

Vermont Health Care Innovation Project Payment Models Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, April 20, 2015, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Don George called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was not present. A quorum was present following the second agenda item. At this time, Bard Hill moved to approve the March 2015 meeting minutes. Abe Berman seconded. A roll-call vote was taken; the motion carried with 3 abstentions.	
2. Episodes of Care Presentation	Alicia Cooper provided an update on the work of the Episodes of Care (EOC) Sub-Group (Attachment 2b). <ul style="list-style-type: none"> • Bundled payments based on episodes were included in Vermont’s original State Innovation Model (SIM) proposal to Centers for Medicare and Medicaid Innovation (CMMI); however, recognizing that bundled payments based on episodes were not a high priority for stakeholders, VHCIP is now pursuing EOC analytics to support delivery system transformation and other VHCIP activities. This work is being pursued by the EOC Sub-Group. Attachment 2b describes the charge of the Sub-Group. • Alicia gave a high-level definition of episodes of care and described how EOC analytics can support delivery system reform and broader VHCIP activities. • The EOC Sub-Group has now met five times. The Sub-Group has undertaken a review of preliminary Payment Models Work Group EOC analytics, existing EOC initiatives across the country and in Vermont (MVP), and discussed the potential for EOC analytics in Vermont. Thus far in Vermont, EOC analyses have been produced at the statewide and regional levels; the Sub-Group hopes to pursue practice-level analytics in the near-term, with the possible goal of including beneficiary-level detail in the future. • The Sub-Group has also discussed releasing an RFP seeking a vendor to provide EOC analytics to providers, and has developed a skeleton proposal describing what the Sub-Group would look for in a vendor (see Att. 2b, Slide 10). These proposed activities would likely provide practice-level EOC analyses. • The Sub-Group is seeking feedback from the Payment Models Work Group before deciding whether or not to pursue an RFP. • The EOC Sub-Group will meet again in early May to review feedback. 	Public Comment period is open through April 30, 2015. Please submit any written comment to Mandy Ciecior (amanda.ciecior@state.vt.us).

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	<p>The group discussed the following:</p> <ul style="list-style-type: none"> • Mike DelTrecco commented that he supports this effort, but it is important to clarify the intent and purpose of this work. How are the organizations doing payment reform going to use episode-based analytics if it won't be tied to payment? • Michael Bailit requested more information on how practice-level information could be useful for providers, and asked about the challenges that could prevent Vermont from pursuing beneficiary-level analyses. Alicia responded that data sources make this a challenge: one of the possible data sources, VHCURES (Vermont Health Care Uniform Reporting and Evaluation System), is de-identified but would be able to support practice-level analytics. The uniform claims extracts from participating payers are another possible data source, but the ability of payers to provider identified data varies, which would make it challenging to implement multi-payer episode analytics at the beneficiary level. Alicia noted that the Sub-Group has seen examples of MVP's episode analytics, all of which are practice-level. MVP reports that these reports have been very constructive for practices, and that beneficiary-level information could cause unnecessary focus on past care, especially outlier cases. • Larry Goetschius: From a practicing physician standpoint, this could support greater awareness of other ways of practicing. Alicia agrees – MVP and Arkansas EOC analytics also compare practices to their peers on various metrics, and have seen early success from this (ex/imaging in Arkansas). Mike DelTrecco agrees. • Mary Alice Bisbee: How will this impact beneficiaries? No beneficiaries are currently participating in the Sub-Group, but all decisions will go through the Payment Models Work Group. Don George noted that this is an inclusive process; Alicia will follow up with Mary Alice to see whether she is interested in joining the Sub-Group. 	
<p>3. Final Feedback on Blueprint Payment Methodology</p>	<p>Don George opened a discussion to provide final feedback on proposed changes to the Blueprint for Health Payment Methodology (Attachment 3). Kara Suter reminded Work Group members that there is ambiguity as to where Blueprint for Health oversight currently resides; this group decided against recommending changes to the Blueprint payment methodology that would go through VHCIP governance and instead will provide less formal feedback directly to the Blueprint Executive Committee for their consideration.</p> <p>Attachment 3 includes feedback developed based on Work Group discussion and written comment. This agenda item seeks to review and clarify this document to ensure it accurately captures previous discussions before it is submitted to the Blueprint Executive Committee.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • Paul Harrington commented that an email he submitted that is included in Attachment 3 accurately represents his feedback. He noted, however, that recent reports suggest that the bill currently before the Legislature that provides increased funds to support the Blueprint is unlikely to pass. Paul suggests 	

