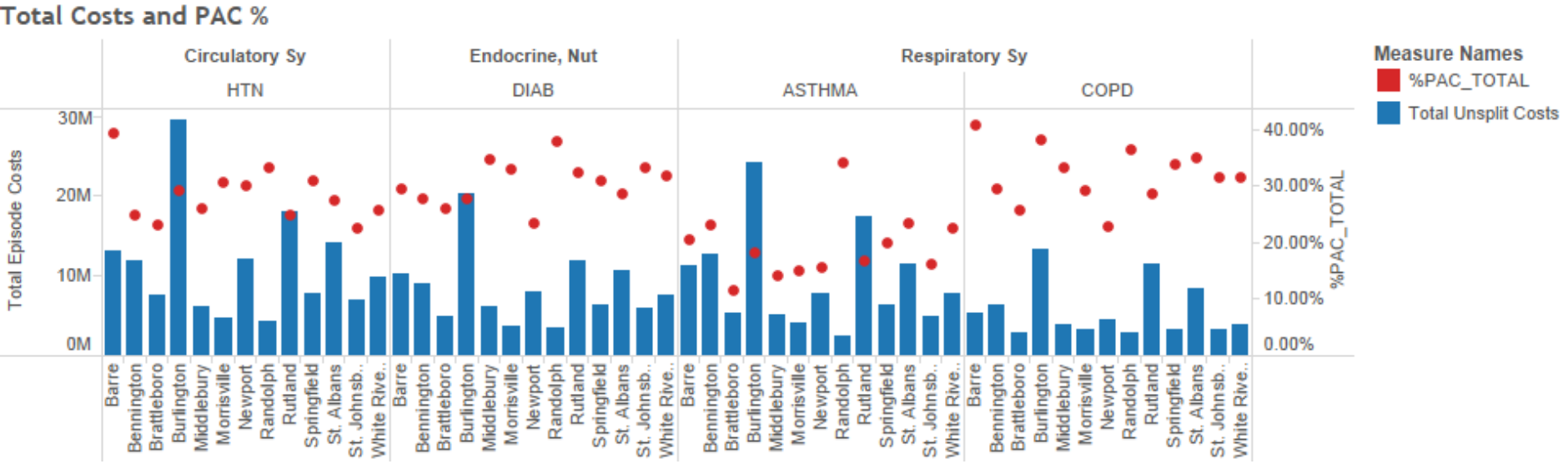


Data Book Slide 38

CHRONIC CARE VARIATION

Payer Variation Chronic Conditions

Medicaid



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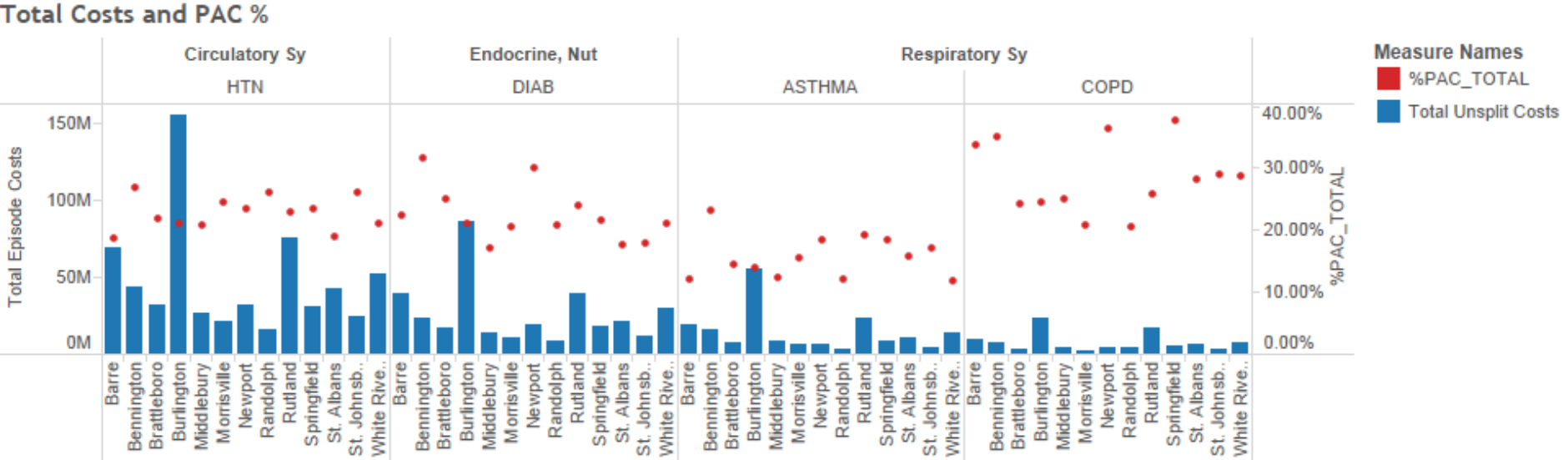
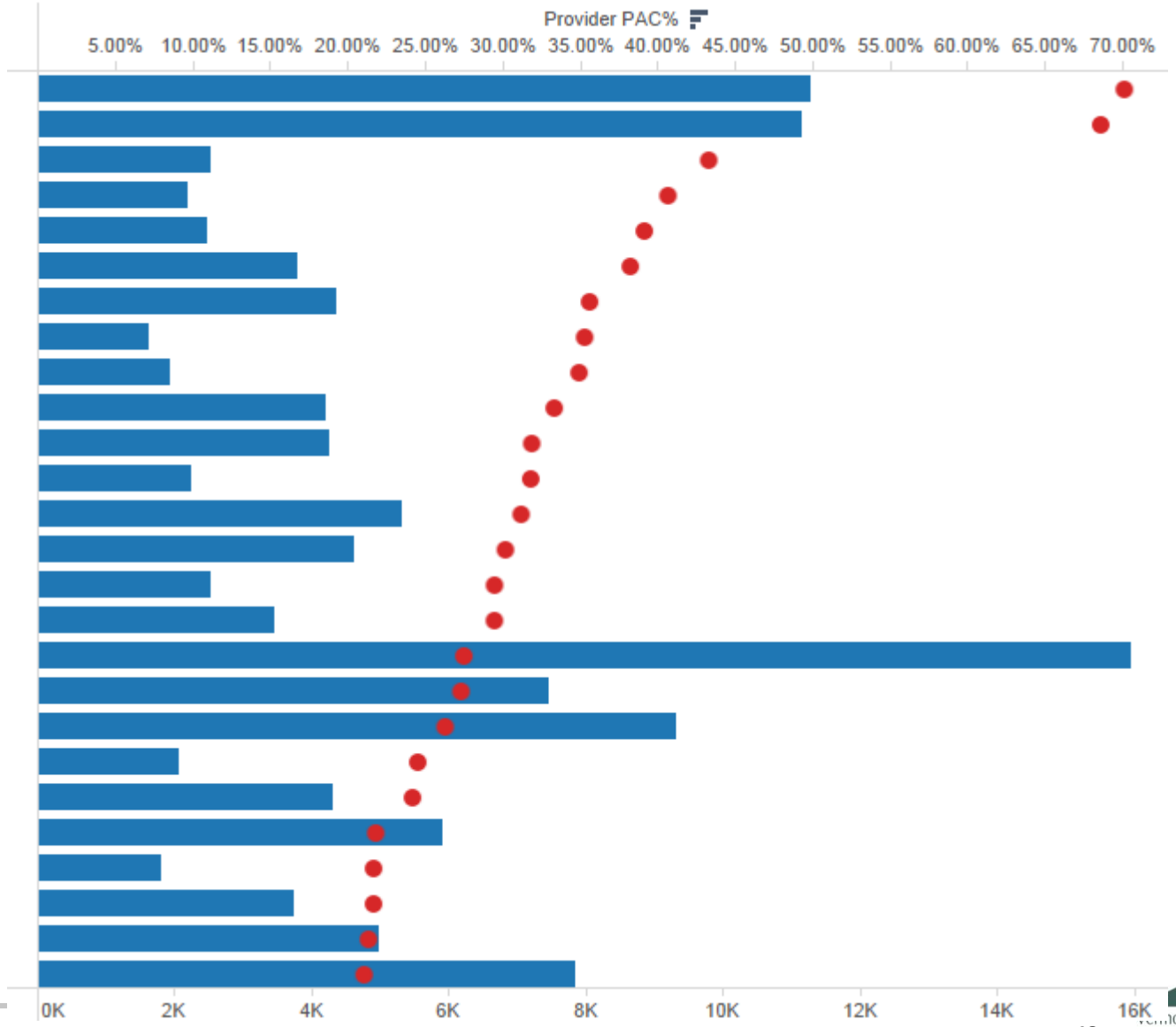


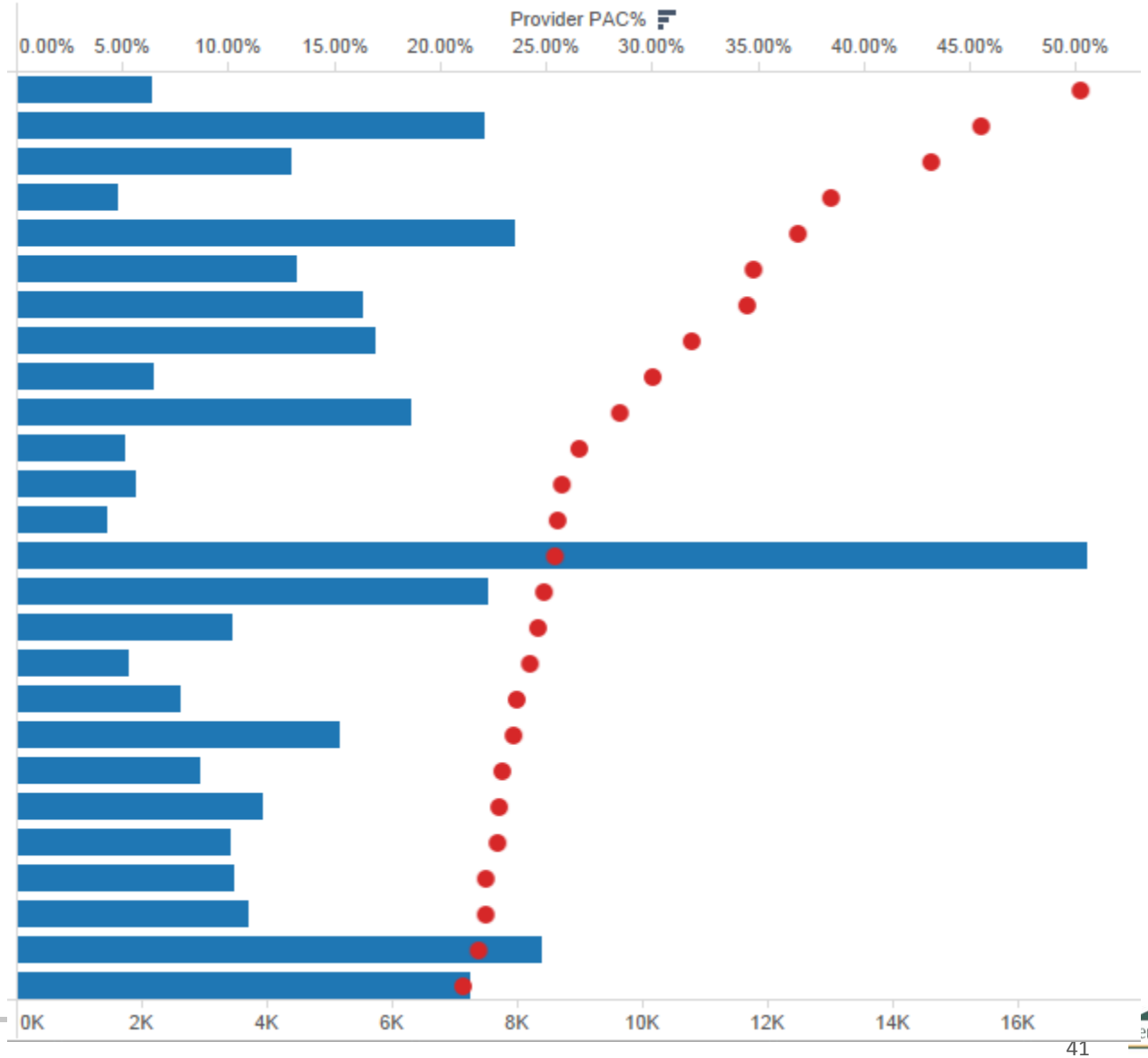
Data Book Slides 40-67

PROVIDER COST AND PAC

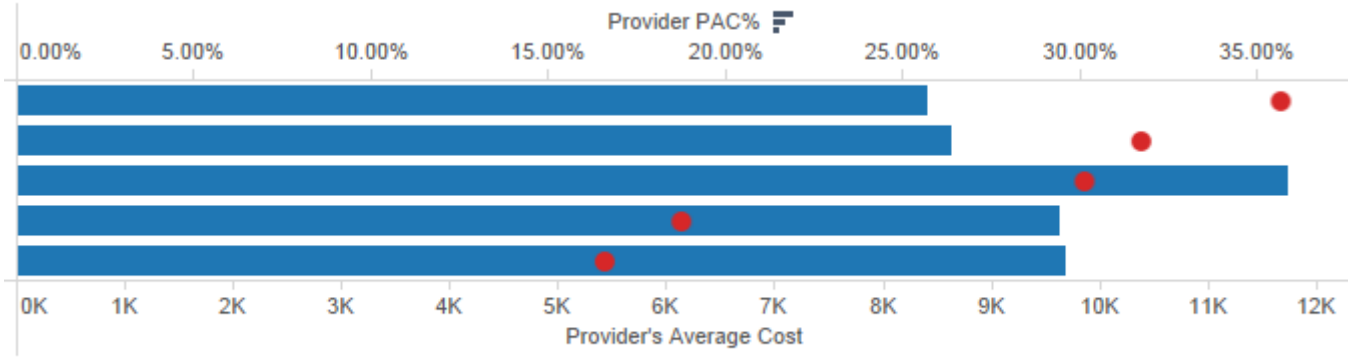
26 Providers with highest PAC % Asthma - Medicaid



