

**VT Health Care Innovation Project  
 Payment Models Work Group Meeting Agenda  
 Monday, April 20, 2015 1:00 PM – 3:00 PM.  
 EXE-4th Floor Conference Room, Pavilion Building, Montpelier, VT  
 Call in option: 1-877-273-4202  
 Conference Room: 2252454**

<b>Item #</b>	<b>Time Frame</b>	<b>Topic</b>	<b>Presenter</b>	<b>Decision Needed?</b>	<b>Relevant Attachments</b>
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Don George and Andrew Garland	Y – Approve minutes	Attachment 1: Meeting Minutes
2	1:10-1:55	Episodes of Care Presentation	Alicia Cooper	N	Attachment 2a: Process Document Attachment 2b: Presentation
3	1:55-2:15	Final Feedback on Blueprint Payment Methodology	Kara Suter	Y – Approve Document	Attachment 3: Feedback
4	2:15-2:55	CMS Next Generation ACO model Presentation	Kara Suter	N	Attachment 4a: Presentation Attachment 4b: ACO Matrix
5	2:55-3:00	Next Steps and Action Items		N	Next Meeting: Monday, May 18, 2015 1:00 pm – 3:00 pm  DVHA Large Conference Room 312 Hurricane Lane, Williston

# Attachment 1



## Vermont Health Care Innovation Project Payment Models Work Group Meeting Minutes

### Pending Work Group Approval

**Date of meeting:** Monday, March 16, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Introductions; Approve Meeting Minutes</b>	<p>Kara Suter called the meeting to order at 1:04pm. A roll call attendance was taken and a quorum was present.</p> <p>Bard Hill moved to approve the February 2015 meeting minutes. Diane Cummings seconded. A roll-call vote was taken and the motion carried.</p>	
<b>2. Updates: EOC Sub-Group; VMSSP Year 3 TCOC</b>	<p><i>Episode of Care (EOC) Sub-Group Update:</i> Alicia Cooper provided an update on the EOC Sub-Group, which has now met three times. Since the last meeting, the group discussed releasing an RFP for providing EOC analytics to providers; a proposal will come before this group in April, likely coupled with a funding request, for a vendor to perform these analyses.</p> <p><i>VMSSP Year 3 Total Cost of Care (TCOC):</i> Cecelia Wu provided an update on Year 3 TCOC planning. Year 2 TCOC is wrapping up, and research for Year 3 TCOC has begun. Year 2 TCOC was an optional track; neither ACO opted in for the proposed categories of service (pharmacy and non-emergency medical transportation). As Medicaid starts Year 3 TCOC research, those categories will still be on the table. DVHA will also look at other services paid and adjudicated by DVHA's claims processing unit, guided by three questions:</p> <ol style="list-style-type: none"> <li>1. Are the ACOs ready to take on the additional service in Year 3, and can the ACOs influence the delivery of the service in Year 3?</li> <li>2. How is the service billed and paid for? (i.e., fee for service, year-end settlement, rebate, or other adjustment that could change the total amount paid?)</li> <li>3. Have other states also included the service in their TCOC calculations?</li> </ol> <p>DVHA is currently researching dental, personal care services, and mental health/behavioral health/substance abuse support service, in addition to pharmacy and non-emergency transportation. Once research is</p>	

Agenda Item	Discussion	Next Steps
	<p>concluded, DVHA will bring findings to this group for feedback (likely May or June 2015).</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> <li>• Is expanded TCOC still mandatory for Year 3? Yes, but DVHA hopes research will be a collaborative process. The first question DVHA asks for each category is whether ACOs are ready and able to influence delivery of the service, so this shouldn't be a one-sided mandate. Paul Harrington noted that the Year 2 experience demonstrates some reluctance from ACOs to take on an expanded TCOC, and commented that he hopes this feedback will be taken into account as Year 3 TCOC is developed.</li> <li>• Personal care services are quite varied – would this look at all personal care services or only some? During the research phase, DVHA is casting a wide net and looking at every service being provided. When it comes to selecting services for inclusion in TCOC, it will likely be less wide. Part of the process will be to create rational groupings for those services.</li> <li>• What does DVHA mean when it asks whether ACOs can influence delivery in a category? Example: Mental health services. ACOs can do something to impact care delivery in this area (example: expanding out-patient access); however, many services in this area fall under the domain of other AHS agencies, and not all are areas where ACOs can have the ability to reduce costs. One of the intents of expanding the TCOC calculation is to include a broader range of providers in this network, strengthening relationships between medical community and providers of specialized services to encourage these groups to find ways to work together in a cost-effective manner.</li> <li>• How will other VHCIP Work Groups be engaged? Engaging other Work Groups will come after research; collaboration on this topic is included in Year 2 VHCIP Work Group Workplans.</li> </ul>	
<p><b>3. Year 2 Vermont Medicaid Shared Savings Program (VMSSP) Gate &amp; Ladder</b></p>	<p>Kara Suter opened a discussion of the proposed Year 2 VMSSP Gate &amp; Ladder methodology, previously discussed at the January and February 2015 meetings of the Payment Models Work Group. The proposal has not changed since January; at the February meeting, the group decided to hold on a vote in order to provide the ACOs with additional information. The ACOs and other interested stakeholders have since been provided with additional information.</p> <p>Paul Harrington requested comment from the ACOs. Healthfirst is not participating in VMSSP and did not have comments on the proposed methodology. OneCare was not in attendance. Joyce Gallimore from CHAC commented that CHAC is comfortable with the change.</p> <p>Paul Harrington moved to table a vote due to OneCare's absence. Kara Suter requested that Paul hold this motion and move onto the fourth agenda item, and noted that delay on this vote has prevented changes to contracts desired by both DVHA and the ACOs; approval by Steering Committee and Core Team will require additional time. Paul agreed to hold the motion until after the fourth agenda item, but would again make his motion if no one from OneCare had joined.</p>	

