

**VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday, March 16, 2015 1:00 PM – 3:00 PM.
Large Conference Room, 312 Hurricane Lane, Williston, VT
Call in option: 1-877-273-4202
Conference Room: 2252454**

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Don George and Andrew Garland	Y – Approve minutes	Attachment 1: Meeting Minutes
2	1:10-1:15	Updates -EOC Subgroup -Yr 3 TCOC	Alicia Cooper and Cecelia Wu	N	
3	1:15-1:45	Yr 2 VMSSP Gate and Ladder	Kara Suter & Alicia Cooper	Y – Vote on Proposed Methodology Changes	Attachment 3: Proposed Changes to Year 2 VMSSP Gate and Ladder Methodology
4	1:45-2:45	Proposed Blueprint for Health Payment Modifications	Kara Suter and Craig Jones	N	Attachment 4: Comments Received
5	2:45-2:55	Review 2015 PMWG Workplan	Don George and Andrew Garland	N	Attachment 5: 2015 Draft Workplan
6	2:55-3:00	Public Comment, Next Steps and Action Items		N	Next Meeting: Monday, April 20, 2015 1:00 pm – 3:00 pm EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Attachment 1

Vermont Health Care Innovation Project Payment Models Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, February 23, 2015, 1:00-3:00pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	<p>Don George called the meeting to order at 1:01. A roll call attendance was taken and a quorum was not present. A quorum was achieved after the third agenda item.</p> <p>Following the third agenda item, Richard Slusky moved to approve the January 2015 meeting minutes. Sue Aranoff seconded. A roll-call vote was taken and the motion passed.</p>	
2. Updates: CHAC TCOC; EOC Sub-Group	<p><i>CHAC Total Cost of Care (TCOC) Update:</i> Cecelia Wu provided an update on CHAC’s decision not to undertake the option TCOC expansion. ACOs had the option to elect to include pharmacy and transportation in TCOC calculations; OneCare and CHAC have both elected not to expand their TCOC definition.</p> <p><i>Episode of Care (EOC) Sub-Group Update:</i> Alicia Cooper provided an update on the EOC Sub-Group, which has now met twice. The Sub-Group has reviewed Vermont’s preliminary analyses around EOCs, previously reviewed by the Payment Models Work Group. The Sub-Group has also studied analytics and measurement work being performed by other entities that could inform EOCs, including MVP, the State of Arkansas (implementing EOCs with support from a SIM Testing grant), and the Blueprint for Health; the group is considering how it might leverage lessons to forward Vermont’s work on EOCs.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • How will TCOC be calculated for Year 3? The optional Year 2 track would have expanded the definition of TCOC. For Year 3, costs recommended by this group and agreed upon by GMCB will be included for all ACOs on a mandatory basis. 	

Agenda Item	Discussion	Next Steps
<p>3. Blueprint for Health – P4P Methodology Discussion</p>	<p>Craig Jones presented four recommendations to modify Blueprint payments to practices and CHTs:</p> <ol style="list-style-type: none"> 1. Increase PCMH payment amounts: <ul style="list-style-type: none"> ○ Composite payment model: Total Payment = Base (UCC, NCQA) +HSA Quality + HSA Utilization <ul style="list-style-type: none"> ▪ Base: Practices would be required to participate in UCC (at least 1 quality initiative per year) and maintain NCQA recognition. Would no longer require higher NCQA scoring, which puts an excessive paperwork burden on practices – focus on must-pass elements. ▪ HSA Quality and Utilization: Create shared incentives to cooperate and coordinate to improve quality and outcomes. 2. Shift to a composite measure-based payment methodology: A composite of core measures which would pay for performance above a benchmark as well as improvement based on past performance. The measures selected for this will drive the work of the UCCs. Utilization measures would also use a standardized total utilization index composite measure; the Blueprint can already calculate this measure. 3. Increase CHT payments and capacity. 4. Adjust insurer shares of CHT costs to reflect market share. <p>The group discussed the following:</p> <ul style="list-style-type: none"> • Could re-purposing of practice facilitators to support UCCs hurt medical home infrastructure? Likely no; Blueprint participation requirements will be tied to participation in UCCs as well as NCQA 2014 requirements, so practices should continue to have access to quality improvement support. • How many core measures can the Blueprint pull from DocSite now? 16 core measures, a mix of claims and clinical. Proxy performance measures could be pulled from some of these. Blueprint has been generating whole-population measures for Medicare, Medicaid, and commercially insured populations – not focused on ACO-attributed populations. • How is the data quality work being done by the Blueprint connected with the data quality work being done by VITL with the ACOs? Data quality at the source (data entry) is very important, as are efforts that improve data quality after entry; the Blueprint and VITL are coordinating their work in this area. • If none of the local quality improvement initiatives applied to a practice, would they need to withdraw from Blueprint participation? Possibly. • Where does authority to regulate UCCs lie? UCCs would design their own quality improvement initiatives. Craig Jones invited specific recommendations on participation requirements. For example: Is one QI project per year sufficient? • When could this be implemented? The Governor recommended payment changes in January 2016; Blueprint would want to begin measurement activities in advance. • If practices choose not to pursue NCQA recognition, can they still participate in other parts of the Blueprint and receive associated payments? No, as it currently stands. Blueprint has discussed this at 	<p>Share feedback or comments with Mandy Ciecior (Amanda.Ciecior@state.vt.us) by March 9th.</p>