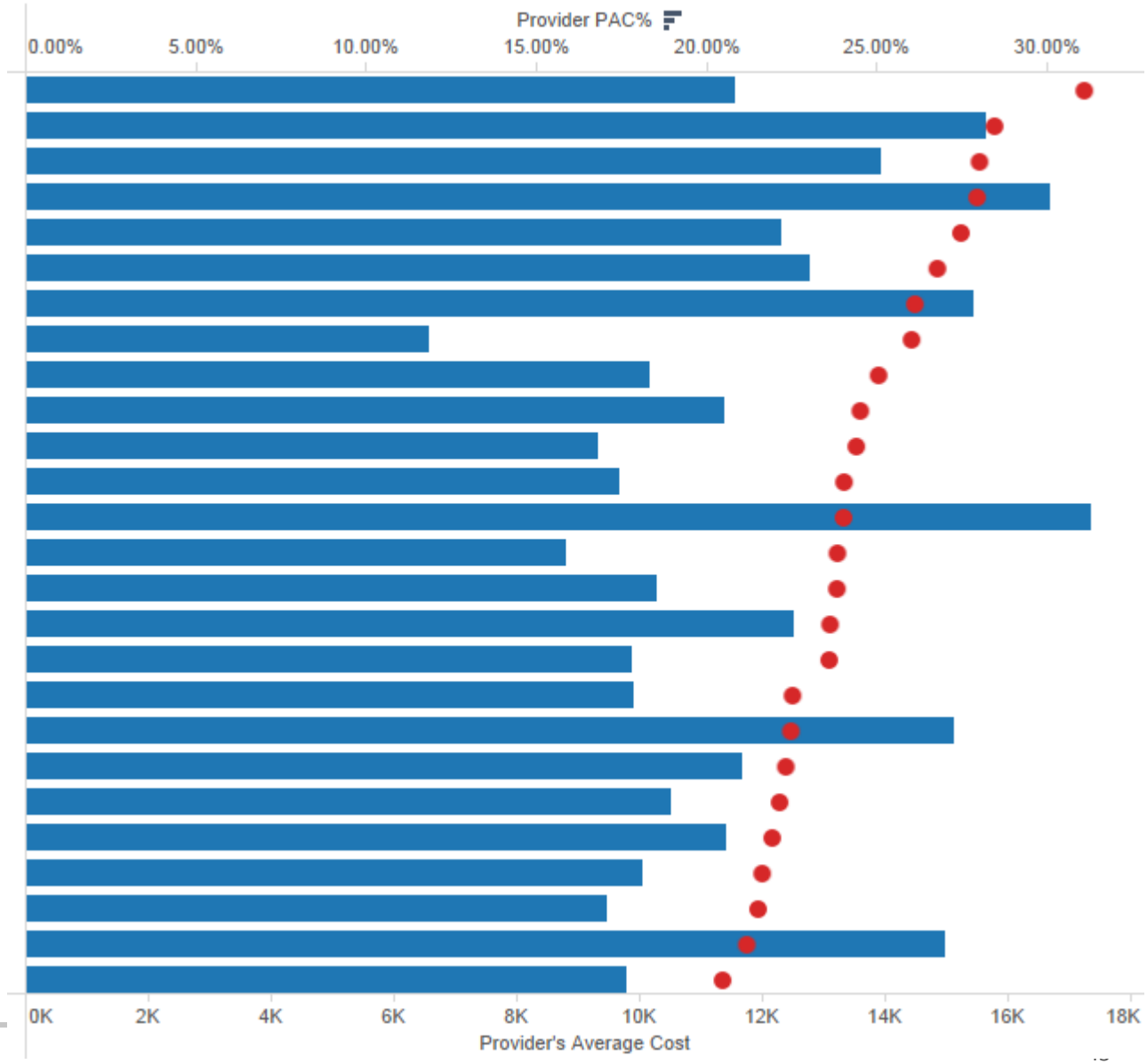
26 Providers with highest PAC % Asthma - Commercial



CAD - Medicaid



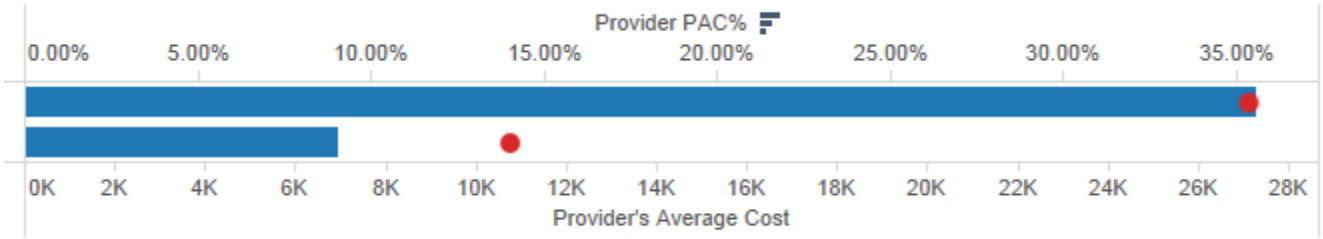
26 Providers with highest PAC % CAD - Commercial



CHF - Medicaid

No Provider with 50+ patients

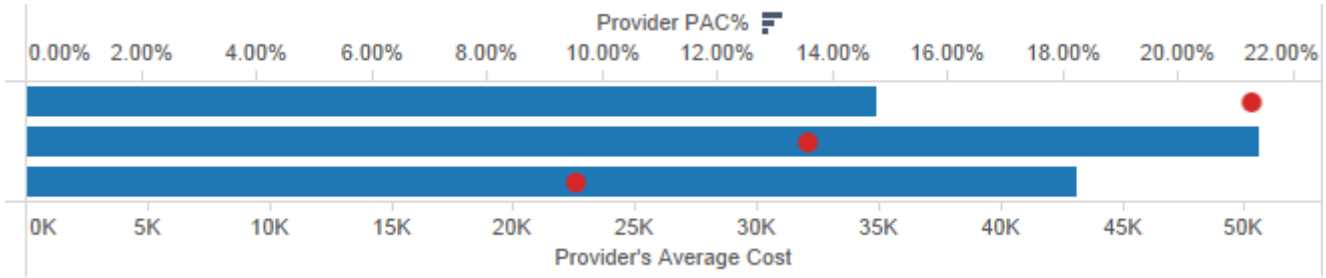
CHF - Commercial



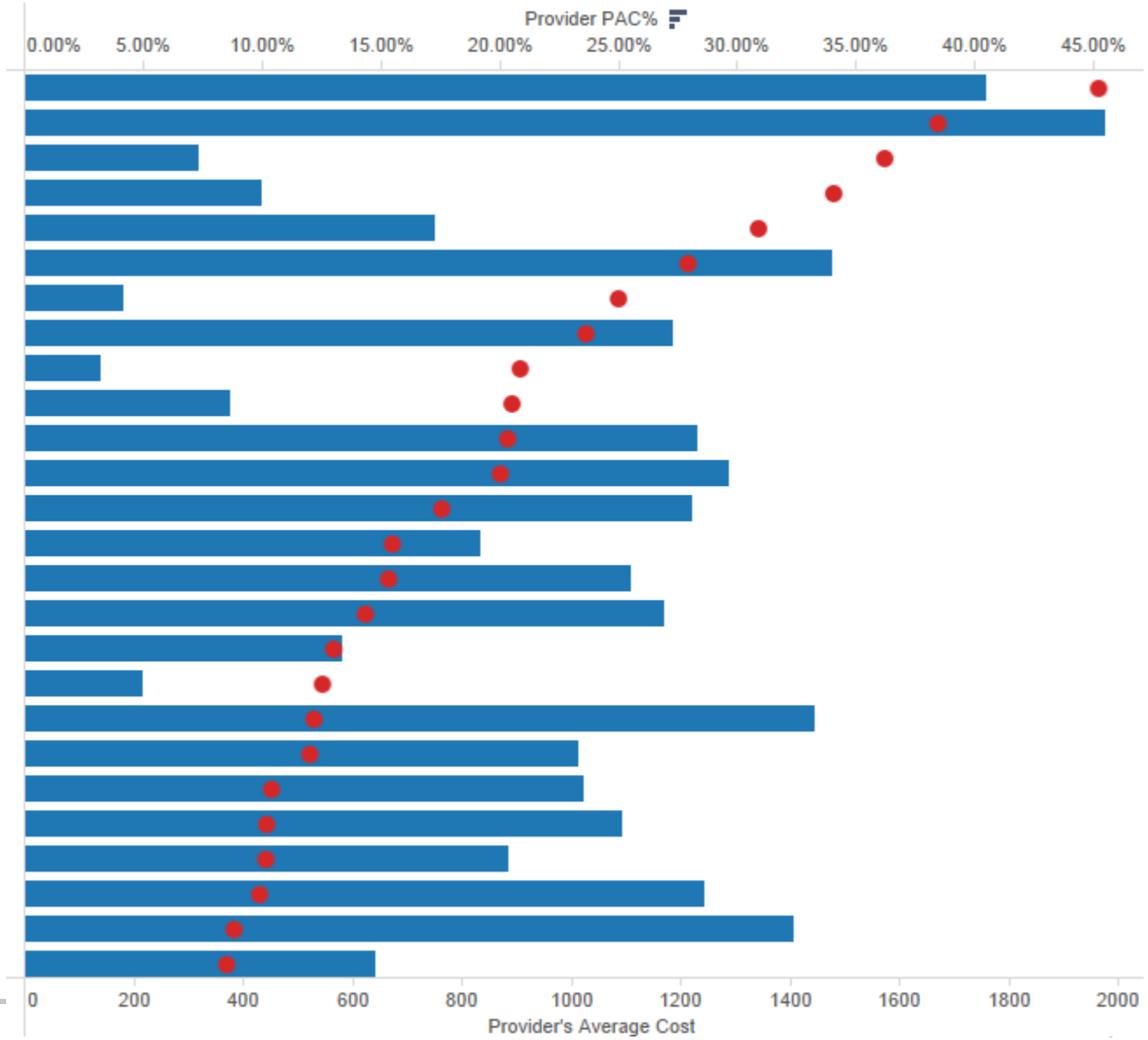
COLON - Medicaid

No Provider with 50+ patients

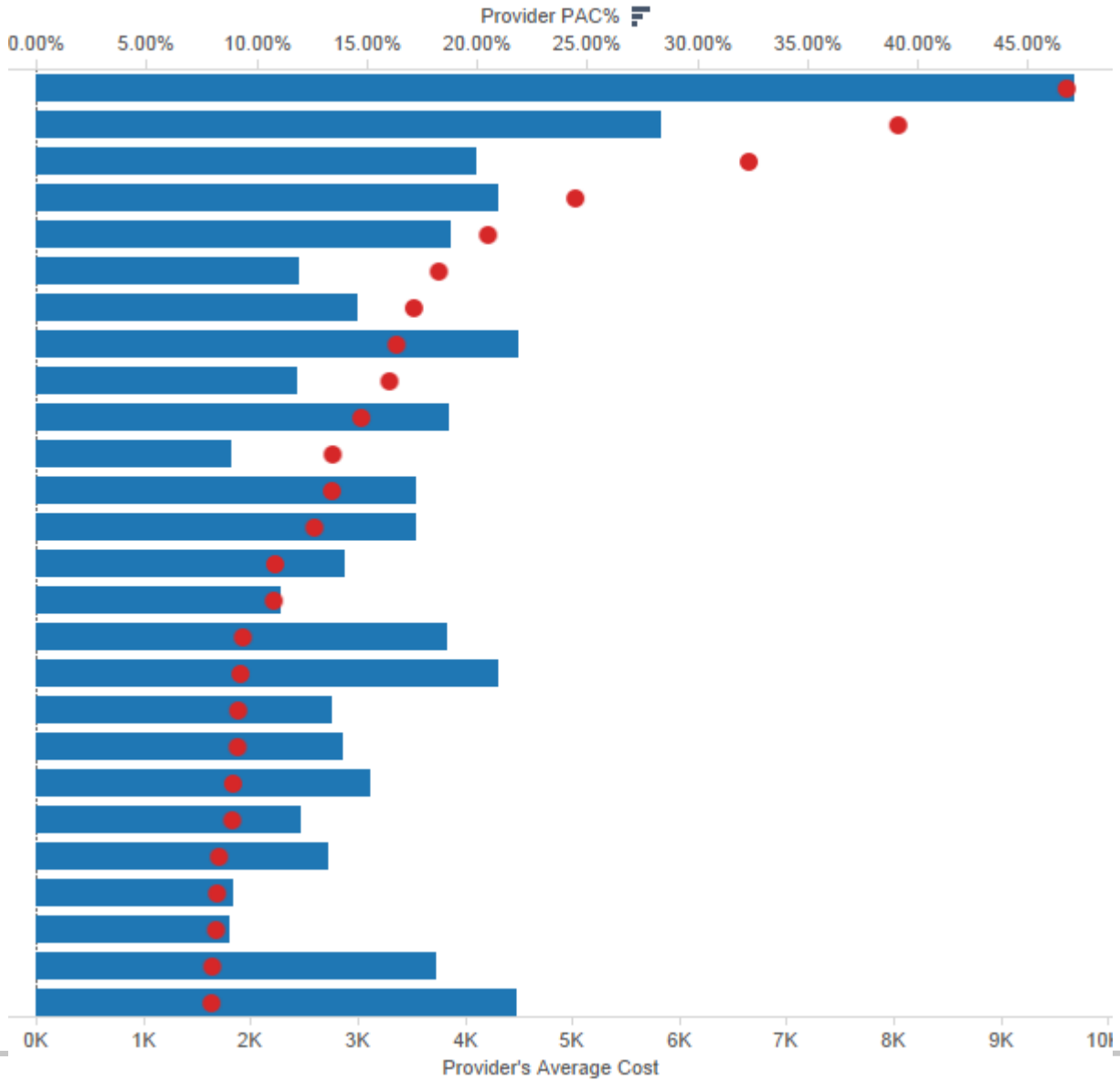
COLON - Commercial



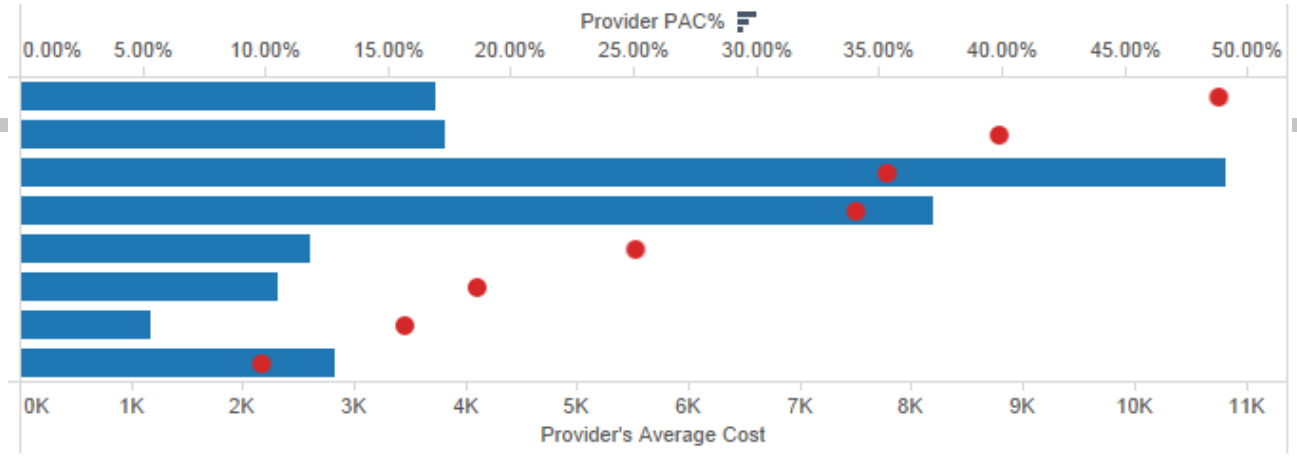
26 Providers with highest PAC % COLOS - Medicaid