Agenda Item	Discussion	Next Steps
	<p>Greg Robinson from OneCare joined the call during the fourth agenda item.</p> <p>Following the fourth agenda item, Kara reopened discussion on this item.</p> <ul style="list-style-type: none"> <li>• Greg Robinson from OneCare commented that after internal discussion, OneCare was comfortable with these changes. OneCare takes issue with the timing of the decision, which requires a decision before OneCare has had time to gather feedback from network partners and OneCare’s board. OneCare requests additional time in the future to gather this feedback. Kara commented that data availability is a challenge for DVHA – claims run out takes time. Greg affirmed that OneCare was now comfortable with the changes and would vote to approve them.</li> </ul> <p>Diane Cummings moved to approve the new methodology. Bard Hill seconded. A roll-call vote was taken. The motion carried with three abstentions.</p>	
<p><b>4. Proposed Changes to Blueprint Payment Methodology</b></p>	<p>Kara Suter opened a discussion of comments on proposed changes to the Blueprint for Health Payment Methodology. The Work Group received three sets of comments, from Michael Bailit of Bailit Health Purchasing, Kara Suter of DVHA, and Georgia Maheras, VHCIP Project Director. Last meeting, this group suggested making recommendations to send to the Steering Committee and Core Team; the proposed changes are also being reviewed by the Blueprint governance structure.</p> <ul style="list-style-type: none"> <li>• Craig Jones commented that the Blueprint governance structure emphasizes local control; however, there has been a call for a statewide governance team with representation that mirrors local governance structures to provide guidance and make decisions about statewide standards and other issues.</li> <li>• Kara Suter clarified her written comments on weighting the components of the proposed payment methodology. In her comments, Kara suggested that payments gradually transition toward outcome-based payment and away from payment that rewards NCQA scoring. Kara noted that process measures are embedded in NCQA scoring, and some combination of process and outcome measures is appropriate, but suggested that the payments should be gradually weighted toward outcomes.</li> <li>• Paul Reiss commented that if the Blueprint is going to adopt the 2014 NCQA standards that are significantly more burdensome, payment amounts must be increased – the proposed ~\$1 PMPM increase to the base payment is not sufficient to keep practices engaged and fund required quality improvement activities. Healthfirst does support paying for outcomes, and wants to move toward paying for outcomes and away from paying for achieving NCQA standards. One option would be to continue paying for 2011 standards, rather than moving to 2014 standards. <ul style="list-style-type: none"> <li>○ Craig Jones noted that this is an option the Blueprint considered. The Blueprint received feedback that stakeholders wanted to continue requiring current NCQA standards. He also</li> </ul> </li> </ul>	<p><b>Please send comments to Mandy Ciecior (<a href="mailto:Amanda.Ciecior@state.vt.us">Amanda.Ciecior@state.vt.us</a>) by March 30, 2015.</b></p> <p><b>DVHA staff will compile comments and develop recommendations for a vote at the April meeting.</b></p>

Agenda Item	Discussion	Next Steps
	<p>noted that new payments do provide a ~\$1 PMPM increase, and that stakeholder feedback was that increase should be part of the base payment rather than as part of performance component. Performance payments depend on Health Service Area performance, rather than practice-based outcomes. Craig also noted that the Blueprint’s recommendation to require NCQA recognition under the 2014 standards emphasizes core, must-pass elements, rather than requiring higher levels of recognition (and excessive documentation) as the Blueprint has in the past.</p> <ul style="list-style-type: none"> <li>○ Paul Reiss noted that an increase of \$1 PMPM is not a raise for practices; it costs more to achieve NCQA recognition under the 2014 standards than this increase would provide, and Medicare will no longer be participating as of 2017. He noted that BCBS and Cigna also oppose sticking with NCQA standards.</li> <li>○ Ted Sirotta commented that maintaining NCQA standards do have real costs, both in terms of staff time to meet the administrative burden of achieving standards, and the time required to meet the standards, which result in decreased patient volume.</li> <li>○ Kelly Lange clarified that BCBS wants to ensure the proposed methodology is reviewed from multiple angles and that weighting is considered. Will any changes need to go to GMCB? This group can provide feedback and suggestions, but Kelly believes that there are still many opinions out there and this process is in the formative feedback stage.</li> </ul> <ul style="list-style-type: none"> <li>● Kara noted that she included some questions in her comments. Will NCQA be optional? Even if so, if funding is weighted there, is it really optional? <ul style="list-style-type: none"> <li>○ Craig noted that in the current proposal, NCQA recognition remains mandatory. Blueprint leadership received comments from the ACOs and providers that recommended continuing to require NCQA recognition and to require participation in at least one community quality improvement effort. He also commented that two Newport practices recently renewed recognition based on 2014 standards and reported to Blueprint staff that the process was improved, and that NCQA had made improvements to some aspects of 2011 recognition that were excessively burdensome.</li> </ul> </li> </ul> <p>Kara offered the group an opportunity to provide comments on the NCQA requirement; the group had no comments.</p> <p>Kara offered the group an opportunity to comment on the weighting of NCQA recognition and participation in the local collaborative, versus quality and utilization performance components. Ted Sirotta commented that he feels the weighting in the payment methodology should be more prescriptive. Kara encouraged members to share comments with staff for discussion at next month’s meeting.</p> <ul style="list-style-type: none"> <li>● Utilization performance – This would likely use RUI, a composite utilization measure already used in</li> </ul>	