Agenda Item	Discussion	Next Steps
	<p>length with the ACOs; CHAC and OneCare are in favor, HealthFirst is split on whether or not to continue requiring NCQA recognition. Craig Jones cited growing research which associates medical home participation with improved quality. NCQA renewal cycle would continue to be rolling (every 3 years) – practices required to renew when previous recognition expires. Craig Jones suggested that the base medical home payment is not just administrative, but reflects care delivered for patients. This is a transitional model to move toward payment reform, not the end goal.</p> <ul style="list-style-type: none"> • Will this be built on a PMPM? Likely yes. • Would Medicare follow this payment structure? No. The federal Multi-payer Advanced Primary Care Practice Demonstration (MAPCP), by which Medicare participates in the Blueprint, ends in December 2016; Medicare will not adjust their payment before that time. Medicaid participation would continue. • What happens in the Governor’s proposal to increase Blueprint payments does not pass? If the proposal doesn’t pass, this increase will not happen. <ul style="list-style-type: none"> ○ Has there been discussion about changing or increasing payments from commercial payers or ACOs to change independent of Medicaid? No. • Where does specialty care or other non-primary care fit in? By linking some component of Blueprint payments to participation in UCCs and putting other provider types on the leadership team of UCCs. If the State and CMS agree on an all-payer waiver, a new payment methodology could address other provider types. Vermont is also looking at possibilities for expanding Health Homes; this could also potentially mean a new payment model. Kara Suter noted that the proposed payment methodology builds on the Blueprint/MAPCP – this isn’t meant for the full spectrum of providers, but rather for those that have already been participating in the Blueprint. • How does this fit with the ~\$40 PMPM Medicare chronic care management code? The Medicare CCM code is a fee-for-service payment for eligible patients and requires a lot of documentation and tracking. It is not population-based; it is a high payment for a sub-set of the population. It drives the system back into targeted care management and does not replace a medical home payment model. Also, practices participating receiving Blueprint payments from Medicare can’t receive chronic care management payments. • Proposed CHT payment changes suggest significantly increased CHT payments from some payers (Medicaid and Blue Cross). How is this being coordinated with GMCB? The Blueprint team will make a formal recommendation to payers, who will be asked to include this as part of their formal rate review proposal. <ul style="list-style-type: none"> ○ This may happen prior to an approved appropriation; this would be a recommendation, not a formal requirement, because of timing. Andrew Garland noted that this will impact multiple pieces of rate filings; insurers will have to be very clear and will have to have conversations with GMCB and the Blueprint through early summer to finalize these. 	

Agenda Item	Discussion	Next Steps
	<p>Kara Suter and Richard Slusky made several suggestions regarding the Blueprint payment methodology:</p> <ul style="list-style-type: none"> • Kara Suter suggested that the Payment Models Work Group may want to make recommendations about a regulatory authority for the UCCs, and how flexible (or not) these structures might be. • Kara Suter noted that the proposed methodology strongly weights NCQA recognition and de-emphasizes payment for outcomes; emphasis on NCQA recognition should be phased down over time to increasingly reward achievement. Research shows that smaller quality-based payments are insufficient to drive change; \$1.50 PMPM may not be enough, in comparison to \$3.50 base payments. • Kara Suter commented that a quality pool would be easier for payers to administer than absolute PMPM payments. PMPM payments are very difficult for payers to budget; payers are required to budget with the assumption that all practices receive the maximum possible performance payments. A quality pool would make absolute PMPM and actual payments somewhat different, though PMPM would still act as a good proxy. This allows payers not to leave money on the table and ensures all costs are covered. • Kara Suter suggested that the Payment Models Work Group may want to make recommendations to standardize attribution methodologies across programs. There are currently many attribution methodologies active in the state, including the Blueprint and ACO methodologies. Absolute PMPMs result in payments that are highly linked to attribution methodology. Also, a quality pool would stabilize total payment amounts even if attribution methodologies change. • Kara Suter recommended that the CHTs attribution methodology should align with other programs. CHTs currently use a unique attribution methodology that relies on self-reporting. CMS is very interested in reducing duplication of payment; CHTs use self-reports for attribution, raising possibility of duplication. A change in attribution methodology would result in decreased attribution to CHTs and impact total payments if we continue to use an absolute PMPM payment. <ul style="list-style-type: none"> ○ Craig Jones noted that CHTs are moving to retrospective attribution. • Richard Slusky suggested that empanelment or prospective attribution might be an option for CHT attribution. Craig Jones noted that this would be an important step that could add value to the system, but it is not one CHTs currently use. The Blueprint would support this change. <ul style="list-style-type: none"> ○ Kara Suter noted that this would need to include something more than self-selecting or auto-assigning patients to a PCP; patients and providers would need to agree together. Craig Jones noted that systems that use this method often put a contract in place between patients and PCPs. Kara Suter commented that for Medicaid, this might require CMS approval. <p>Craig Jones invited review and feedback of this proposal prior to the Blueprint Executive Committee meeting in a few weeks. He emphasized that this proposal links core measures to medical home incentive, strengthens medical home incentives, and links incentives to participation in UCC structure. Share any feedback or comments with Mandy Ciecior (Amanda.Ciecior@state.vt.us) by March 9.</p>	