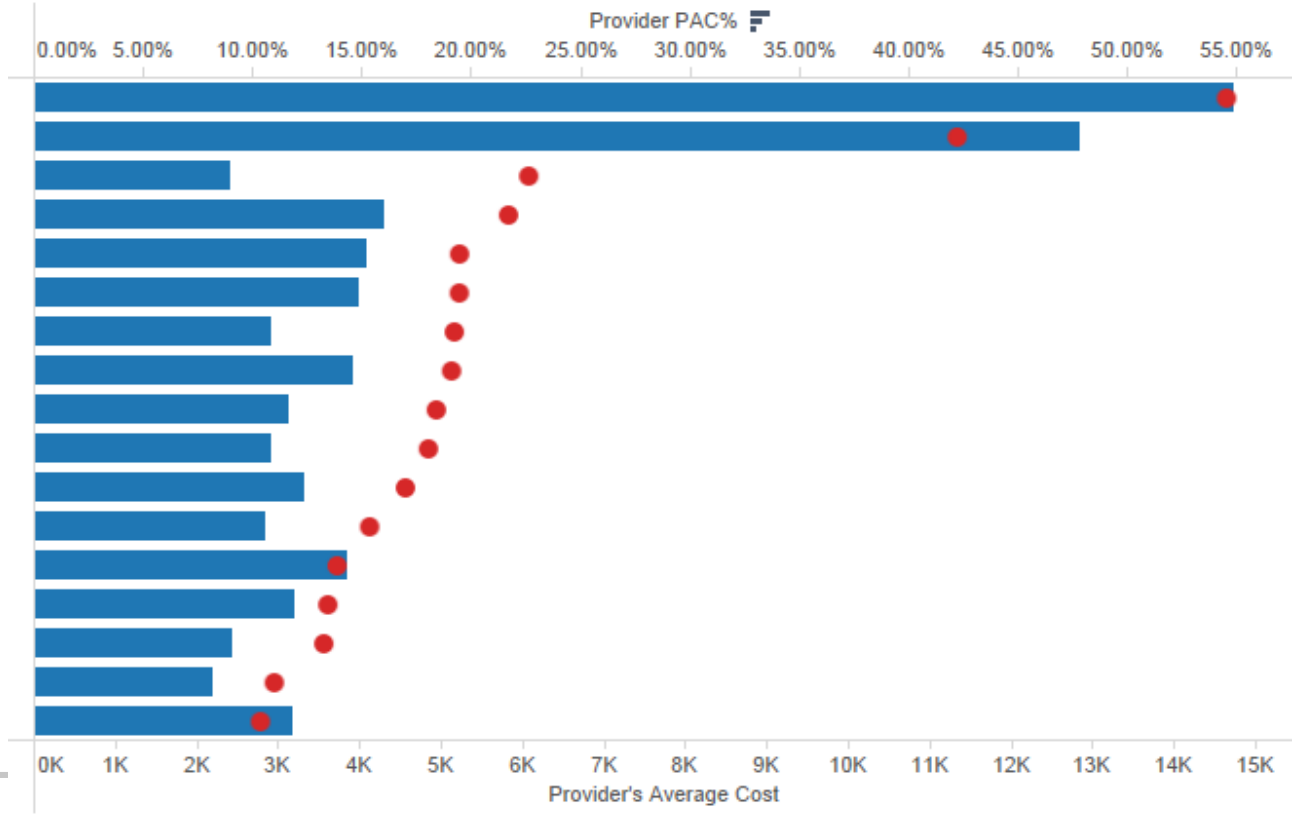
26 Providers with highest PAC % COLOS - Commercial