Agenda Item	Discussion	Next Steps
	<p>VMSSP. Worth up to \$0.75 PMPM based on HSA-level performance.</p> <ul style="list-style-type: none"> <li>Quality performance – The ACOs are working to identify a subset of core ACO measures to recommend for this. That subset would form a composite, with benchmarks. Worth up to \$0.75 PMPM based on HSA-level performance.</li> </ul> <p>Kara noted that DVHA staff will develop recommendations based on the current proposal, as well as recommendations for a more prescriptive proposal, to present to this group next week. Paul Harrington suggested staff also looking at relevant legislation currently before the Legislature.</p> <p>Paul Harrington suggested inviting Todd Moore from OneCare to present at the April meeting, since Todd has worked closely with Craig on Blueprint-ACO integration. Greg Robinson from OneCare also requested more detail on the proposed measures. Kara requested that members submit any comments to staff by 3/30.</p> <p>Richard Slusky asked why recommendations proposed by this workgroup would go through VHCIP governance, rather than directly to the Blueprint leadership. Georgia Maheras noted that there is overlapping jurisdiction on this issue; and a desire to gather as much feedback as possible. It would also go through AHS approval process, though Georgia is not sure whether it would need to go to GMCB. Richard suggested clarifying governance for these decisions. Craig Jones commented that statute requires a recommendation from Blueprint leadership; however, Blueprint leadership is seeking broad input to incorporate into this plan, and believes the current plan has broad stakeholder support. Kara prefers that any recommendation receives review from Steering Committee and Core Team before sending to Blueprint governance; whether or not this Work Group is sending a recommendation on for review or for a vote is up for discussion. Craig commented that having good representation from the ACOs is very important to the Blueprint.</p>	
<p><b>5. Review 2015 PMWG Workplan</b></p>	<p>Kara Suter introduced the Year 2 Workplan for the Payment Models Work Group. This revision is based on updates to the Year 2 operational plan, as well as cross-work group interactions. Kara asked members to review the Year 2 Workplan to familiarize themselves with the work ahead, and noted that staff and co-chairs would welcome comments or questions about this document.</p> <ul style="list-style-type: none"> <li>Paul Harrington suggested that we add a presentation on the newly announced Medicare Next Generation ACO program to the group’s agenda in the next few months, along with a discussion of whether Vermont’s SSPs might follow that path. Kara agreed, and commented that the group will receive an in-depth presentation on this at next month’s meeting.</li> <li>Mike Hall commented that the workplan domains that were set out here don’t capture conversations about next steps, whether that means global budgets, or the next version of ACOs, or something else. Kara agreed that this thinking is part of the Year 3 TCOC conversation, but noted that there’s no one-size-fits-all payment reform solution. Mike commented that he would not want conversations about payment reform or global budgeting to focus on only on providers who are farthest along; the sooner</li> </ul>	<p><b>Send any additional workplan comments to Sarah Kinsler (<a href="mailto:sarah.kinsler@state.vt.us">sarah.kinsler@state.vt.us</a>).</b></p>

Agenda Item	Discussion	Next Steps
	<p>we start talking about how to include all providers across the care continuum and all populations into payment reform, the better. Mike specifically identified the value-based purchasing work described on line 26 of the workplan; Kara clarified that this refers to a specific funded project, not a broader project.</p> <ul style="list-style-type: none"> <li>• Richard Slusky noted that there is a process going on with the ACOs and payers concurrently; the overall intent is to move to value-based payments. Richard also noted that much work is now being done between the Blueprint staff, ACOs, and many community providers to coordinate care and care management activities at the local and regional level. Value-based payment incentives should support these activities and efforts toward collaboration. Exactly how payments to medical providers and DLTSS providers will be linked has yet to be determined, but is a critical issue. Richard also noted that providers' decisions to participate in VMSSP, commercial, or Medicare ACO programs, is a decision only the providers can make; the discussions will be among affected parties, though this group can provide information to inform decision-making.</li> <li>• Rachel Seelig commented that she would like to add input from the DLTSS Work Group to Item 10 on the Workplan (currently notes input from QPM Work Group).</li> </ul>	
<p><b>6. Public Comment, Next Steps, and Action Items</b></p>	<p>No further comments were offered.</p> <p>Next steps:</p> <ul style="list-style-type: none"> <li>• Finalize recommendations to be shared with Blueprint for Health leadership on payment model modifications. Please send comments or proposals to Mandy Ciecior (<a href="mailto:Amanda.Ciecior@state.vt.us">Amanda.Ciecior@state.vt.us</a>) by March 30 so that a vote can be held at the April meeting.</li> <li>• Presentation on Medicare Next Generation ACO model, with implications for commercial and Medicaid ACO programs.</li> <li>• Additional comments on Workplan should go to Sarah Kinsler (<a href="mailto:sarah.kinsler@state.vt.us">sarah.kinsler@state.vt.us</a>).</li> <li>• Alicia Cooper suggested a presentation from the EOC Sub-Group at the April meeting; Kara agreed.</li> </ul> <p><b>Next Meeting:</b> Monday, April 20, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.</p>	