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	<p>this group wait until we know the final amount of revenue passed to support these changes. For this reason, he intends abstain from any vote on recommendations.</p> <ul style="list-style-type: none"> • Don George noted that recommendations and feedback are different. Don agrees with Paul that a recommendation would be premature; however, this is not a recommendation but collected feedback from members. He suggests that we continue this discussion. • Kara Suter suggests that the word “recommendation” is removed from any document this group submits to the Blueprint Executive Committee. Kara also noted that if there is legislative action, it will be for the period starting July 1, 2015; not submitting feedback now means that the Work Group would have to put something together quickly if legislation does pass. Kara suggests any feedback to the Blueprint Executive Committee supports a sound methodology rather than absolute dollar amounts. • Don George feels comfortable with this feedback going through the VHClP governance process, but notes that it isn’t an action item so should not need to. • Bard Hill clarified that this is feedback to the Blueprint Executive Committee without a funding source. Kara Suter agreed. Don George noted that this group has had a number of presentations from Craig Jones, who has indicated that he welcomed feedback from this group. • Richard Slusky agreed that there are principals this group could reaffirm. Richard asserted that it is clear that primary care is essential and foundational to the health of our health care delivery system, and that we are trying to support primary care practices and practitioners through whatever means we can, whether through enhanced payments, focus on coordination and collaboration between practices, or other means. In the proposal the Blueprint has made, there are specific implications, including that primary care practices should be National Committee for Quality Assurance (NCQA) certified in order to receive enhanced payments (a base level of standards set for primary care practices eligible for enhanced payments); that enhanced payments should be based on a defined set of performance measures; and that we are interested in supporting enhanced payment to community health teams (CHTs) to support their efforts to coordinate and collaborate with other providers through Unified Community Collaboratives (UCCs) and other efforts. The amount of money and interaction with other payment models are yet to be determined, but Richard suggests these could be guiding principles. • Kara Suter asked – is NCQA recognition voluntary for practices? Pat Jones believes that in the current version of the proposal, NCQA recognition is required for providers to receive Blueprint payments (see Jenney Samuelson’s 4/13 presentation to the Quality and Performance Measures Work Group). • Kara Suter suggested that the group discuss the relative amounts of base payment (based on NCQA recognition) and additional payments based on performance/quality. Kara has suggested that the relative amount of payment based on performance/quality increase over time, and the relative amount of payment based on NCQA recognition decrease over time. • Don George noted that the Work Group is not trying to reach consensus today and suggested that we identify commenters with each item of feedback in the document we submit to the Blueprint Executive Committee. Kara agreed with this suggestion and said that DVHA staff will ensure comments are 	

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	<p>attributed following this meeting.</p> <ul style="list-style-type: none"> • Richard Slusky suggested that his earlier comments (that NCQA recognition should be a prerequisite for enhanced base payments; that there should be additional payments to support and reward high performance; and that there should be additional payments to support CHTs) should be attributed to him and added to this document. • Kara Suter added that if UCC participation will be a requirement in the future, there will need to be rules that define this to help payers feel comfortable. <p>Paul Harrington moved to forward this feedback, with additional attribution to be added by DVHA staff, to the Blueprint Executive Committee. Kara Suter seconded, with the recommendation that the final list of feedback is distributed to the Work Group via email for final review before it is sent on.</p> <ul style="list-style-type: none"> • Larry Goetschius made a further recommendation that new funding allocated to CHTs be used based on recommendations by UCCs; this will support UCC leadership within each health service area. Kara agreed to add this to the document as well before it is distributed to Work Group members for review. <p>A roll-call vote was taken and the motion carried with 3 abstentions.</p>	
<p>4. CMS Next Generation ACO Model Presentation</p>	<p>Kara Suter presented on the Next Generation Accountable Care Organization (ACO) Model, announced by the Centers for Medicare & Medicaid Services (CMS) in March.</p> <ul style="list-style-type: none"> • The Next Generation Model attempts to address concerns about previous Medicare ACO models, including attribution and benchmarking. It also aligns with the CMS goal to quickly increase the percentage of Medicare payments that are value-based payments over the next few years. • Kara invited the ACOs to comment on their own experiences under previous Medicare ACO programs. <ul style="list-style-type: none"> ○ Abe Berman from OneCare agreed that retrospective attribution was a challenge of the Medicare Shared Savings Program (MSSP) and Pioneer ACO programs. ○ Kara noted that Vermont’s Medicaid Shared Savings Program (VMSSP) and Commercial Shared Savings Program share many of these issues; Vermont will need to decide how to address them. ○ Abe commented that one of the goals of the Next Generation Model is to provide additional flexibility for providers to pursue alternative payment methodologies and support additional providers taking on down-side risk and moving toward population-based payments. • <i>Key Changes:</i> Kara discussed key ways the Next Generation Model differs from previous Medicare ACO models. These include fixed benchmarks; four payment tracks that encourage ACOs to move toward capitation; higher levels of risk and reward; increased access to some service types as part of loosening of utilization management controls; payments to beneficiaries that reward staying in-network; increased communication between CMS and beneficiaries; and larger minimum beneficiary requirements. (Attachment 4b compares the Next Generation Model with Pioneer ACO, MSSP, VMSSP, Commercial SSP models.) • <i>Key ACO Qualifications and Program Timeline:</i> Abe Berman noted that in terms of participation in the 	