COPD - Medicaid



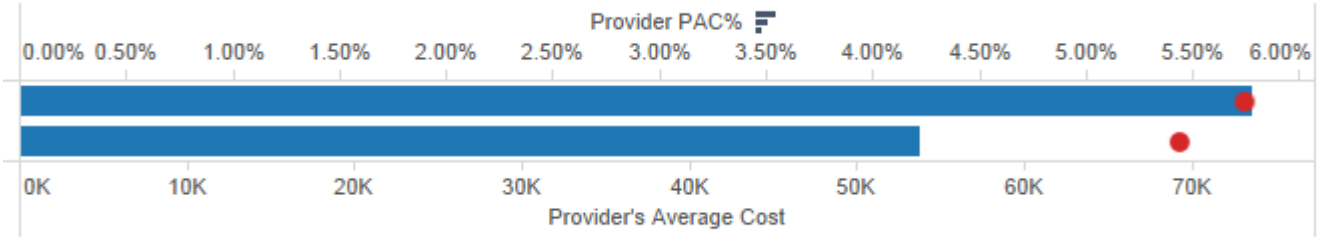
COPD - Commercial



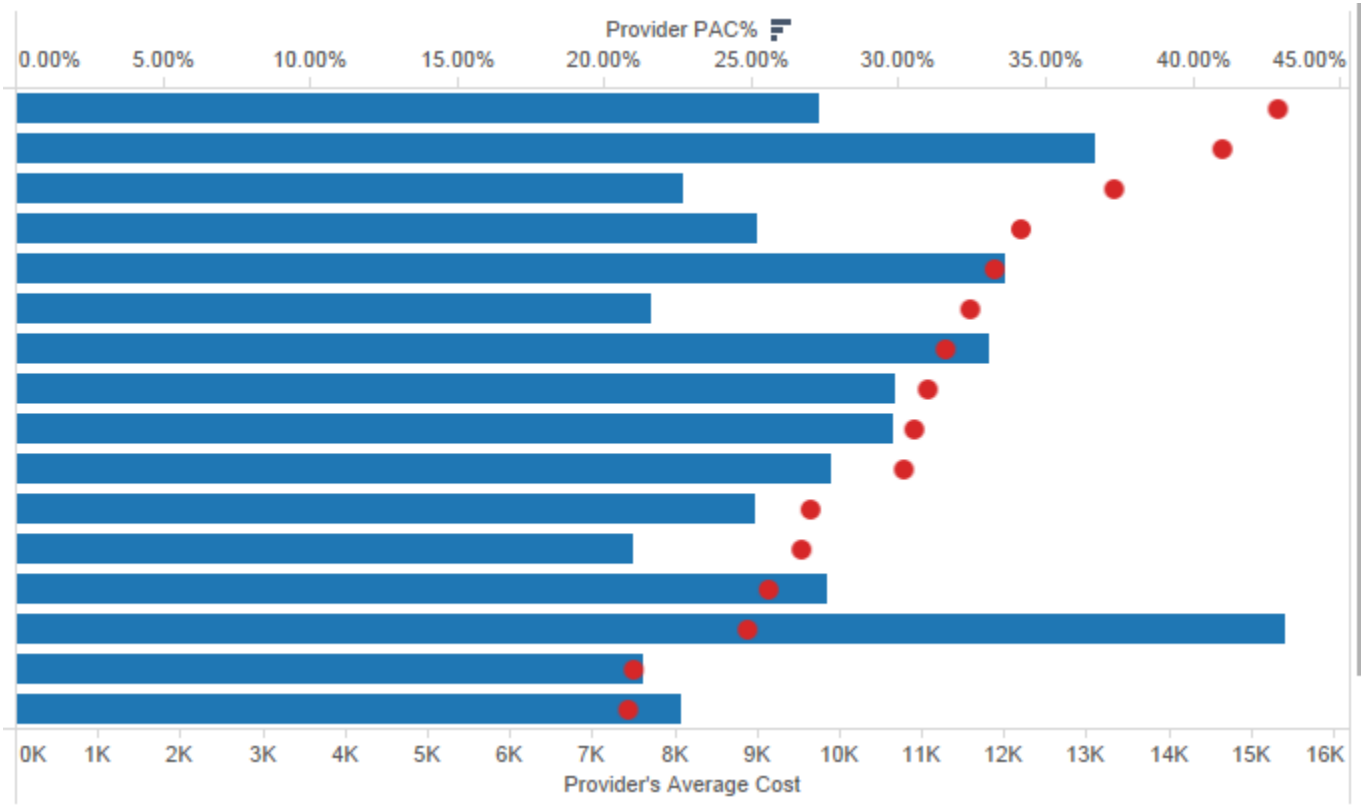
CxCABG - Medicaid

No Provider with 50+ patients

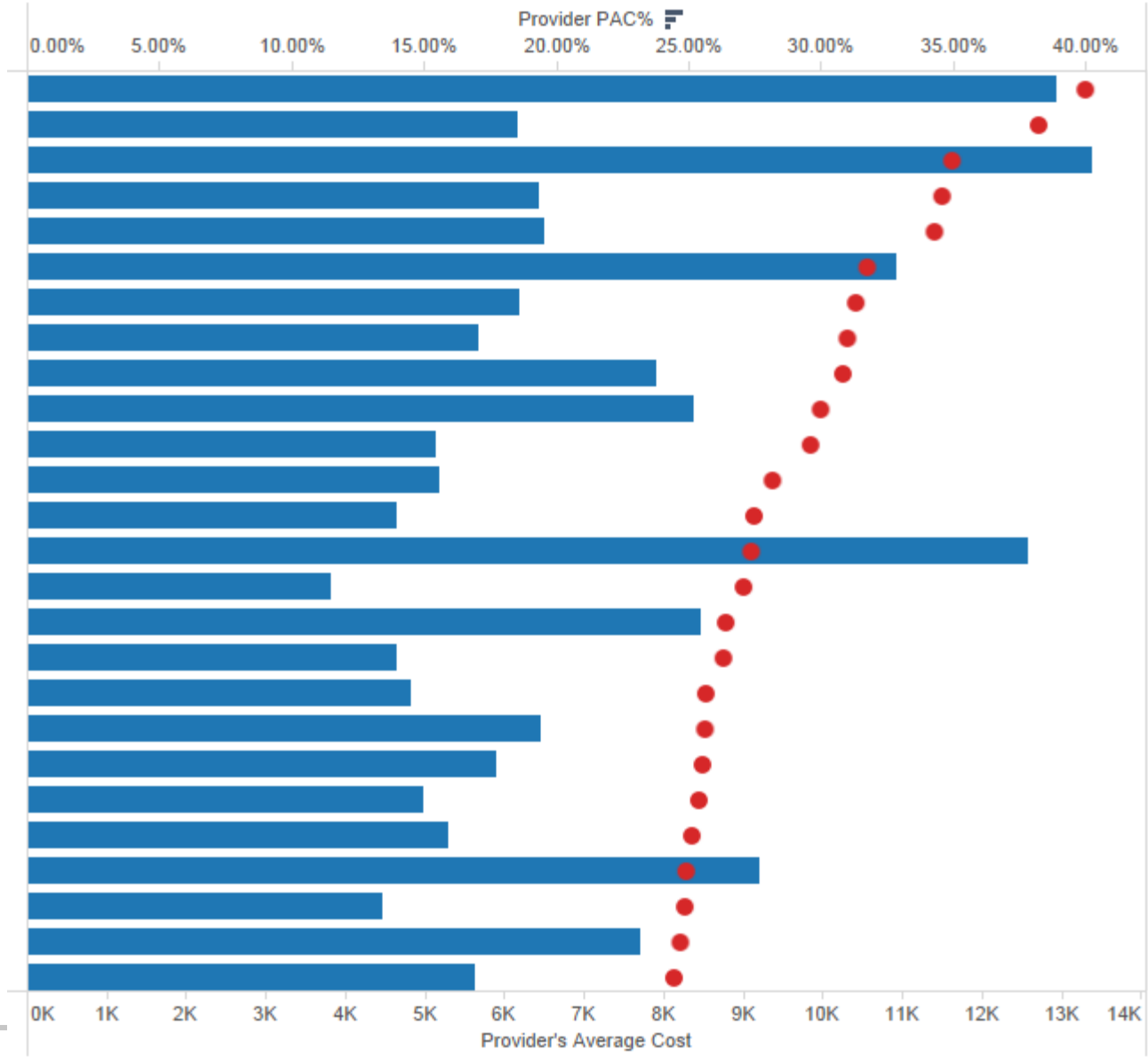
CxCABG - Commercial



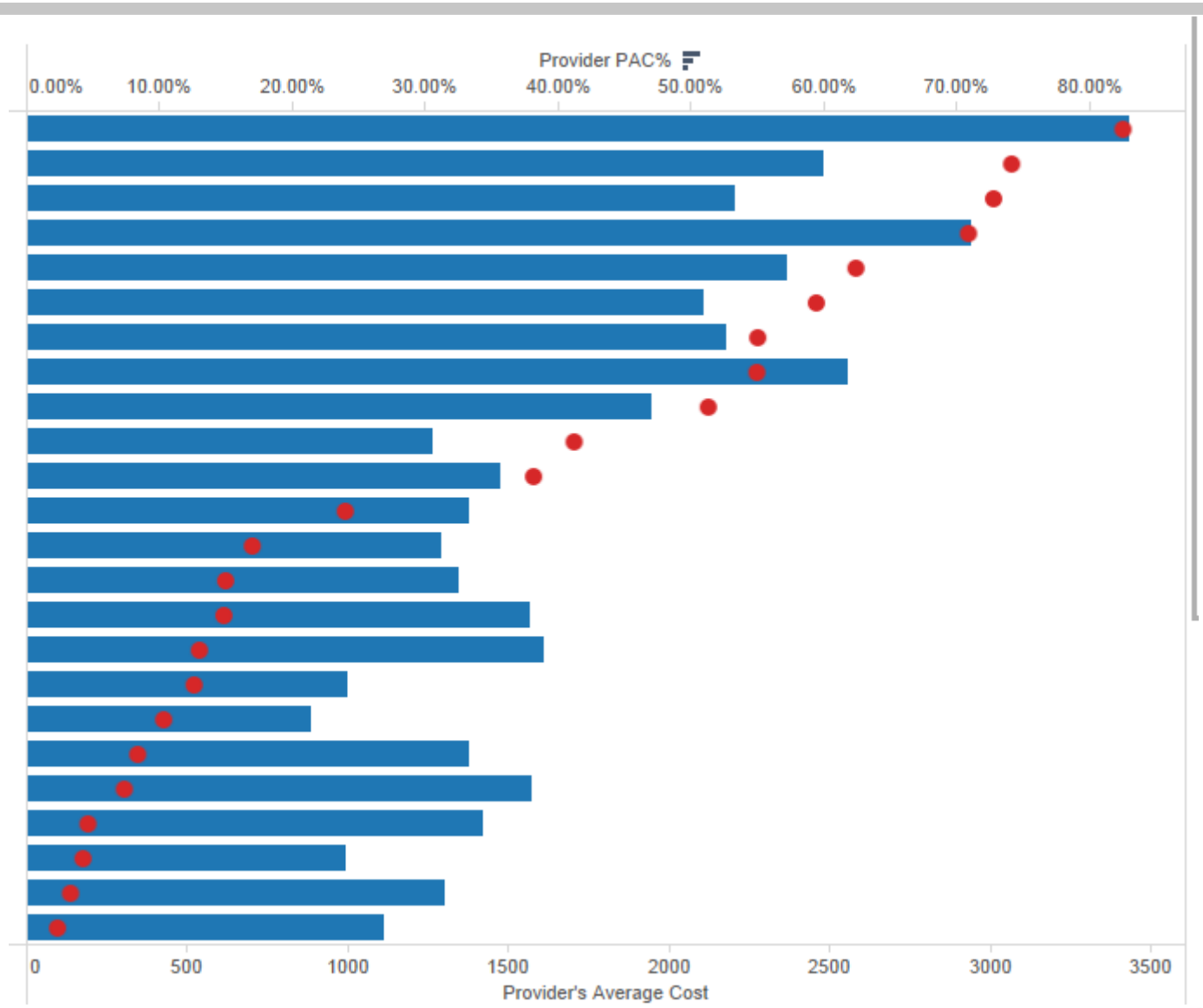
DIAB - Medicaid



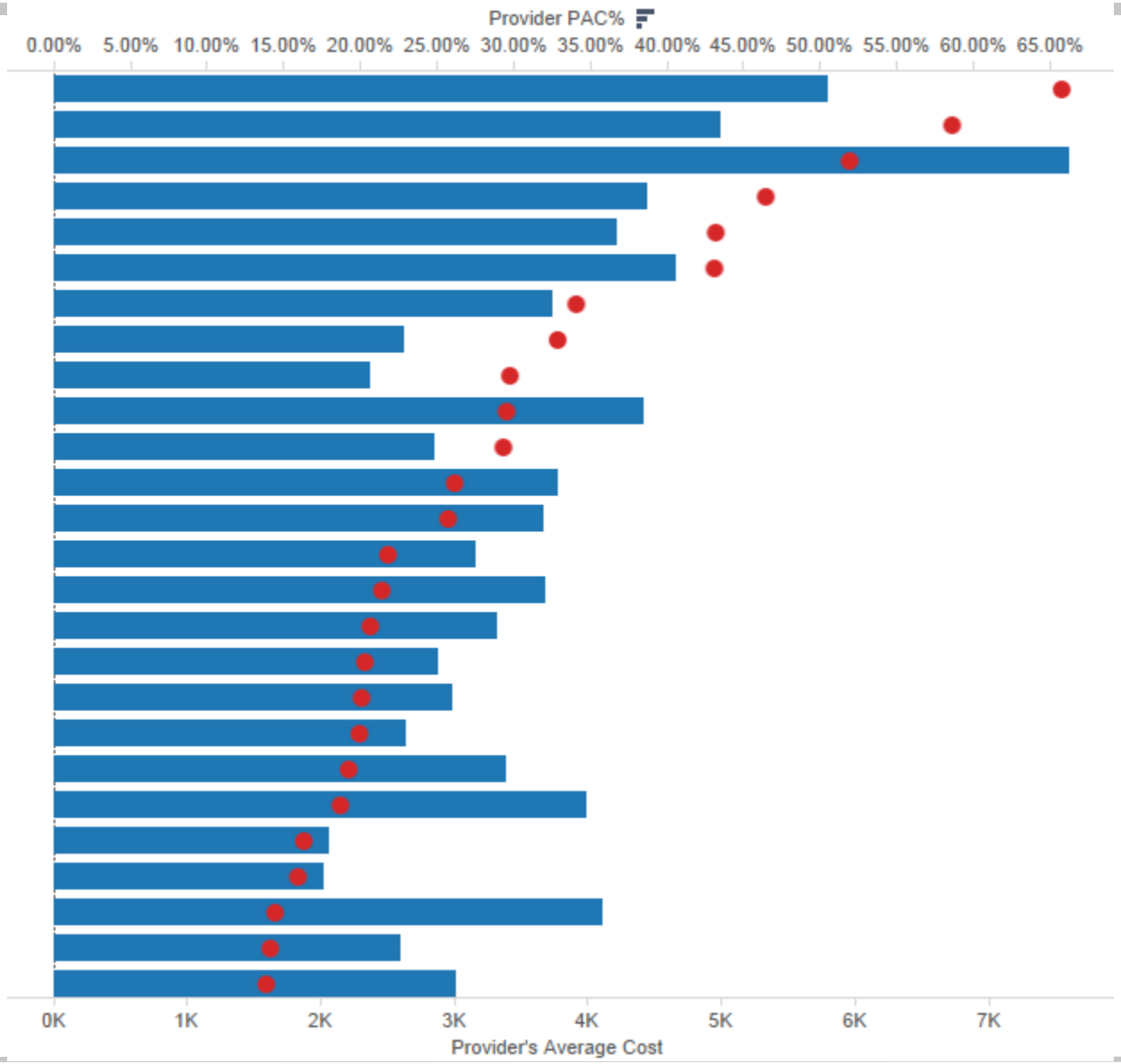
26 Providers with highest PAC % DIAB - Commercial



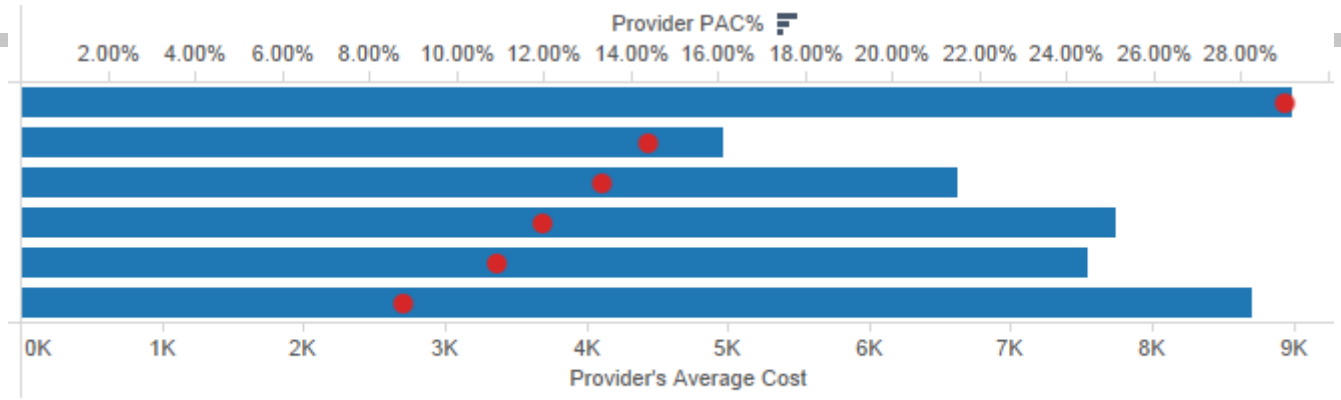
EGD - Medicaid



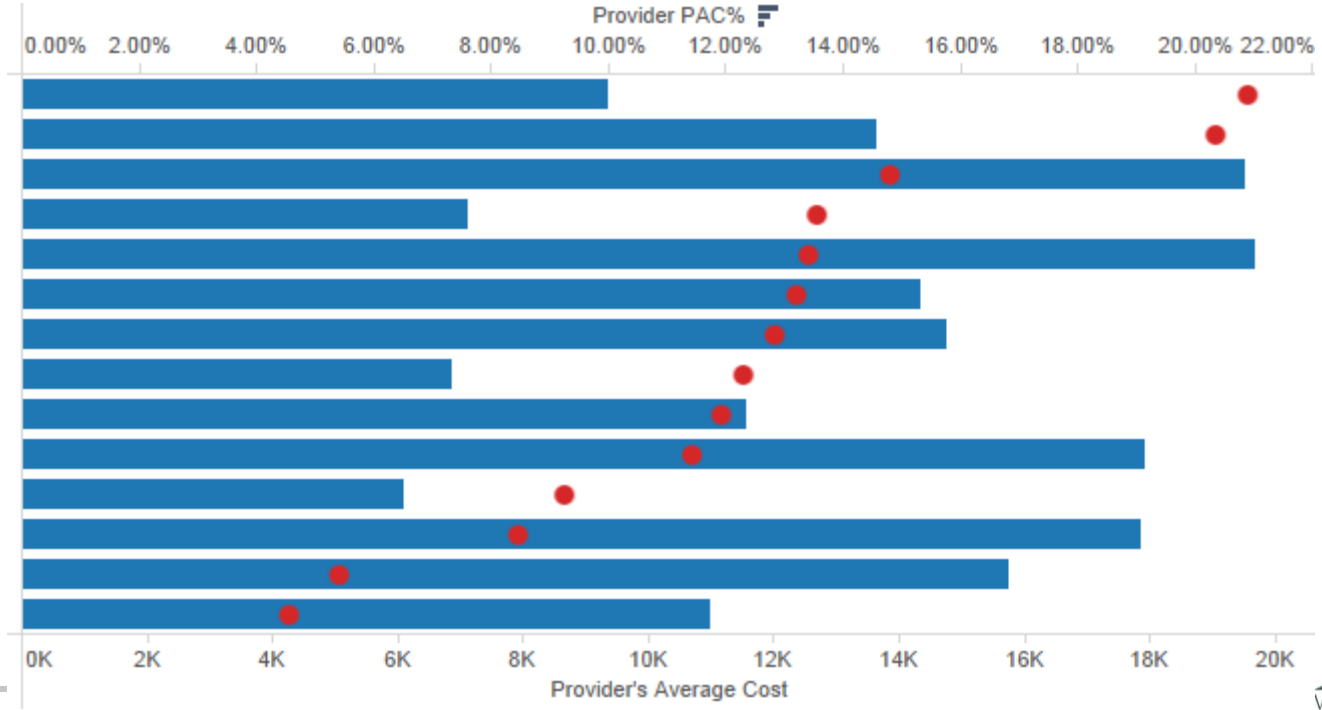
26 Providers with highest PAC % EGD - Commercial