# Attachment 2a

## Episodes of Care Sub-Group 2015 Work Summary & Charter

### Members:

Aranoff, Susan	Department of Disabilities, Aging, and Independent Living
Cooper, Alicia	Department of Vermont Health Access
Del Trecco, Mike	Vermont Association of Hospitals and Health Systems
Fullem, Leah	OneCare Vermont
Fulton, Catherine	Vermont Program for Quality in Health Care
Garland, Andrew	MVP Health Care
Harrington, Paul	Vermont Medical Society
Jones, Craig	Vermont Blueprint for Health
Jones, Pat	Green Mountain Care Board
Lange, Kelly	Blue Cross Blue Shield of Vermont
Murphy, Sean	Blue Cross Blue Shield of Vermont
Simpatico, Tom	Department of Vermont Health Access
Tanzman, Beth	Vermont Blueprint for Health
Ward, Norman	OneCare Vermont

### Episodes of Care Sub-Group Meeting Schedule:

#### *Phase 1 – Sub-Group Develops Proposal*

- *January 29 Sub-group Meeting*
- *February 12 Sub-group Meeting*
- *March 6 Sub-group Meeting*
- *March 26 Sub-group Meeting*
- *April 16 Sub-group Meeting*
- *May 7 Sub-group Meeting*

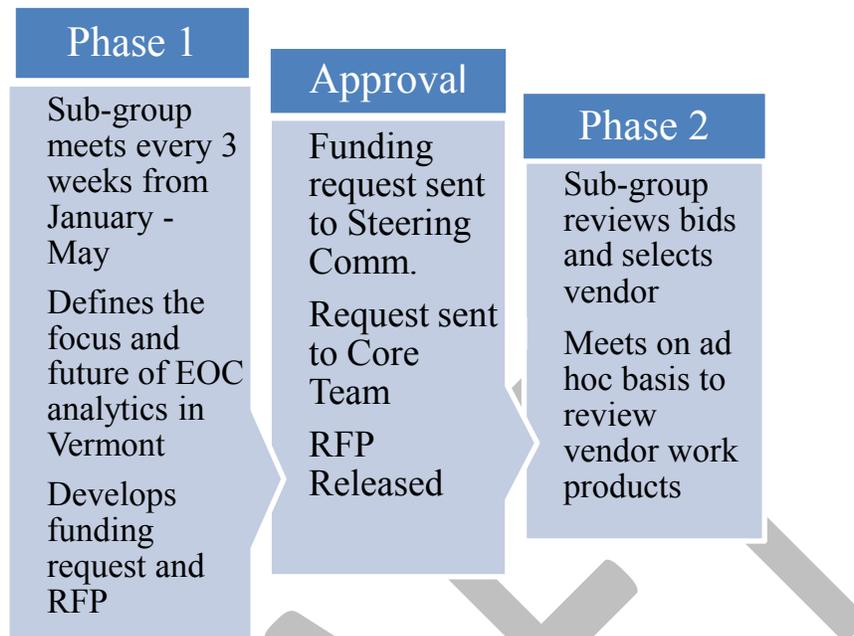
Materials can be found: <http://healthcareinnovation.vermont.gov/node/842>

#### *Planned Next Steps*

- Monday, May 18: Funding Request to **PMWG**
- Wednesday, May 27: Funding Request to **Steering Committee**
- Monday, June 1: Funding Request to **Core Team**

#### *Phase 2 – Sub-Group Oversees Project Launch*

- Reviewing bids and vendor selection
- Ad hoc meetings after contract execution to review reports and coordinate dissemination



**Phase 1 Meeting Topics:**

***January 29: Introduction, Priority-Setting***

- Sub-group discussed the overall focus for Episode analytic work and reports to be distributed to providers and stakeholders
  - Discussion around alignment between Episodes work and other State initiatives
  - Discussion of CMS’ goals toward more value-based programming
  - Clarified the distinction between using EOC analysis for payment reform and as an informative tool
- Review current programs
  - Reviewed current initiatives to ensure no similar initiatives were in place in the state
  - Conducted a brief review of prior Episodes analytics by HCl3
  - Andrew Garland briefly discussed MVP’s EOC initiative
- Future of Episodes in Vermont
  - Discussed alignment with other initiatives, ensuring providers are not overwhelmed with reports
  - Discussed pros and cons of a large analysis (>10 episodes) or a smaller, more focused analysis (5-10 episodes)

***February 12: Reviewing Current Reports***

- Beth Tanzman provided the sub-group with a presentation on the Blueprint for Health Practice and HSA Profiles

- Andrew Garland gave the sub-group an overview of the Episodes Reports that come from MVP's vendor
- Sub-group expressed a preference to use a similar approach and request analyses on a 'universe of episodes' rather than a small number of episodes
- Discussed data source options for future analytics work (e.g. VHCURES; individual payer claims)