Agenda Item	Discussion	Next Steps
4. Medicaid Year 2 Gate and Ladder	<p>Alicia Cooper opened a discussion of the proposed Year 2 Medicaid Shared Savings Program Gate & Ladder methodology, previously discussed at the January meeting of the Payment Models Work Group. The proposal has not changed since January; if the proposal is approved today, it can be incorporated into Year 2 contracts.</p> <p>Paul Harrington moved to adopt the proposed methodology; Kara seconded.</p> <ul style="list-style-type: none"> • Alicia Cooper clarified that negative points applied for significant improvement decline are only applicable to Performance Improvement points. • OneCare agrees with tying benchmarks to HEDIS national benchmarks, including absolute points. OneCare is currently not clear on differences between current percentages and percentiles on an ACO basis, and will need some additional data to be clear on the magnitude of the change; OneCare is in favor of the change overall but expressed a need for additional information prior to approval of this piece. Additional data is expected around March 10. <ul style="list-style-type: none"> ○ OneCare has also expressed concerns about the additional two measures recently approved by Core Team but not yet implemented; it's unclear what the impact of this will be. <p>Paul Harrington moved to table the motion until the March 16 meeting.</p> <p>Kara Suter proposed an amendment to the original motion: to vote on the proposal but hold on voting on the changes to the Gate. Paul Harrington seconded.</p> <ul style="list-style-type: none"> • Why is this better for DVHA to approve some changes now? Assures moving forward (with all changes other than the Gate) and allows DVHA to prepare for contract changes. It also simplifies this group's discussion at the next Work Group meeting, leaving only the Gate on the table. • Statistically significant improvement at a 95% confidence level is challenging with a small population, even if the improvement is large, and could be especially challenging looking at measures on a regional basis as the Blueprint does – could we narrow the confidence range? Improvement points are a trade-off to mirror Medicare's methodology. Kara Suter clarified that at the regional/HSA-level, Medicaid has not run into challenges related to small numbers. • Julia Shaw suggested waiting and voting on all pieces together. <p>Paul Harrington withdrew the original motion.</p>	<p>Share feedback or comments with Mandy Ciecior (Amanda.Ciecior@state.vt.us) by March 9th.</p>
5. Public Comment	<p>No further comments were offered.</p>	
6. Next Steps, Wrap Up and Future Meeting Schedule	<p>Next Meeting: Monday, March 16, 2015, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston</p>	

Attachment 3

Proposed Year 2 VMSSP Gate & Ladder Methodology

Based on feedback received during the public comment period and recommendations from the Quality and Performance Measures Work Group regarding payment measure targets and benchmarks, as well as recent changes to the Medicare Shared Savings Program, the PMWG co-chairs and staff propose the following changes to the Gate & Ladder methodology for Year 2 of the Vermont Medicaid Shared Savings Program (VMSSP). These proposed changes:

1. **Increase the minimum quality performance threshold for shared savings eligibility;**
2. **Include the use of absolute points earned in place of a percentage of points earned to eliminate the need for rounding; and**
3. **Allow ACOs to earn “bonus” points for significant quality improvement in addition to points earned for attainment of quality relative to national benchmarks.**

The proposed framework assumes that the VMSSP in Year 2 will use the 10 measures approved for Payment by the VHCIP Core Team and the GMCB, and that ACOs will be eligible to earn a maximum of 3 points per measure for a total of 30 possible points. ACOs would have to earn at least 16 out of 30 points to be eligible for any earned shared savings. If an ACO earns 24 or more points, they would be eligible to receive 100% of earned shared savings.