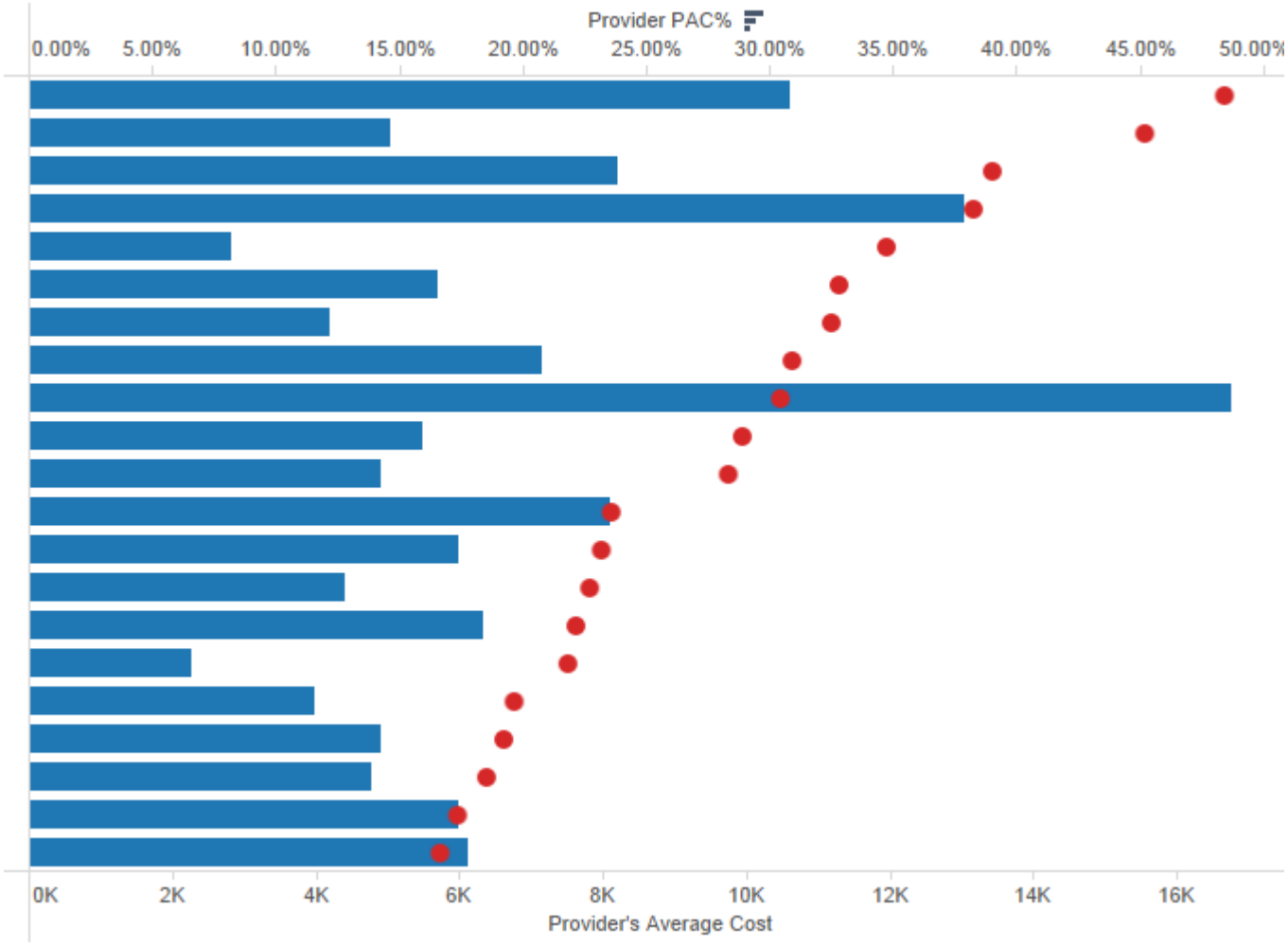
GBSURG - Medicaid



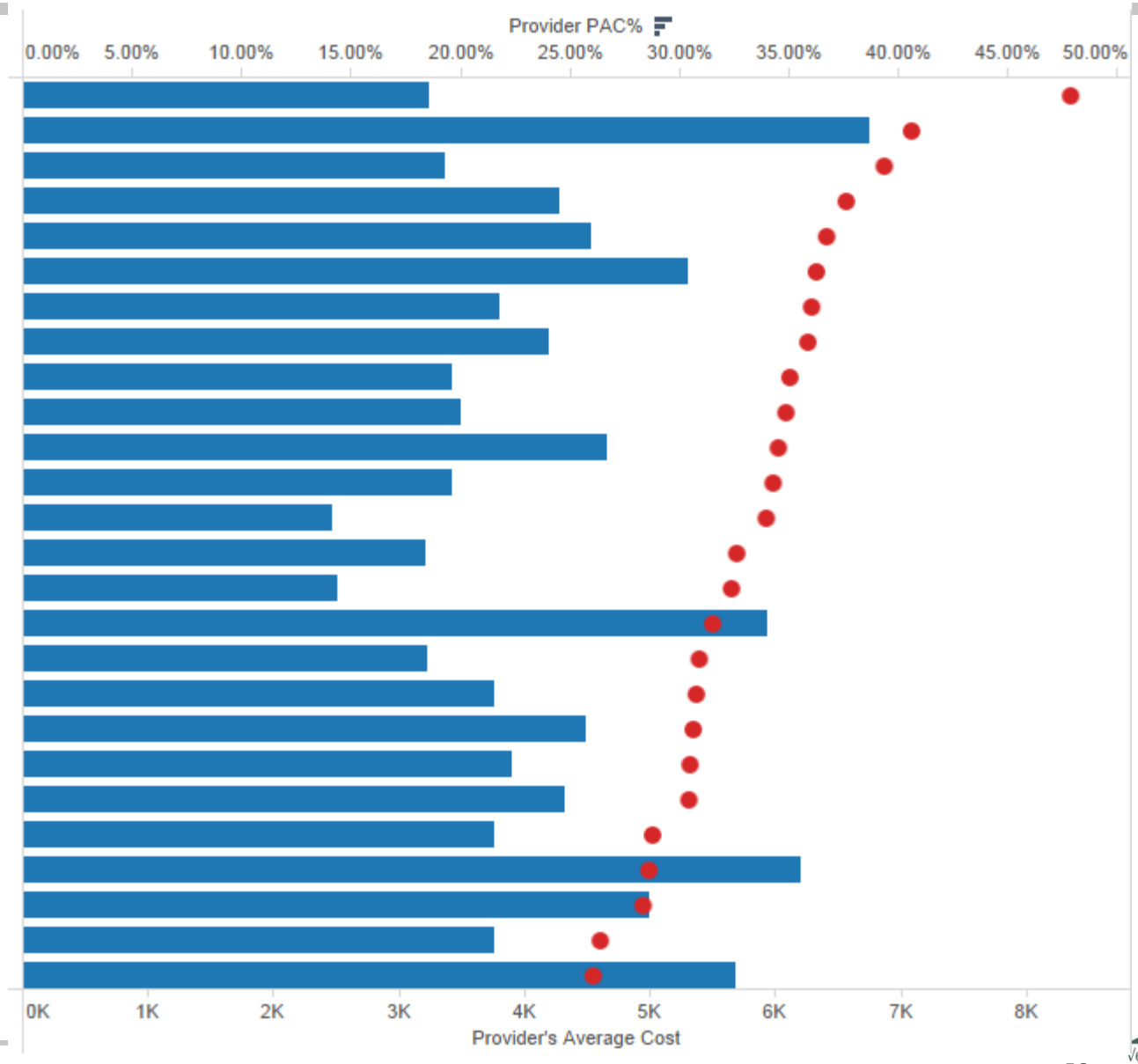
GBSURG - Commercial



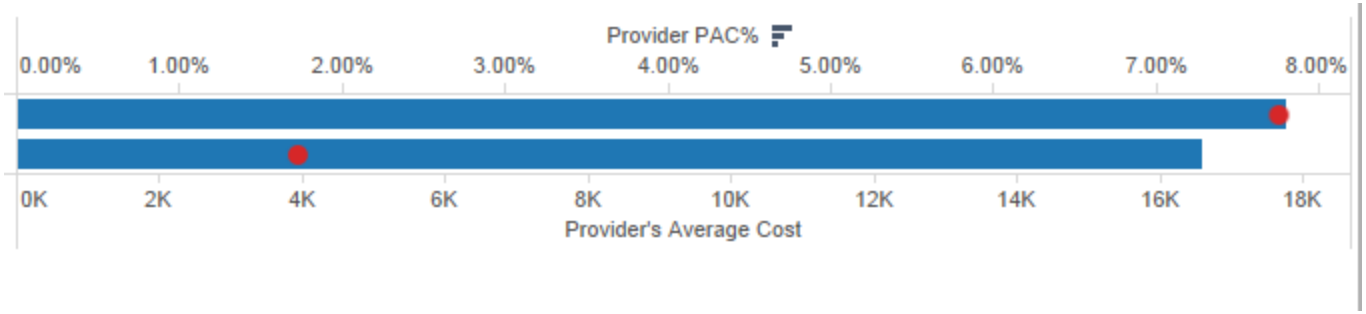
GERD - Medicaid



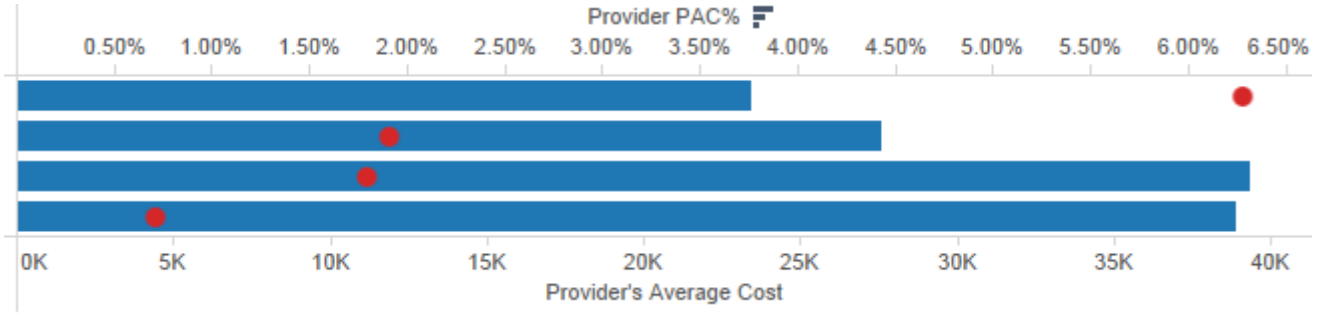
26 Providers with highest PAC % EGD - Commercial



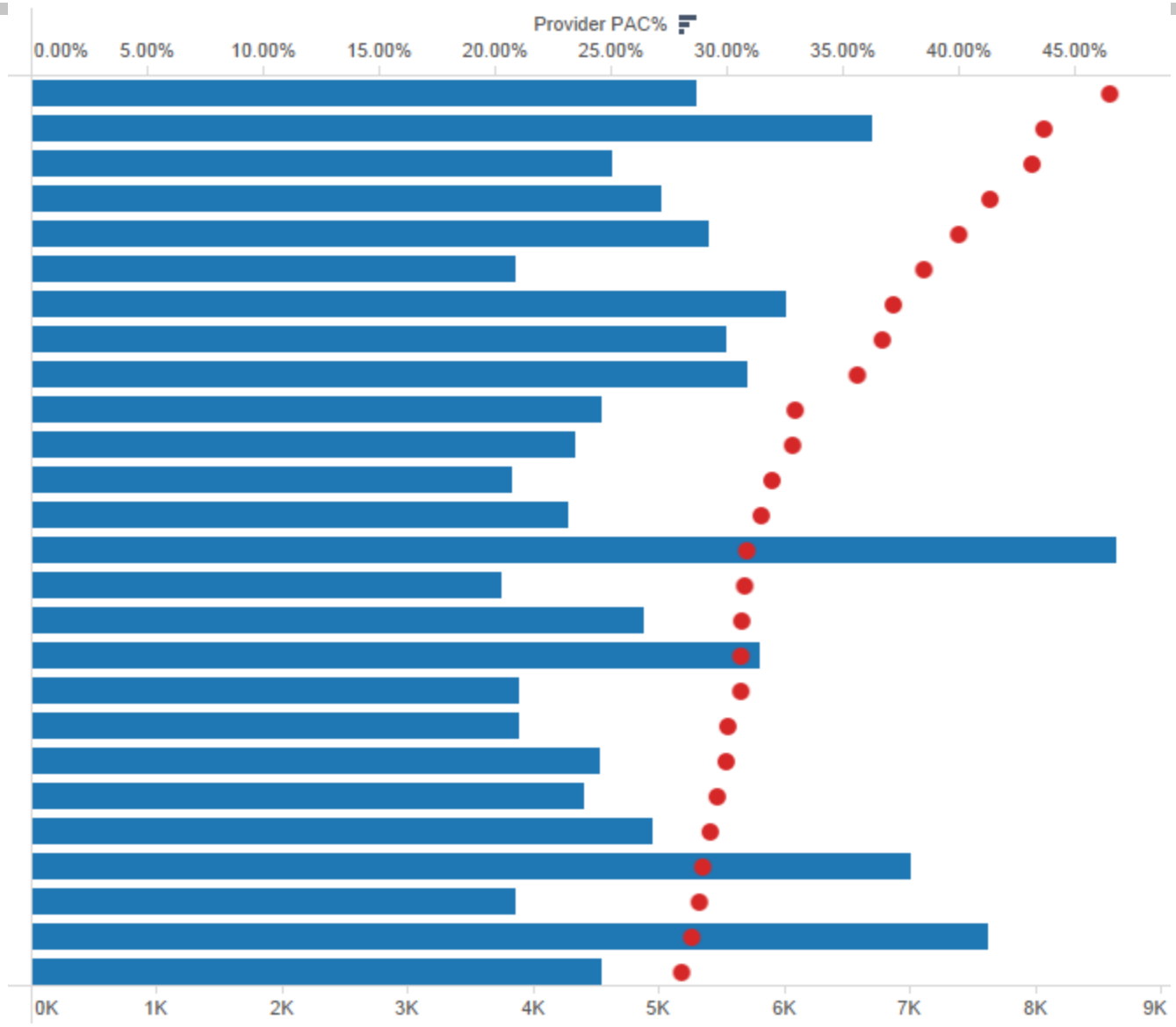
HIPRPL - Medicaid



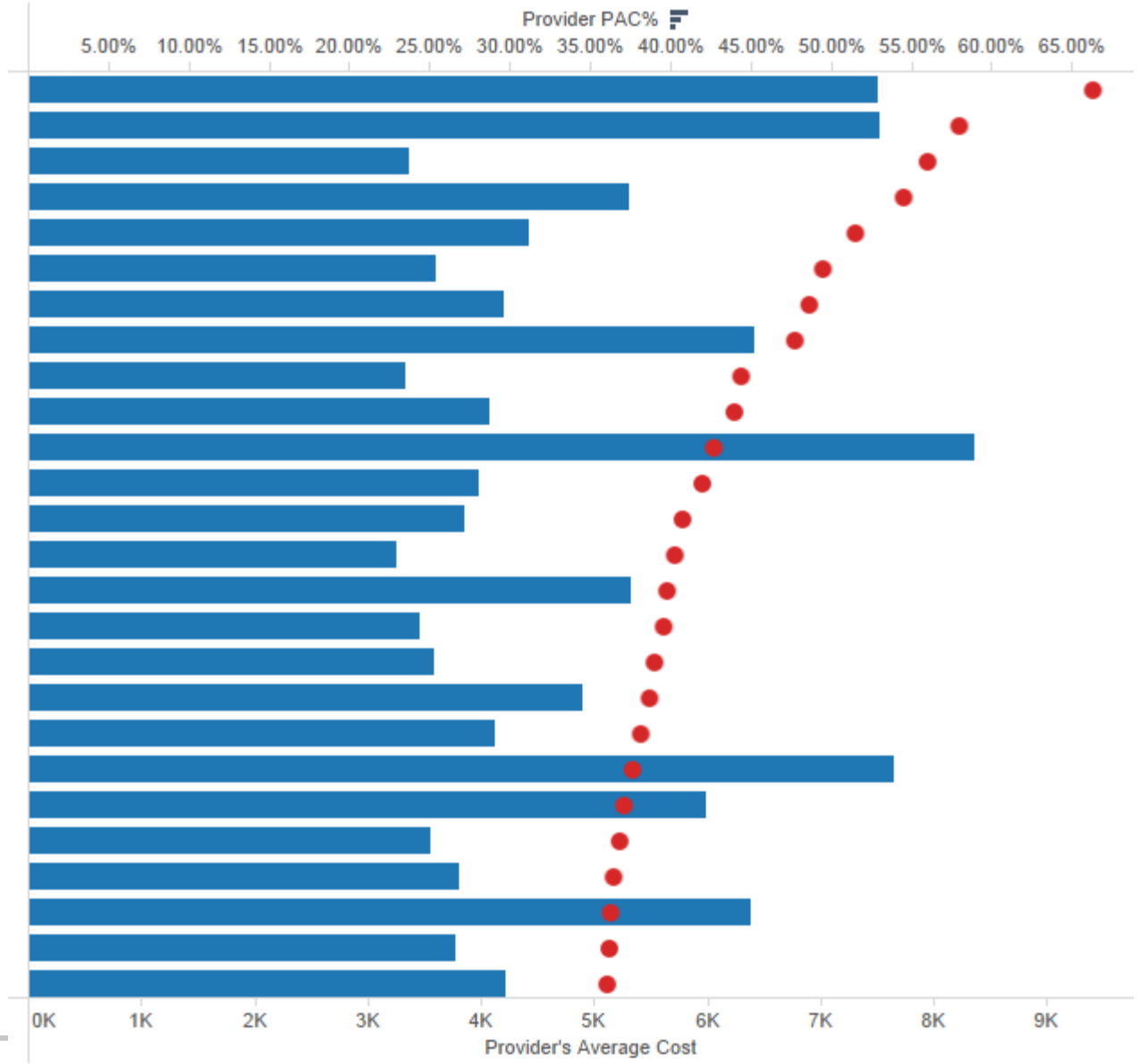
HIPRPL - Commercial



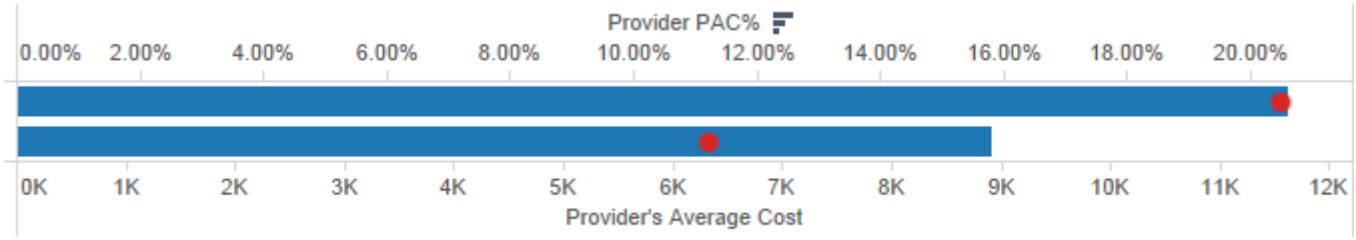
26 Providers with highest PAC % HTN - Medicaid



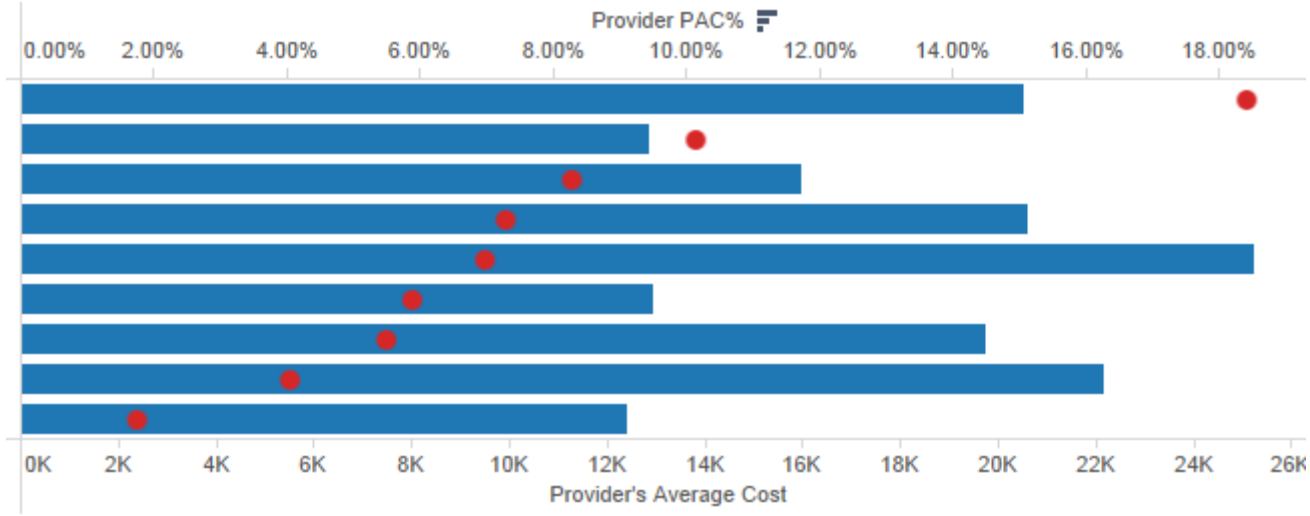
26 Providers with highest PAC % HTN - Commercial