***March 6: Provider Reports and Dissemination***

- Reviewed Arkansas' SIM EOC reports and discussed the benefits and limitations of that approach
- Discussed expectations of a potential analytics vendor
- Discussed preferred frequency of reports and possible activities for provider engagement and education

***March 26: Developing an RFP for Vendor Support***

- Discussed the question of sustainability after SIM funding ends and the benefits that aggregate EOC data can provide to stakeholders
- Continued to discuss data source options
- Discussed estimated costs, and the ability to leverage existing structures within the State to disseminate reports and engage providers

***April 16: Additional Discussion of Outstanding Items***

- The sub-group discussed the reoccurring issue of using data that is de-identified and the ability for these reports to then be actionable for providers and stakeholders
- Discussion occurred around whether using information that could come from this initiative, although not perfect, would still be of some benefit to stakeholders
- The idea that we need to enhance VHCURES before moving forward with Episodes work was also brought forth

***May 7: Finalization of Proposal Materials***

- Finalization of Funding Request and RFP, incorporating changes suggested by PMWG members

## **Episodes of Care Sub-Group Work Charter**

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### **I. Purpose**

The Episodes of Care sub-group will play a key role in developing and defining the future of Episodes data use in Vermont. The sub-group will recommend a number of episodes for further exploration using already established selection criteria. The sub-group will also aid in the development of a Request for Proposals (RFP) to elicit bids from potential vendors to produce user-friendly data reports related to selected episodes in the State. Sub-group members will be asked to provide recommendations regarding:

- selection and definition of episodes
- methodological considerations
- identification of appropriate quality measures
- report development and dissemination for delivery system transformation including identification of the need for additional provider supports to enhance the use of data and analytics
- bid review and vendor selection

### **II. Membership**

The Episodes of Care sub-group will consist of a variety of healthcare experts from across the State. Membership will include an array of individuals to include those such as: health care providers, health plan representatives, ACO representatives, advocates and State employees with a range of expertise including clinical practice, data analytics, and quality improvement.

### **III. Sub-group Expectations**

- Membership of this sub-group will require members to attend approximately one meeting every three weeks during the first four months, and on an ad-hoc basis thereafter; members should be able to make attending these meetings a priority in their schedule.
- Members will demonstrate a good understanding of Episodes of Care and the ability to think critically about issues that arise in meetings. Information may be distributed to the Sub-group in advance of meetings to ensure all members are prepared to contribute.
- Members will be expected to represent the perspective(s) of their stakeholder groups in all discussions and decisions.
- Members are to keep the statewide goal of the triple aim in mind during discussions and decision-making.
- Members will aid in establishing clear guidelines and expectations for the funding request for vendor support to further develop Episodes of Care data utilization in Vermont.
- Members should understand that the process will seek but not mandate consensus. Members should support the goals of the process, but members are free to disagree on specific decisions within the process. If consensus cannot be reached on specific topics, divergent views will be reflected in the minutes

#### **IV. Meeting Format**

Meetings will be 120 minutes in length and held in Williston or Montpelier. A call-in or webinar option will be provided for members who are unable to attend in person. All sub-group meetings and activities will be subject to provisions of the Vermont Open Meeting Law.

DRAFT

# Attachment 2b

# Attachment 3

## Workgroup Recommendations

### Comments Received

- Place a performance-based payment on top of an enhanced PMPM; additionally, place that performance-based payment on top of a primary care capitation payment that includes the \$3.50 PMPM
- Tie quality incentives to individual practice performance, and utilization incentives to HSA performance.
- Have provider organizations obtaining performance incentive payments agree to pass down those incentives to direct line staff (clinical and/or non-clinical) in a manner of their choosing
- Clarify the regulatory framework under which the UCC would operate and its oversight authority
- Align CHT and P4P attribution with other programs (SSPs) and take steps to clearly demonstrate non-duplication of payments
- Create a phased plan that increasingly weights P4P based on performance on a set of processes (like the must-pass elements of the NCQA scoring process) and outcomes measures with an accompanying reduction in administrative NCQA scoring support over time.
- Adopt a relative distribution/quality pool approach to the primary care P4P model as absolute PMPM payments are difficult to budget for and budgeting for maximum possible performance payments will likely leave money on the table
- Allow the Quality and Performance Measures Work Group to review and make recommendations on the construct of the outcomes based portion of the P4P
- Ensure that any measures chosen have sources of data that are generally agreed upon by providers and payers as being cost-effective and reliable
- Provide full transparency and clear regulatory or other guidance on how P4P payments would be calculated and what oversight would be included in the calculations.
- More detail needs to be developed and agreed upon with regard to how improvement versus a threshold will be scored
- Leverage VDH's existing district offices

### Voiced in the minutes

- If moving to the 2014 NCQA standards, payment amounts must be increased to keep practices engaged and effectively fund required quality improvement activities.
- Consider moving toward paying for outcomes and away from paying for achieving NCQA standards
- The payment structure should be more prescriptive in how it will weight each component

## St. Albans HSA comments on the recommendations to modify Blueprint payments to primary care practices and CHTs

### 1. Increase PCMH payment amounts:

- Composite payment model: Total Payment = Base (UCC, NCQA) +HSA Quality + HSA Utilization
  - 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.