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	<p>Next Generation program, CMS is seeking organizations that are experienced at and comfortable with taking downside risk; CMS only expects to approve 15-20 ACOs for this program. ACOs cannot participate in both MSSP and the Next Generation program. ACOs can begin participation in either 2016 or 2017; both tracks will end in 2020. Selection criteria are similar to the VMSSP and Commercial SSP programs, and could support Vermont in gathering lessons about ACO qualifications and selection criteria.</p> <ul style="list-style-type: none"> • <i>Participating Providers:</i> Concept of participating providers has transformed since MSSP: the Next Generation model will include provider suppliers (attributing providers, consistent with MSSP), and new categories including preferred providers (provide benefit enhancements, ex/telehealth or home visits – not attributing), and Next Generation Affiliates (including Capitation Affiliates, who could participate in capitation arrangements, and Skilled Nursing Facility [SNF] Affiliates, which would circumvent SNF 3-Day Rule). • <i>Financial Benchmark:</i> The Next Generation Model is based on a prospective benchmark that takes into account a one-year historic spend, regional projected trend, risk adjustment, and a discount based on quality and both regional and national efficiency. (See Attachment 4a, Slide 11 and Appendix A.) • <i>Risk Arrangements and Payment Mechanisms:</i> Two possible risk arrangements; four possible payment mechanisms offers non-fee-for-service revenue options for interested providers. Capitation is an option beginning in 2017. (Note: In Option 2, Normal FFS + Monthly Infrastructure Payment, monthly infrastructure payments are included in total spend during year-end reconciliation of benchmark and actual spend; see Appendix B for additional information on payment mechanisms.) • <i>Beneficiaries:</i> Beneficiary eligibility is similar to the MSSP eligibility requirement. See Slide 15 for details. Richard Slusky notes that at least 50% of ACOs’ patients (including Medicare, Medicaid, and commercially insured) must be covered under outcomes-based contracts by the end of the first performance year. Alignment (attribution) is claims-based, with some exceptions, and will include voluntary alignment (a new feature), which supersedes claims-based alignment. • <i>Benefit Enhancement:</i> The Next Generation Model offers incentive payments to beneficiaries for receiving services within the ACO’s network. It also conditionally waives certain Medicare payment requirements. <ul style="list-style-type: none"> ○ Bard Hill observed that none of the Next Generation Model payment methodologies impact beneficiary cost-sharing; he also noted that CMS’s ACO programs have been focused on incentivizing organizations rather than individuals and asked whether there was more movement in that direction planned. Kara replied that there not information available about CMS’s plans beyond this new model. Bard also noted that people who enter a SNF or nursing home under Medicare sometimes stay and become eligible for Medicaid. Kara suggested that the benefit enhancements offered under the Next Generation Model, especially the waiver of the 3-Day SNF Rule, offer an incentive to do better in this area. Julie Wasserman noted that this is a potential cost shift. Abe Berman noted that the requirement that 50% of ACOs’ patients are 	

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	<p>under outcome-based contracts will hopefully prompt providers to be more conscious of spending and utilization across all payers, not just Medicare.</p> <ul style="list-style-type: none"> ○ Bard suggested that home health is also a key player here, and wonders how this will fit in. Kara suggested that the post-discharge house visits support increased access to home health and similar services. CMS is also encouraging ACOs to develop relationships with providers like home health. Larry Goetschius suggests that there could have been bigger opportunities for home care/home visits for people with chronic illnesses who are not acutely ill and will otherwise not be eligible for home-based services. Kara notes that a capitated affiliate with a Next Generation ACO could receive reimbursement for this if the ACO chooses to put money toward this. ○ Mike Hall asked whether this could involve a waiver of the 60-day episode for home-based services. Kara noted that this would not apply until an agency entered into a capitated arrangement with a Next Generation ACO. <ul style="list-style-type: none"> ● <i>Quality and Performance:</i> Measures are similar to MSSP, minus one measure. The major change is that CMS is moving away from current scoring methodologies to a “discount” approach. ● Appendices offer details on the discount methodology, payment mechanisms, savings and loss calculation, and claims-based alignment. <p>The group discussed the following:</p> <ul style="list-style-type: none"> ● Larry Goetschius asked whether any Vermont ACOs were planning on applying. Abe Berman responded that OneCare will be filing a Letter of Intent, but may choose not to apply. Joyce Gallimore responded that Community Health Accountable Care (CHAC) will not apply. 	
<p>6. Public Comment, Next Steps, and Action Items</p>	<p>Public Comment:</p> <ul style="list-style-type: none"> ● Richard Slusky commented that there have been questions about how the Next Generation Model could dovetail with the potential All-Payer Model. Richard noted that they are different tracks, but have similar intents: both support an all-payer movement toward value-based payment. Don George asked whether this means that an All-Payer Model would ask Vermont providers to step up to the challenging requirements of the Next Generation Model. Richard responded that this would likely be the case, with potentially some additional flexibility. ● Mary Alice Bisbee asked a question about how co-insurance as a Medicare beneficiary would interact with membership in an ACO. Kara Suter responded that it would not. <p>Next steps:</p> <ul style="list-style-type: none"> ● DVHA team will update the Blueprint feedback and share with members via email before submitting to the Blueprint Executive Committee. <p>Next Meeting: Monday, May 18, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.</p>	