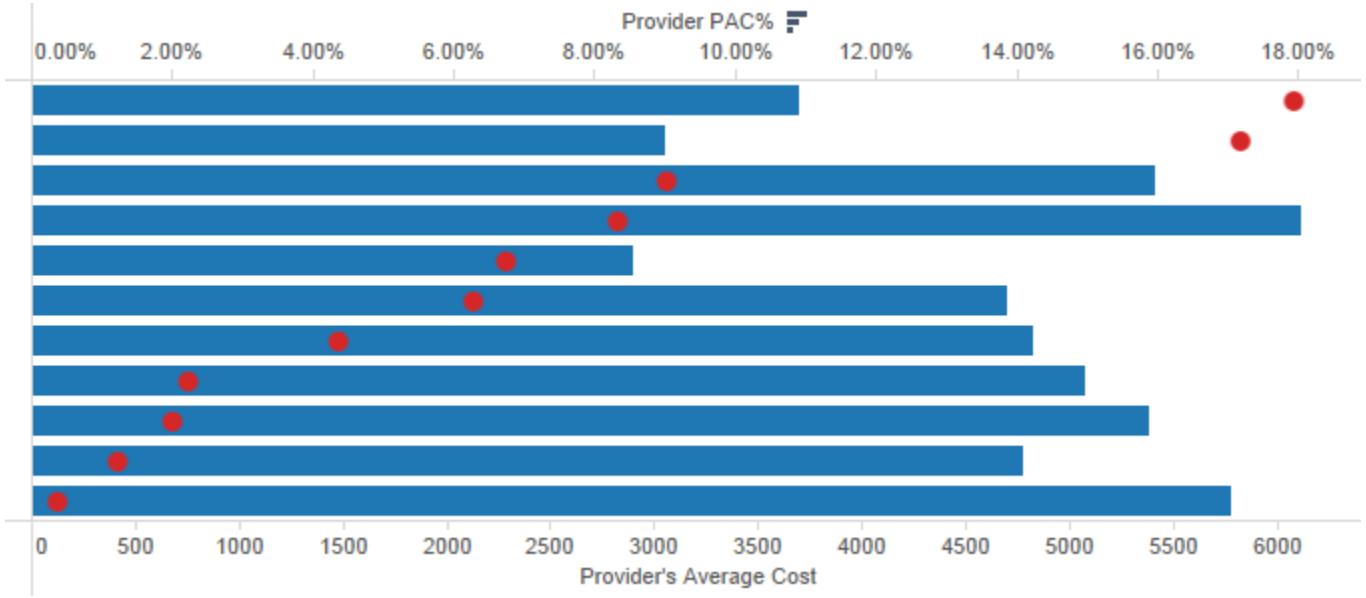
HYST - Medicaid



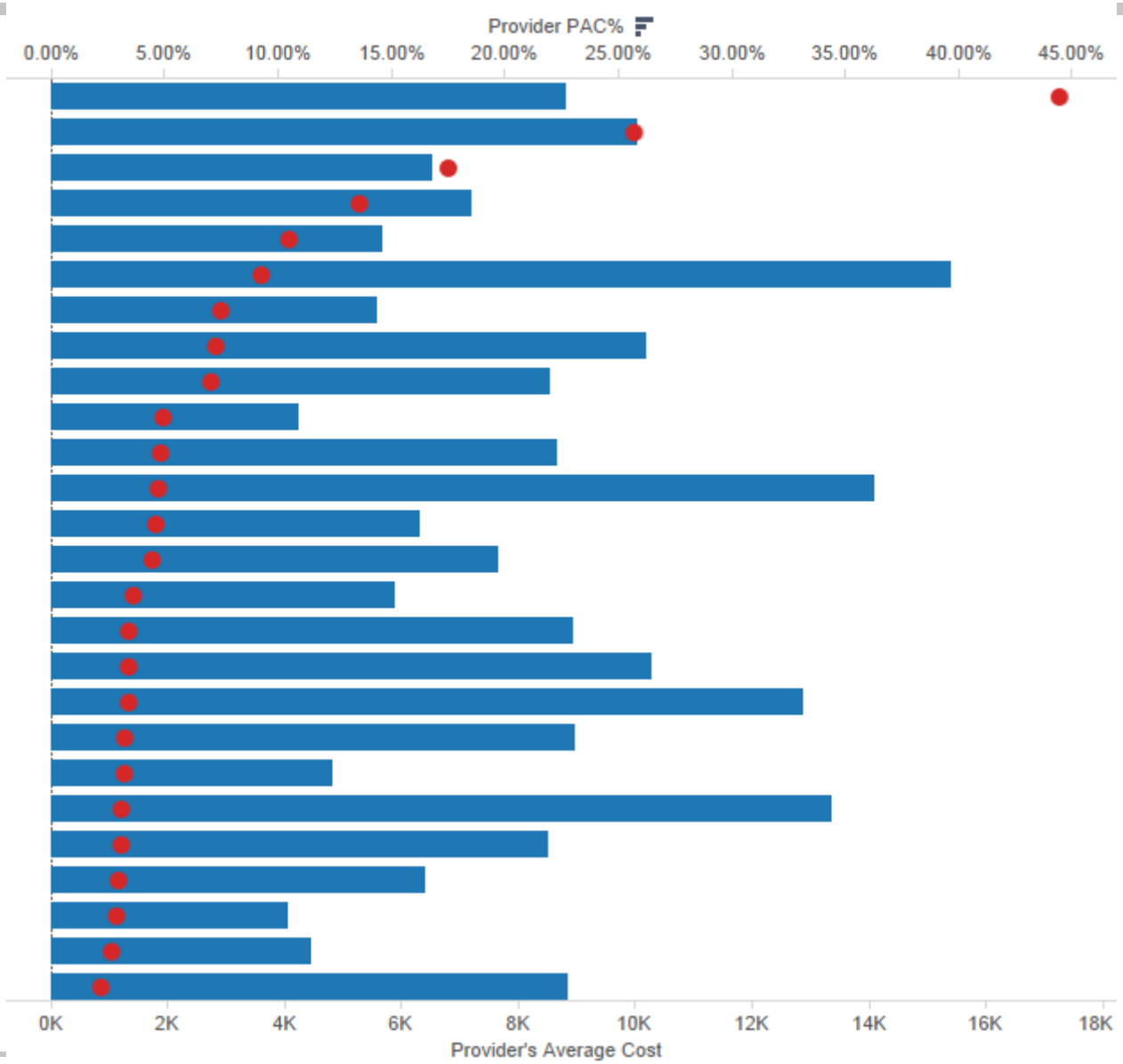
HYST - Commercial



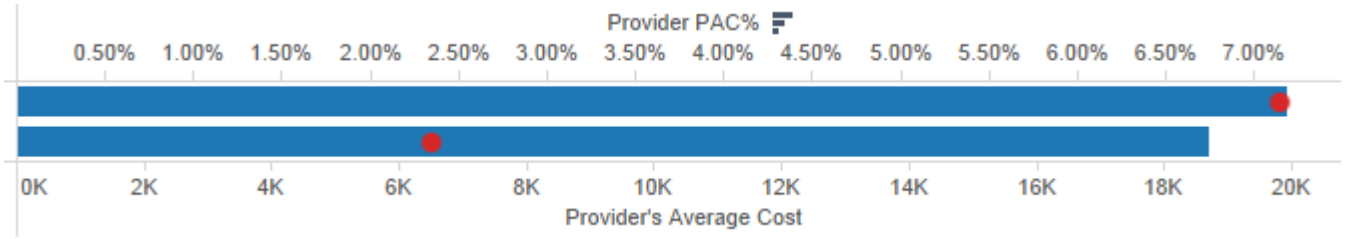
KNARTH - Medicaid



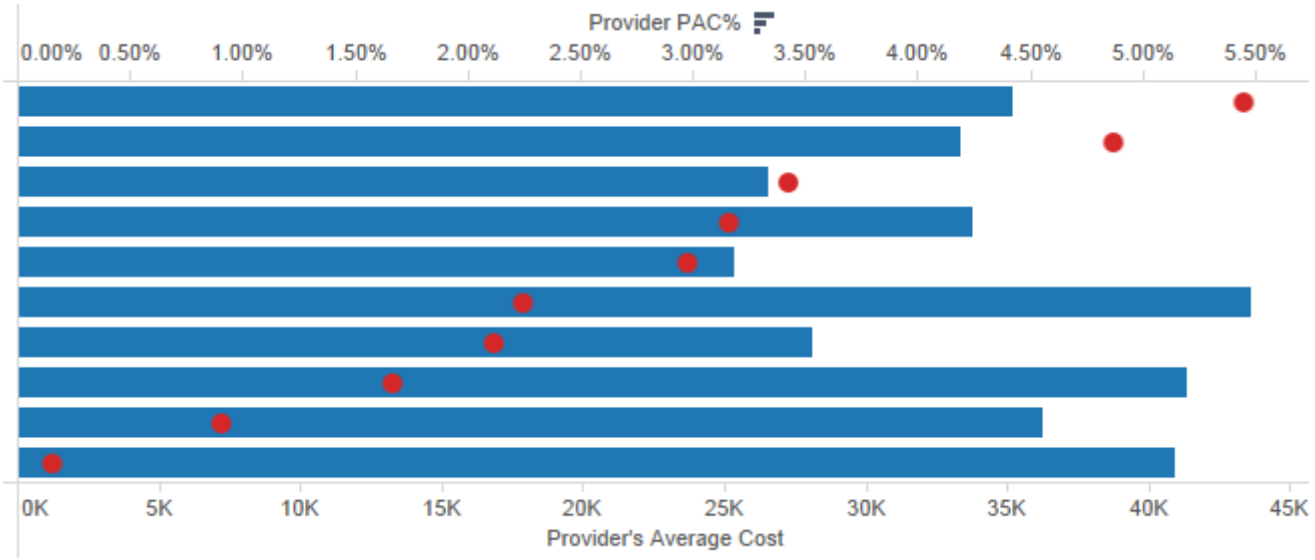
26 Providers with highest PAC % KNARTH - Commercial