We support the intent of the proposed increase in PCMH payment amounts. We believe the implementation of the Patient-Centered Medical Home (PCMH) model in primary care has produced real savings for the health system, as evidenced by two years of lower Total Cost of Care for patients managed by a PCMH compared to patients managed in non-PCMH practices. Every three years, the NCQA updates the PCMH standards, increasing the requirements for recognition, but also getting closer to the model of care that will improve outcomes. Many primary care practices have indicated they will not seek recognition under the 2014 PCMH standard without an increase in the PPPM and CHT funds. The work required for recognition exceeds the incentives in the current payment model. Therefore to continue progress toward new models of care that improve quality while reducing cost, we support increasing the base PPPM to \$3.50 and adding pay-for-performance incentives (HSA quality and utilization measures).

We support the adoption of two specific HSA quality and utilization measures – the “Total Resource Use Index (RUI) Excluding SMS” and the “Preventive Quality Indicator (PQI) for Chronic Disease: Rate of Hospitalization for Ambulatory Care Sensitive Conditions”. We support the use of these two HSA-level measures to promote and incentivize collaboration across each health service area. These measures assess outcomes rather than processes.

Since \$0.75 PPPM for each measure is a small incentive, we recommend that incentives are assessed and performance is reported quarterly to deliver rewards as soon as improvements are achieved. Since incentives are calculated on retrospective results, we request that reporting date ranges end no later than 90 days prior to reporting period. Practices should be able to see immediate results from any efforts to reduce utilization or ACS admissions, or they may forgo the opportunity to improve these important measures.

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.

We support composite measure-based payment methodologies that align with other payment reform activities. The PQI Chronic Composite measure is a VHCIP core measure. We support composite measures, because improving single-process or condition measures requires a narrow focus that may not result in system-level savings.

3. Increase CHT payments and capacity.

We support doubling the Community Health Team (CHT) payment. Population management, health risk assessment and stratification, self-management support to improve healthy health behaviors and care coordination to improve utilization are not covered services in the current fee-for-service payment model. These services require specific resources that have been supplied by the Blueprint via the CHT. It's true that care management for complex patients has recently become a reimbursable service, but

only by CMS, so it targets a sub-population based on payer rather than health status and risk. The CHT model allows primary care practices to implement true population management models to manage health risks, prevent costly utilization and improve quality of life for individuals.

At current CHT funding levels, most small practices do not qualify for full-time care coordinators. Part-time care coordination does not lead to coordinated care, because practice teams spend time coordinating to the coordinator's schedule instead of coordinating patients' care. Increasing the CHT funding will increase CHT capacity so that most practices will qualify for full-time care coordination, which will further improve delivery of new models of care.

4. Adjust insurer shares of CHT costs to reflect market share.

We support adjusting the insurer shares of CHT costs to reflect market shares. This seems like an equitable approach to sharing this investment in new care models that reduce cost and improve quality.

*-- Respectfully submitted by Candace Collins, VT Blueprint for Health project manager for the St. Albans Health Service Area.*

## **Comments from Paul Harrington, Vermont Medical Society**

As you may know, the legislation providing the revenues for the increased Blueprint funding has an extremely uncertain future. Therefore, it might make more sense to wait until the underlying revenue bill has been passed, and signed into law, before trying to determine the optimum methodology for distributing any additional Blueprint funds.

Best wishes, Paul

# Attachment 4a

## CMS Next Generation ACO Model

Payment Models Work Group  
April 20<sup>th</sup>, 2015



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### Why is there a new ACO model?

- To address concerns about certain design elements of the existing Pioneer Program and the MSSP
- CMS has the goal of moving ACOs towards greater risk assumption
- HHS seeking to have 85 percent of Medicare fee-for-service payments linked to a quality component by 2016 and 90 percent by 2018



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### What were the previous concerns?

- Earning savings is increasingly difficult with every additional performance year (ACOs need to outperform themselves)
- There is a high turnover in beneficiary alignment\* which may reduce the effectiveness of care interventions and limit the gains for these investments
- Limited flexibility in adjusting the experience trend in response to price changes that impact the ACO

\*also referred to as attribution



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## Duration

- The Next Generation ACO Model Agreement will have an initial term that consists of three performance periods for ACOs entering in 2016 and two performance periods for ACOs entering in 2017.
- There will be the potential for two additional one-year extensions regardless of entry year.
- Both tracks will end in 2020




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## Evaluation Criteria

- CMS will evaluate applications in accordance with specific criteria in five key domains:
  - (1) organizational structure;
  - (2) leadership and management;
  - (3) financial plan and experience with risk sharing;
  - (4) patient centeredness; and
  - (5) clinical care model
- CMS estimates selecting 15 to 20 applicants




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## Participants in Next Generation ACOs

- Provider/Suppliers:
  - Physicians or other practitioners in group practice arrangements
  - Networks of individual practices of physicians/practitioners
  - Partnerships between hospitals and physicians/practitioners
  - FQHCs, RHCs, CAHs
- Preferred Providers:
  - ACOs may contract with preferred providers to offer applicable benefit enhancements to aligned beneficiaries (ex: provide expanded telehealth services, post-discharge home visits, etc— see later slides for information on benefit enhancement)
  - Role based on benefit enhancements, therefore these providers will not be associated with alignment/quality reporting through the ACO.