Points Earned (out of 30 possible points)	Percentage of Points Earned	Percentage of Earned Shared Savings
16-17	53.3-56.7	75
18	60.0	80
19-20	63.3-66.7	85
21	70.0	90
22-23	73.3-76.7	95
≥24	≥80.0	100

In addition to earning points for attainment of quality relative to national benchmarks, ACOs would be eligible to earn one additional point for every measure that is compared to a national benchmark for which they improved significantly relative to the prior program year. “Bonus” improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks (see table below). As such, an ACO could earn up to 7 “bonus” points for improvement; however, no ACO may earn more than the maximum 30 possible points.

This approach will further strengthen the incentives for quality improvement in the VMSSP by providing ACOs with both external quality attainment targets (in the form of national benchmarks) and internal quality improvement targets (by rewarding change over time).

Year 2 Payment Measure		VMSSP Benchmark Method	Eligible for “Bonus” Improvement Point
Core-1	Plan All-Cause Readmissions	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
Core-2	Adolescent Well-Care Visits	National Medicaid HEDIS benchmarks	X
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	National Medicaid HEDIS benchmarks	X
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	National Medicaid HEDIS benchmarks	X
Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	National Medicaid HEDIS benchmarks	X
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	National Medicaid HEDIS benchmarks	X
Core-7	Chlamydia Screening in Women	National Medicaid HEDIS benchmarks	X
Core-8	Developmental Screening in the First Three Years of Life	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	National Medicaid HEDIS benchmarks	X

Note: Core-1, Core-8, and Core-12 will be ineligible for additional improvement points because these measures are already using ACO-specific change-over-time improvement targets. If national Medicaid benchmarks become available for any of these measures in future, the measures may then become eligible for additional improvement points.

Example

Year 2 Payment Measure		Year 1	Y1 Attainment Points	Year 2	Y2 Attainment Points	Y2 Improvement Points
Core-1	Plan All-Cause Readmissions	15.4	2	15.2	2	
Core-2	Adolescent Well-Care Visits	50.9	2	57.7	2	1
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	75.9	0	80.4	1	1
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	33.6	1	34.8	1	0
Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	52.4	3	49.5	3	0
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	27.3	2	29.7	2	0
Core-7	Chlamydia Screening in Women	47.0	0	47.6	0	0
Core-8	Developmental Screening in the First Three Years of Life	28.2	2	36.3	3	
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	18.8		17.2	2	
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	43.1		38.9	2	1
Sub-Total			12		18	3
Total Points			12/24		21/30	

Statistically significant improvement in Year 2 relative to Year 1 for three eligible measures results in the ACO being awarded 3 “bonus” improvement points. These points are added to the 18 points the ACO receives for quality performance relative to benchmarks, yielding a total of 21 points out of the total possible 30 points.

In the case of Core-3 (LDL-C Screening), the ACO improves from below the national 25th percentile to the national 25th percentile, and therefore earns a point for attaining a higher target relative to national benchmarks. This improvement also represents significant improvement relative to the ACO’s performance in the prior year, resulting in an additional improvement point for this measure.

In the case of Core-2 (Adolescent Well-Care Visits), the ACO does not improve enough to meet the national 75th percentile, but achieves significant improvement relative to the ACO’s performance in the prior year. Thus, the ACO is still awarded for significant improvement, and continues to have an incentive to improve relative to national benchmarks.

Methodological Considerations

This methodology would award an ACO up to 1 additional bonus point for quality performance improvement on each Payment measure that is being compared to a National benchmark. These bonus points would be added to the total points that the ACO achieved for each Payment measure based on the ACO's performance relative to National benchmarks. Under this proposal, the total possible points that could be achieved, including up to 7 bonus points, could not exceed the current maximum 30 total points achievable.

For each qualifying measure, the state or its designee would determine whether there was a significant improvement or decline between the performance year and the prior year by applying statistical significance tests¹, assessing how unlikely it is that the differences of a magnitude as those observed would be due to chance when the performance is actually the same. Using this methodology, we can be certain at a 95 percent confidence level that statistically significant changes in an ACO's quality measure performance for the performance year relative to the prior program year are not simply due to random variation in measured populations between years.

The awarding of bonus points would be based on an ACO's net improvement on qualifying Payment measures and would be calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. Bonus points would be neither awarded nor subtracted for measures that were significantly the same. The awarding of bonus points would not impact how ACOs are separately scored on Payment measure performance relative to national benchmarks.

Consistent with the current VMSSP methodology, the total points earned for Payment measures, including any bonus quality improvement points, would be summed to determine the final overall quality performance score and savings sharing rate for each ACO.

¹ VMSSP would use the same methodology for calculating significance (t-test) as MSSP.