KNRPL - Medicaid



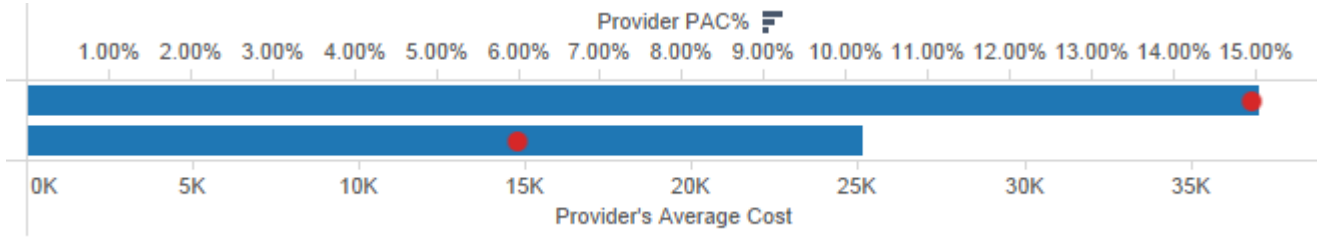
KNRPL - Commercial



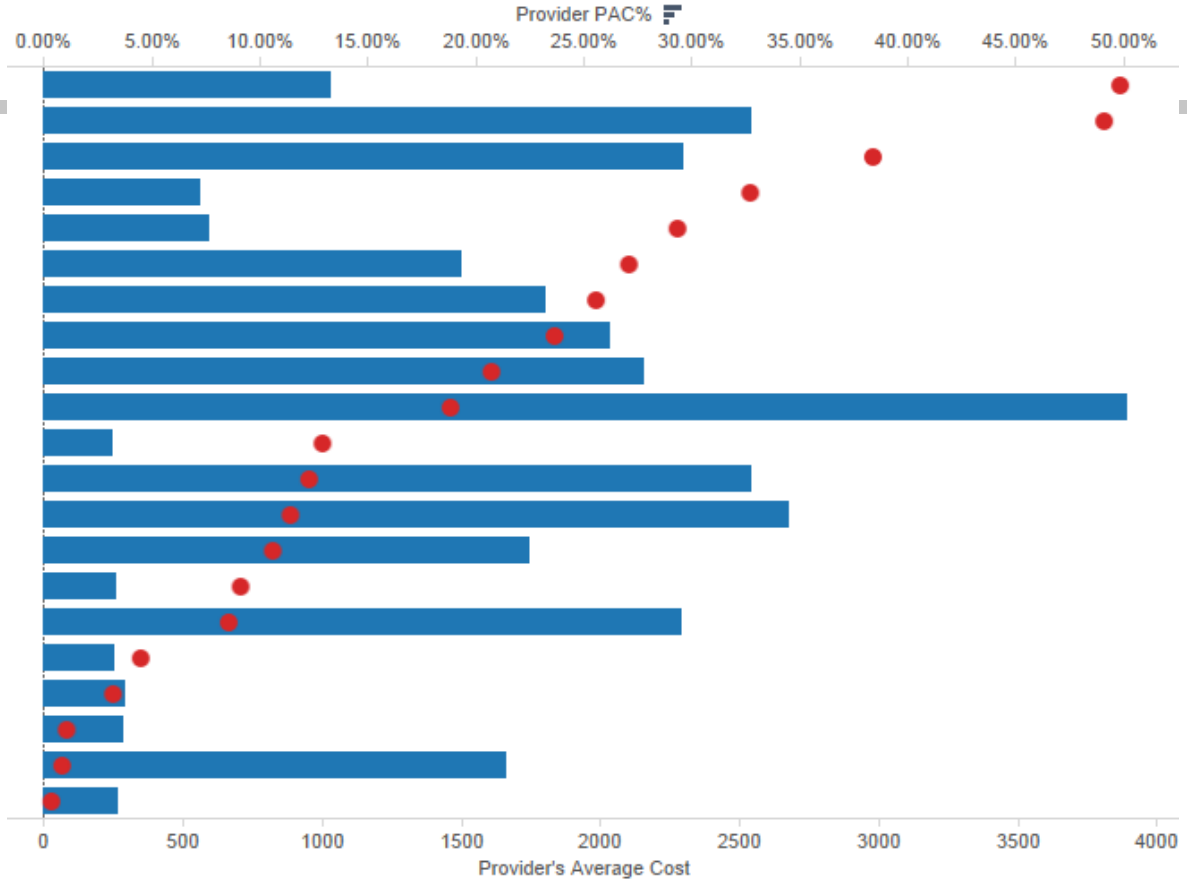
PCI - Medicaid

No Provider with 50+ patients

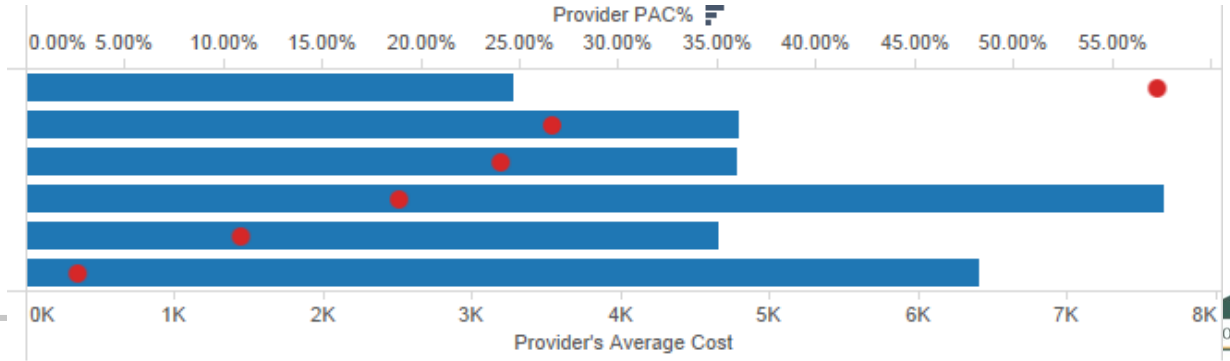
PCI - Commercial



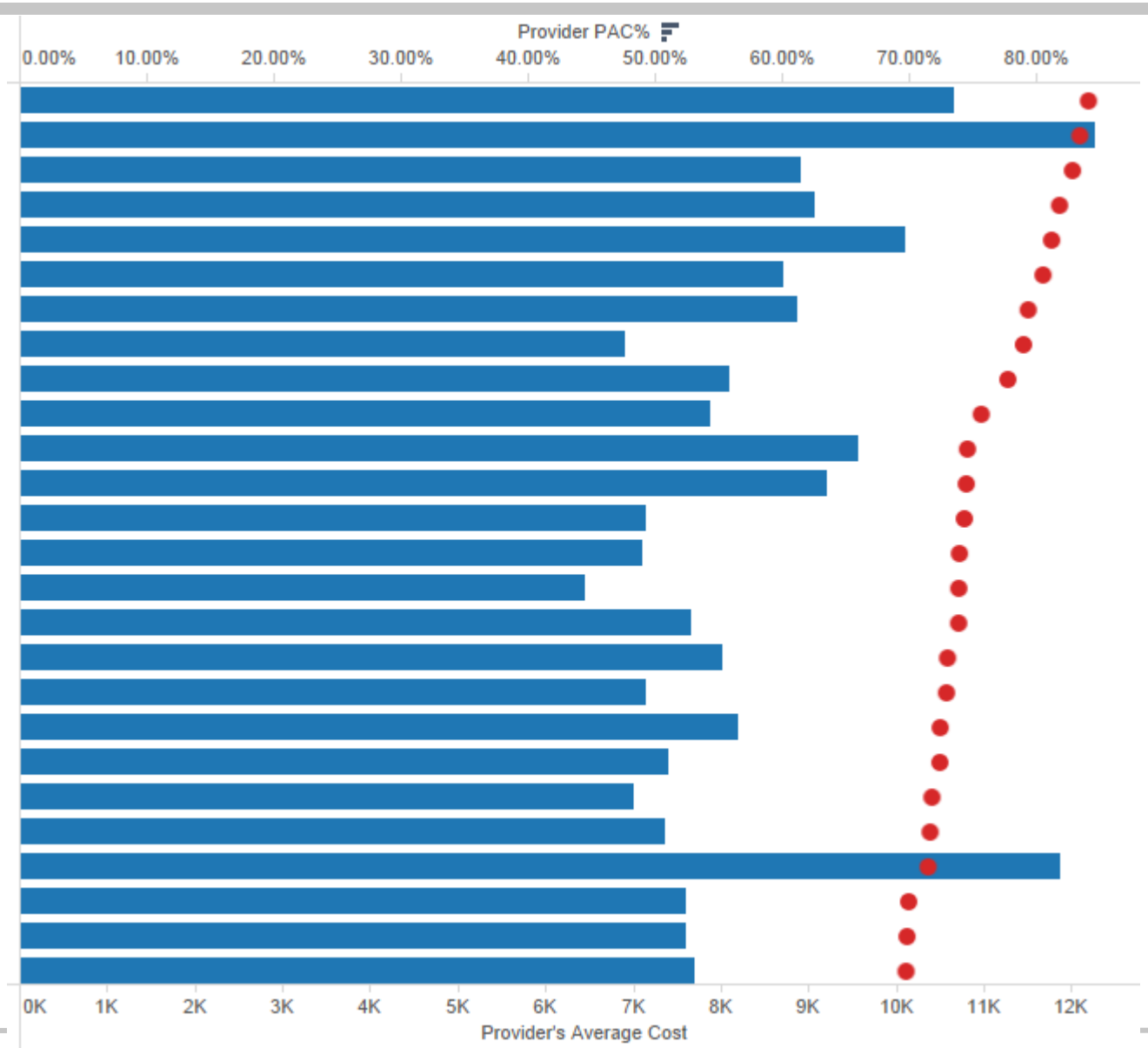
PNE - Medicaid



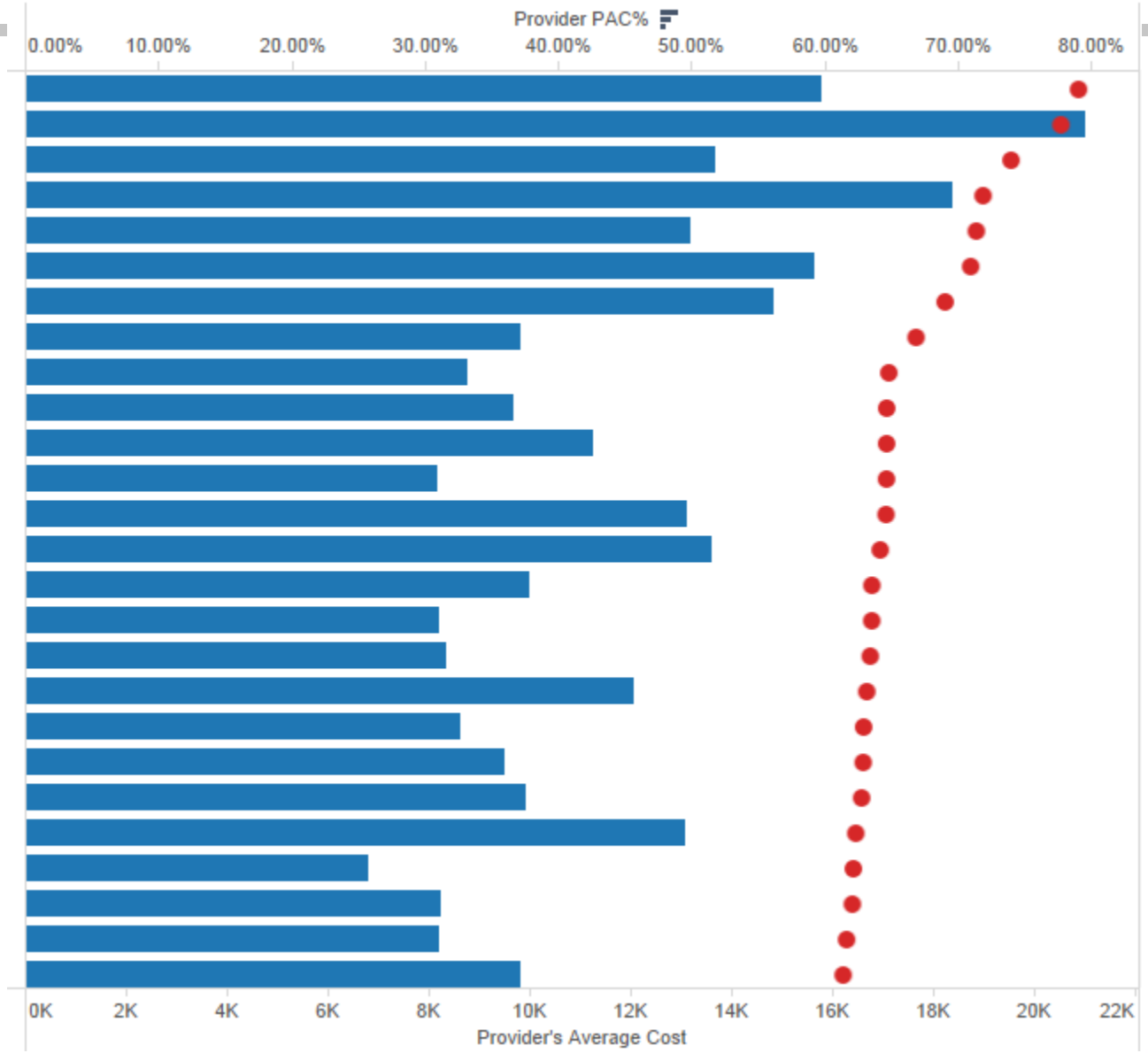
PNE - Commercial



26 Providers with highest PAC % PREGN - Medicaid



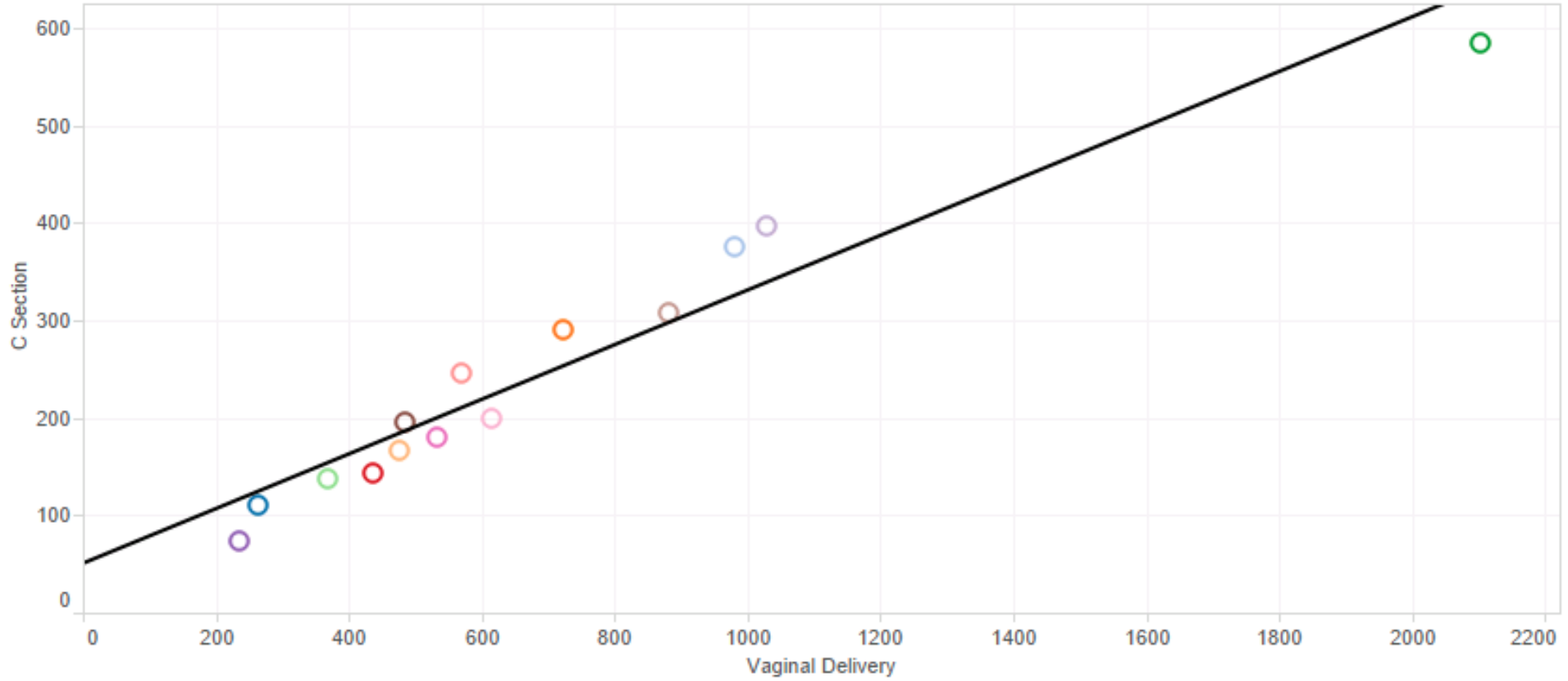
26 Providers with highest PAC % PREGN - Commercial