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## Participants in Next Generation ACOs (cont'd)

- Next Generation Affiliates:
  - Next Generation ACOs may contract with other individuals and organizations to advance ACO cost and quality goals
  - Two types of Next Generation Affiliates:
    - Capitation Affiliates - Medicare providers/suppliers with whom the ACO contracts to participate in capitation with regards to Next Generation Beneficiaries
    - SNF Affiliates - SNFs to which Next Generation Providers/Suppliers or Preferred Providers may admit Next Generation Beneficiaries according to the SNF 3-Day Rule benefit enhancement (see later slides).

	Alignment	Quality Reporting Through ACO	Population-Based Payments	Capitation	Coordinate Care Network	A Day SNF Rule*	Telehealth	Post-Discharge Care Unit
Provider Network	●	●	●	●	●	●	●	●
Preferred Provider					●	●	●	●
SNF Affiliate					●	●		
Capitation Affiliate				●	●			

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## Financial Benchmark

- Prospective Benchmark:
  - In contrast with the MSSP and Pioneer approaches, under the Next Generation financial model, CMS will calculate the ACO's expenditure benchmark\* prior to the start of each performance year using the following four steps:
    - 1.) Baseline – calculate using one year of historic baseline expenditures
    - 2.) Trend – trend the baseline forward using a regional projected trend
    - 3.) Risk Adjustment – using full prospective HCC risk score, applied to both baseline and performance year populations, with annual 3% cap on increase-decrease
    - 4.) Discount – derived from quality/efficiency adjustments and applied to benchmark (See Appendix A for discounting methodology)

\* Further information about benchmark calculation and other details of financial methodology to be released by CMS at a later date



## Risk Arrangements

- A Next Generation ACO may choose between two risk arrangements:
  - 1) Increased Shared Risk - 80% sharing rate for performance years 1 to 3 and 85% for performance years 4 and 5, and with a 15% savings/loss cap in all years
  - 2) Full Performance Risk -100% risk for Part A and Part B expenditures in each year with a 15% savings/loss cap
- The 80%, 85% and 100% provide much greater rewards and risk than in the MSSP or Pioneer ACO program.



## Payment Mechanisms

- The Next Generation Model will test the effectiveness of four payment options
  - 1.) **Normal Fee-For-Service (FFS):** The first payment arrangement provides normal FFS payments (represents no change from Original Medicare)
  - 2.) **Normal FFS + Monthly Infrastructure Payment**
  - 3.) **Population-Based Payments (PBP)**
  - 4.) **Capitation (beginning in 2017)**
- ACOs can elect any payment option regardless of performance year (not a progression through the different payment mechanisms)
- Reconciliation will be done at end of each performance year
- None of the payment mechanisms will affect beneficiary out-of-pocket expenses.

\*See Appendix B for additional payment information

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## Savings and Loss Calculation

- Determined by comparing total Parts A and B spending for Next Generation beneficiaries to the benchmark (with individual expenditures capped at the 99th percentile)
- Risk arrangement is then applied to determine the ACO's share of savings or losses.
  - Savings or loss will be determined annually following a year-end financial reconciliation
- Additionally, CMS will account for monthly payments made through PBP, infrastructure payments, or capitation, which may result in monies owed from CMS to ACOs (or vice versa), that are separate from shared savings or losses.

\*See Appendix C for example savings and loss calculation

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## Beneficiaries

- Beneficiary eligibility
  - During the performance year, beneficiaries must:
    - Be enrolled in both Medicare parts A and B
    - Not be enrolled in a Medicare Advantage plan or other managed care plan
    - Not have Medicare as a secondary payer
    - Be a resident of the U.S.
    - Must live in a county in the Next Generation ACO's service area
    - Not have received more than 50% of their Evaluation and Management services ("E&M Services") from practitioners in counties outside of the Next Generation ACO's service area during base or performance years.
- At least 50% of the new ACOs' patients have to be covered under outcomes-based contracts by the end of year one

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## Beneficiaries (cont'd)

- Alignment:
  - Claims-based: Next Generation Model will use the Pioneer methodology to prospectively align beneficiaries in a two-step alignment algorithm. (See Appendix D for alignment algorithm)
  - Voluntary (supersedes claims based): At beginning of each Performance Year, beneficiaries may confirm/deny their care relationships with specific Next Generation Providers/Suppliers, which will affect alignment for subsequent year.



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## Benefit Enhancement

- CMS will make direct payments to each Next Generation beneficiary who receives at least 50% of Medicare services from Next Generation Provider/Suppliers, Preferred Providers, and Affiliates.
  - Approximately \$50 PBPY, paid semi-annually.
- CMS will conditionally waive certain Medicare payment requirements as part of the Next Generation ACO Model.
  - **3-Day SNF Risk Waiver.** CMS will waive the requirement of a three-day inpatient hospital stay before admission to a skilled nursing facility.
  - **Telehealth Expansion.** CMS will waive, under certain circumstances, the requirement that beneficiaries be located in a rural area and at a specified type of originating site to be eligible for telehealth services.
  - **Post-Discharge House Visits.** CMS will make available waivers to allow incident-to claims for home visits for non-homebound beneficiaries by licensed clinicians under general (not direct) supervision.