Data Book Slides 69-72

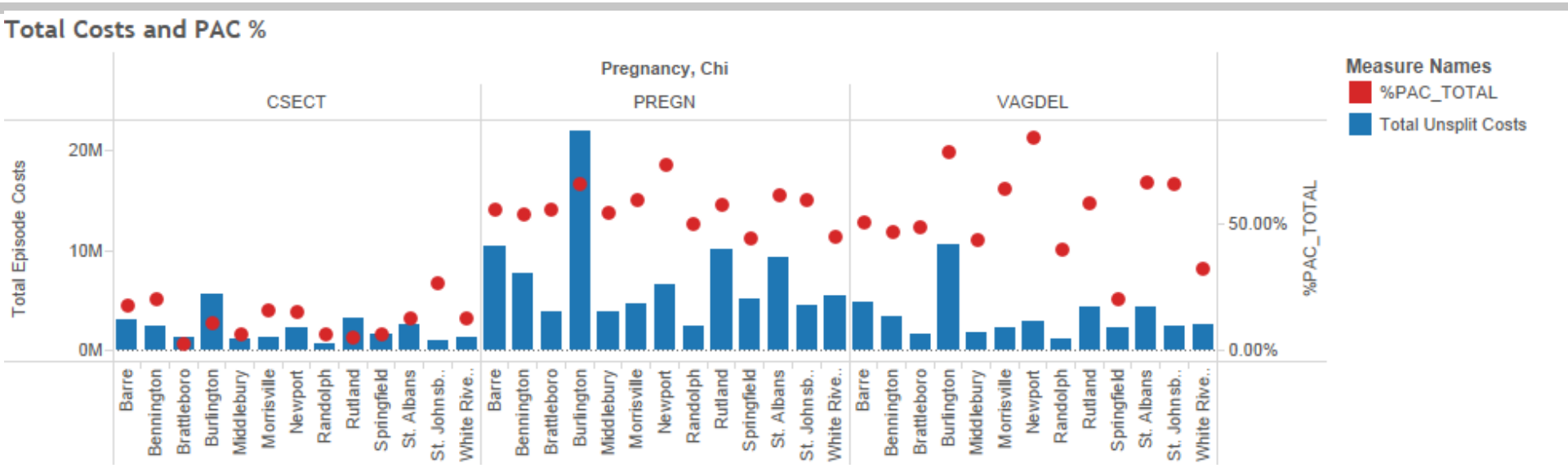
A FOCUS ON PREGNANCY

Number Of C-Sections & Vaginal Births By HSA – Commercial

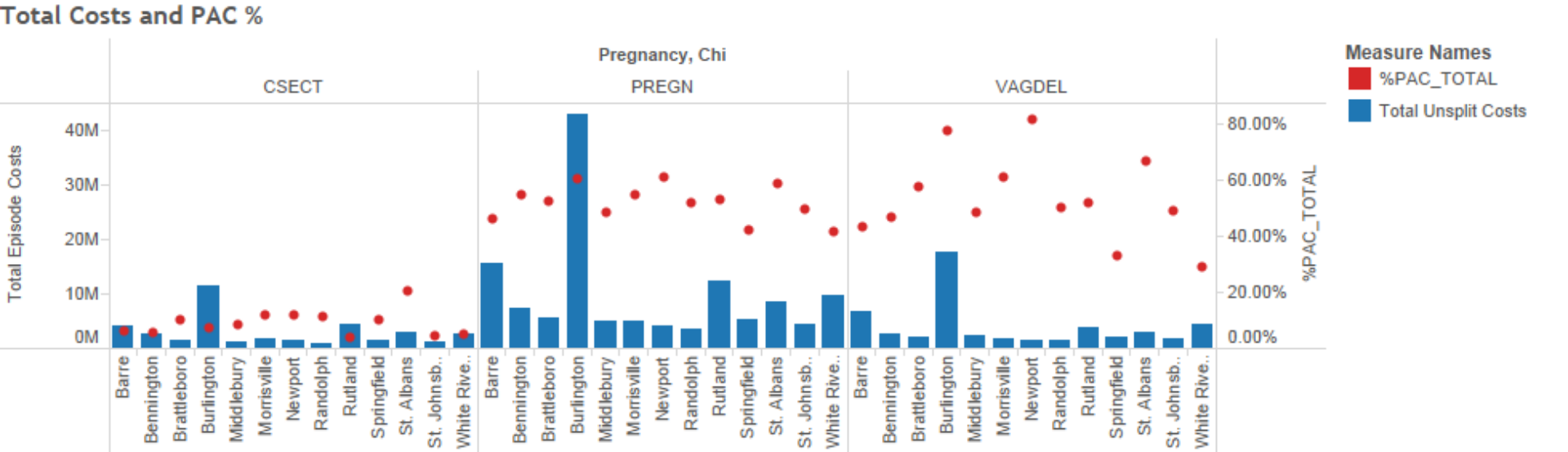


Payer Variation in Pregnancy/ Delivery

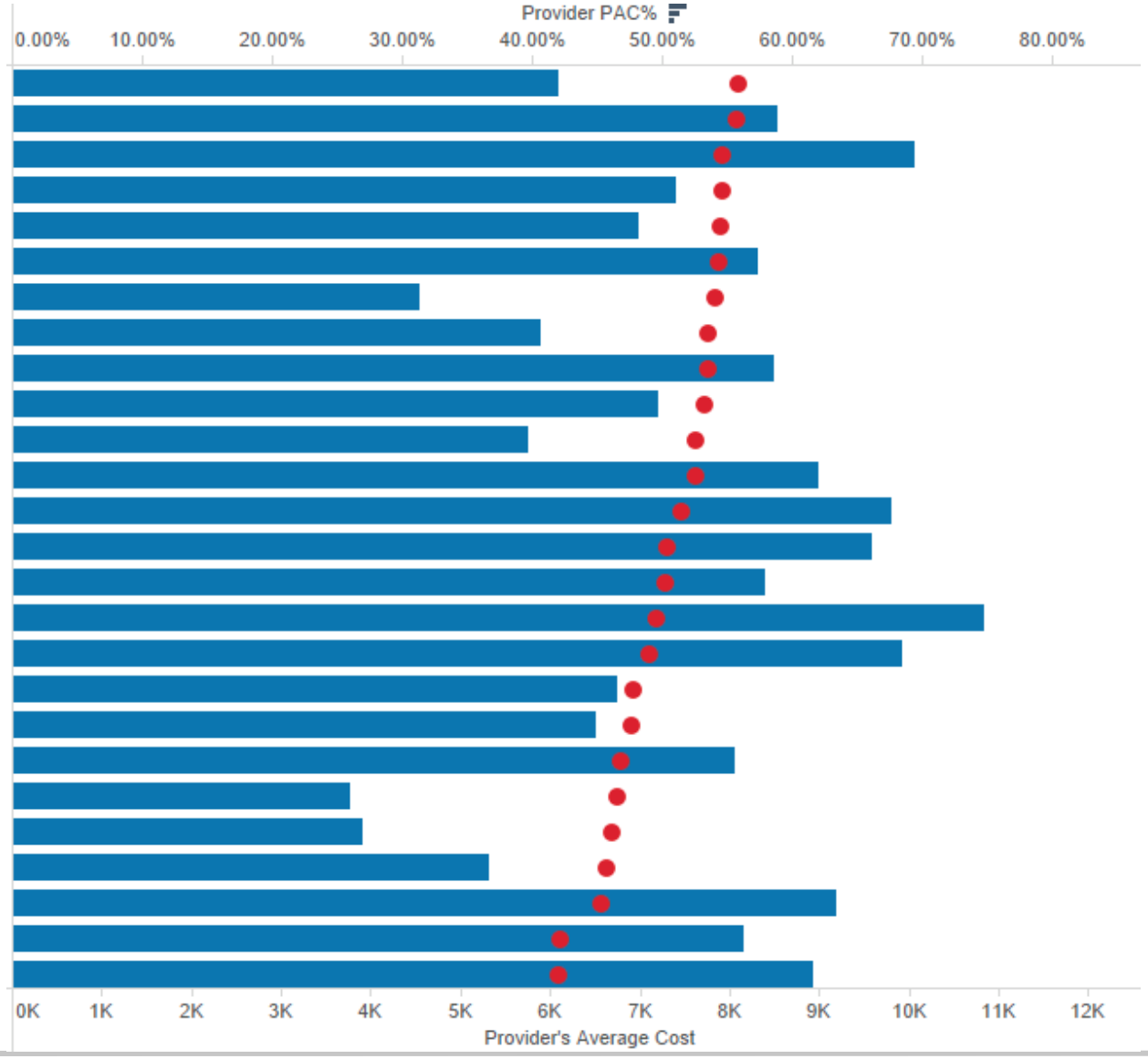
Medicaid



Commercial



Average Pregnancy & Delivery Costs And Pac Rates, By Provider, Commercial



Distribution & Volume of Providers For Pregnancy & Delivery Episodes

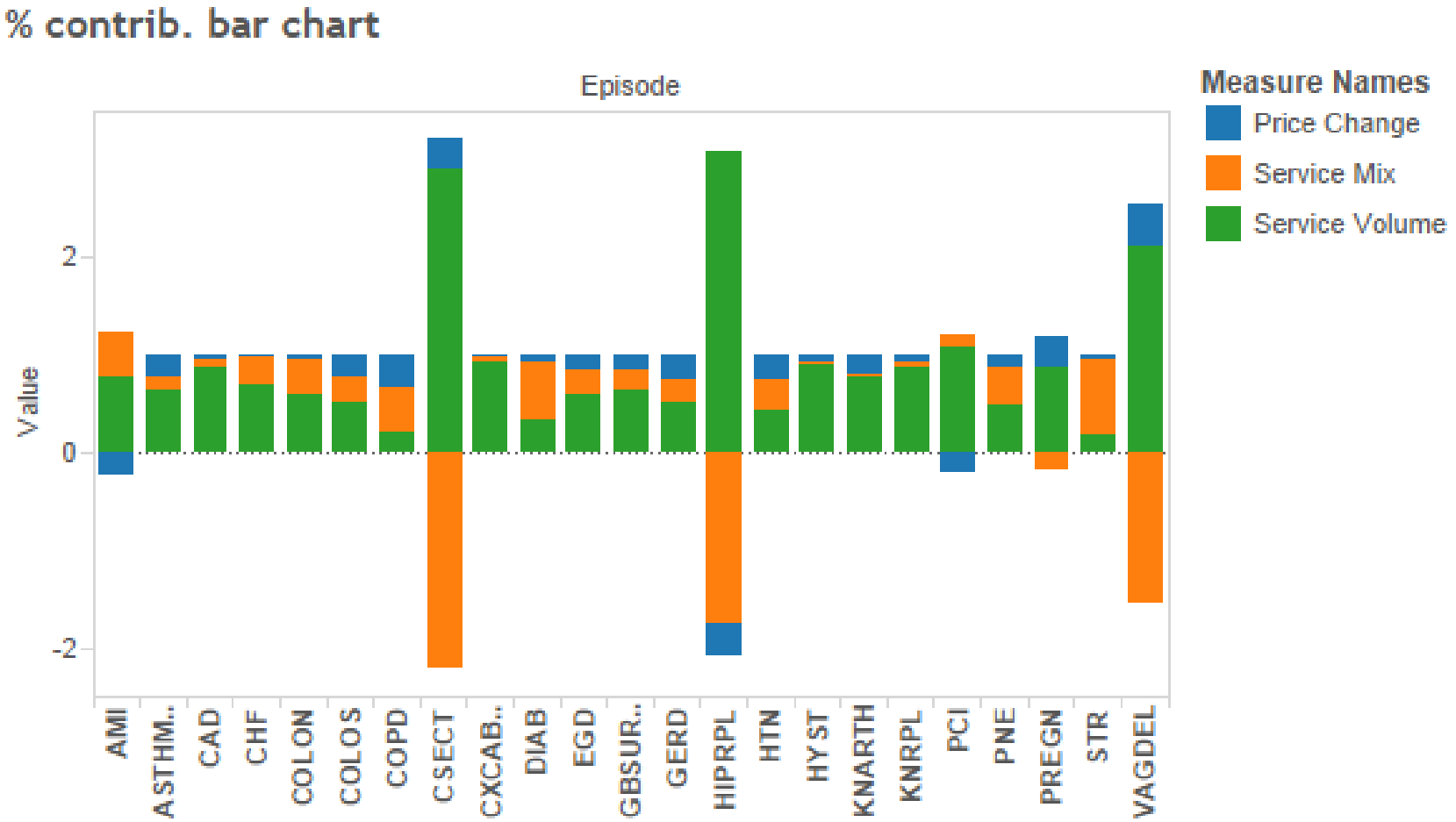
- The X axis represents the average of total episode costs by provider
- The Y axis represents the PAC % -- Note that elective C-section and early inductions are considered PACs
- The size of the bubble represents the volume of episodes
- All plotted providers have at least 30 complete episodes

Data Book Slides 74-75

DRIVERS OF VARIATION WITHIN EPISODES

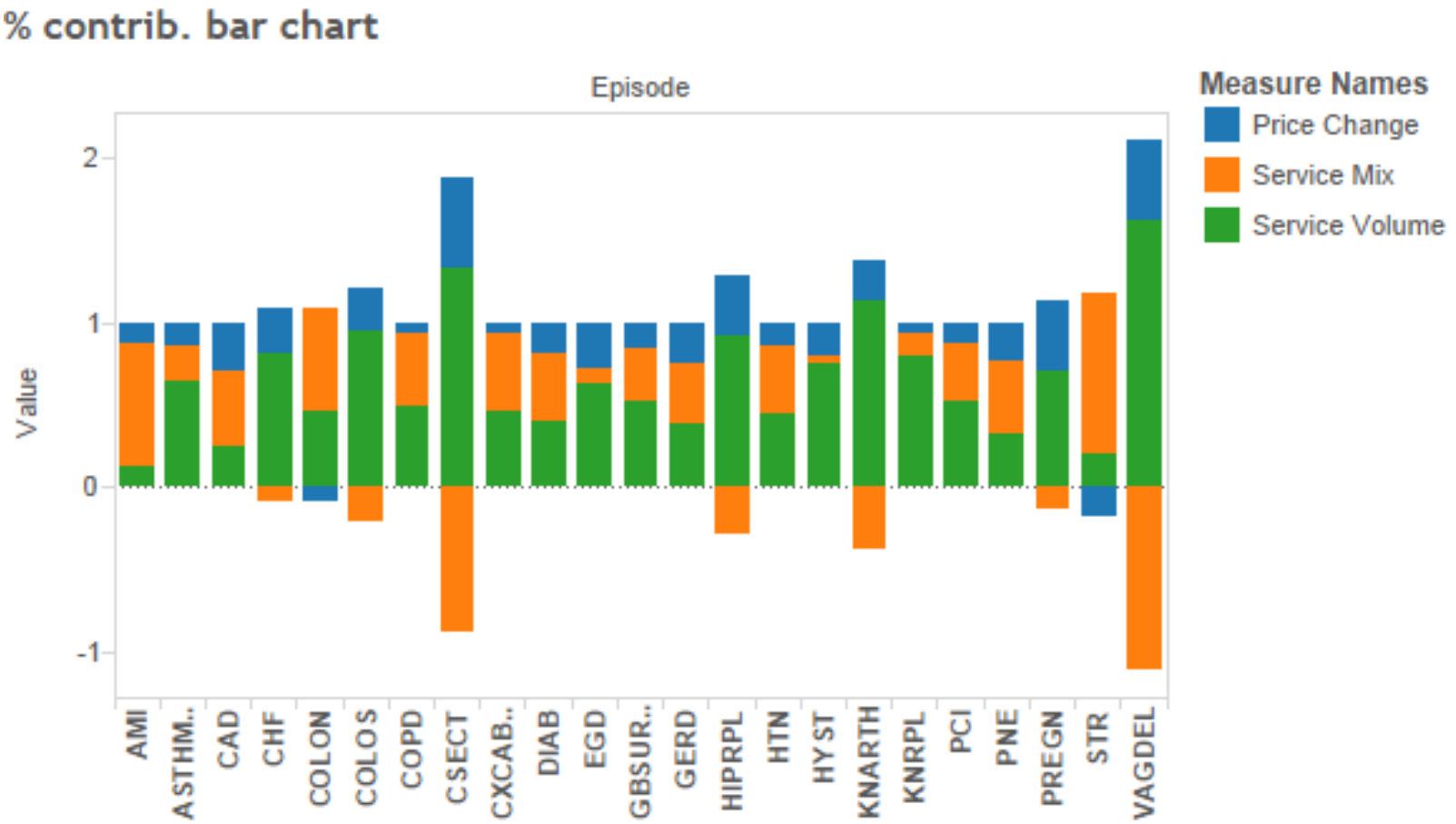
Percent Contribution

Medicaid



Percent Contribution

Commercial



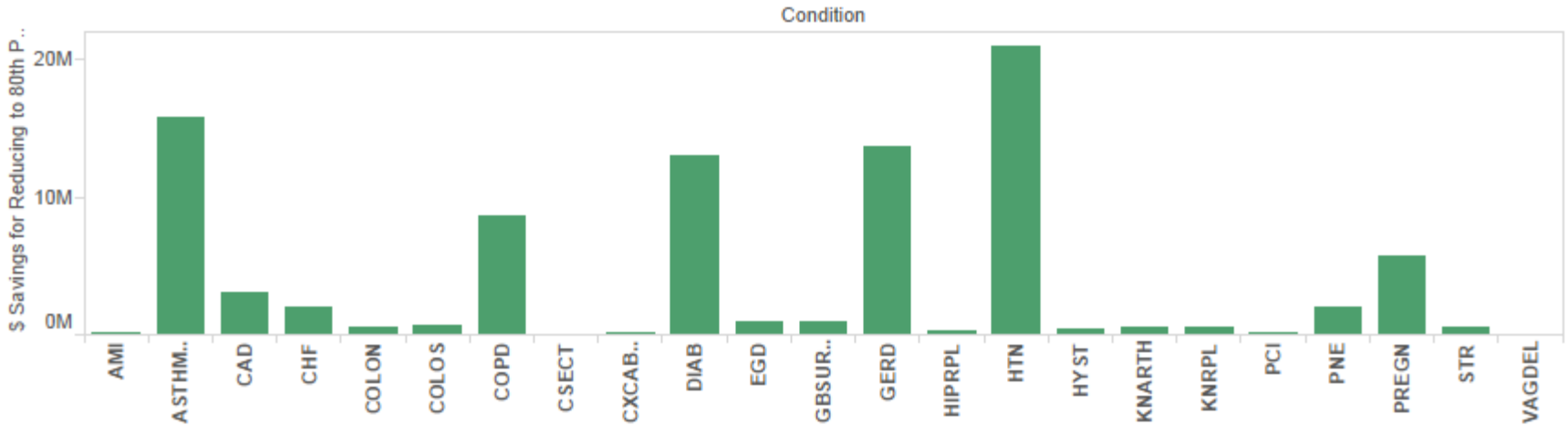
Data Book Slide 77

SAVINGS POTENTIAL

Savings Potential

Medicaid

$ Savings Bar Chart



Commercial

$ Savings Bar Chart