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## Quality and Performance

- The Next Generation Model will adopt the MSSP quality measure set, except for the electronic health record (EHR) measure for a total of 32 measures

Performance Year	Initial Benchmark	Quality Score Used in Initial Benchmark	Benchmark Update	Quality Score Used in Update
PY1 (2016)	Late Fall 2015	100%	N/A	N/A
PY2 (2017)	Late Fall 2016	Approximated mean quality score	Summer 2017	Actual quality score for 2016 service dates.
PY3 (2018)	Late Fall 2017	Actual quality score for 2016 service dates.	Summer 2018	ACO to elect either: 1) Keep actual quality score for 2016 service dates; OR 2) Actual quality score for 2017 service dates (if higher).



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## Appendix

- A: Discount Methodology
- B: Payment Mechanisms
- C: Savings and Loss Calculation
- D: Claims-Based Alignment



## Appendix A: Discount Methodology

- Discount
  - Unlike MSSP, the Next Generation ACO model will not use an MSR, instead it will apply a discount once the baseline has been calculated, trended and risk-adjusted.
  - 3 factors included in the discount:
    - 1.) Quality score: ranges from 2.0–3.0%**
      - Utilizes the following formula:  $[2.0\% + (1 - (\text{quality score}))]$ .
      - Ex: an ACO with 100% quality score would have a discount of 2.0%; an ACO with a 0% quality score would have a quality discount of 3.0%
      - In PY1, a quality score of 100% will be applied to all Next Generation ACOs.
    - 2.) Regional efficiency: range from -1–1%**
      - Compares ACO's risk-adjusted historical per-capita baseline to risk-adjusted regional FFS per capita baseline (determined by ACO beneficiaries' counties of residence).
    - 3.) National efficiency: range from -0.5–0.5%**
      - Compares the risk-adjusted county FFS baseline to risk-adjusted national FFS per capita spending.



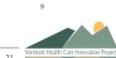
## Appendix A: Discount Methodology

### Example: ACO A

Calculating the Discount	Illustrative Amount
<b>1. Quality</b>	
Quality Score	100%
Quality Component	2.0%
<b>2. Regional Efficiency</b>	
ACO Risk-Adjusted Baseline	\$8,000
Regional FFS Risk-Adjusted Baseline	\$8,500
Regional Efficiency Ratio	0.94
Regional Efficiency Discount Component	-0.6%
<b>3. National Efficiency</b>	
Regional FFS Risk-Adjusted Baseline	\$8,500
National FFS Risk-Adjusted Baseline	\$10,500
National Efficiency Ratio	0.81
National Efficiency Discount Component	-0.5%
<b>Example ACO A Discount</b>	<b>0.9%</b>

- In PY1, 100% will be used as the quality score for all Next Generation ACOs:
  - $[2.0 + (1 - 1.0)]\%$
- Example ACO A's historic baseline expenditures are 6% less expensive than regional FFS—ACO is rewarded for this attainment by having the discount reduced by 0.6%.
- ACO is in a very low cost region (19% below national FFS)—ACO is rewarded with 0.5% discount reduction (the maximum regional-to-national FFS discount reduction).

$$2.0 + (-0.6) + (-0.5) = 0.9$$



## Appendix A: Discount Methodology

### Example: ACO B

Calculating the Discount	Illustrative Amount
<b>1. Quality</b>	
Quality Score	100%
Quality Component	2.0%
<b>2. Regional Efficiency</b>	
ACO Risk-Adjusted Baseline	\$12,000
Regional FFS Risk-Adjusted Baseline	\$13,000
Regional Efficiency Ratio	0.92
Regional Efficiency Discount Component	-0.8%
<b>3. National Efficiency</b>	
Regional FFS Risk-Adjusted Baseline	\$13,000
National FFS Risk-Adjusted Baseline	\$11,500
National Efficiency Ratio	1.13
National Efficiency Discount Component	0.4%
<b>Example ACO B Discount</b>	<b>1.6%</b>

- In PY1, 100% will be used as the quality score for all Next Generation ACOs:
  - $[2.0 + (1-1.0)]\%$
- Example ACO B's historic baseline expenditures are 8% less expensive than regional FFS—ACO is rewarded for this attainment by having the discount reduced by 0.8%.
- ACO is in a region whose spending is 13% higher than national FFS—ACO's discount is increased by 0.4% to reflect this regional-to-national FFS differential.



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## Appendix B: Payment Mechanisms

- Normal FFS + Monthly Infrastructure Payment
  - Next Generation Providers/Suppliers receive normal FFS reimbursement and ACO receives from CMS an additional per-beneficiary per month (PBPM) payment unrelated to claims.
    - No more than \$6 PBPM
    - Infrastructure payments will be recouped in full from ACO during reconciliation regardless of savings/loss.
    - ACOs electing this track required to have sufficiently large financial guarantee (as compared to other payment mechanisms) to assure repayments to CMS
  - Goal: to facilitate investments in infrastructure to support ACO activities
  - Offer a stable and predictable payment option throughout the performance year

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## Appendix B: Payment Mechanisms

- Population-based Payments (PBP)
  - Next Generation ACOs determine a percentage reduction in FFS payments to its Next Generation Provider/Suppliers, which is then paid to the ACO on a monthly basis.
    - ACO may apply a different percentage reduction to different subsets of Provider/Suppliers
    - Provider/Suppliers participating in PBP must agree to permit CMS to reduce their Medicare reimbursements by the specified percentage.
    - Aggregate monthly payments from CMS to the ACO may be updated periodically throughout the Performance Year
  - Provides Next Generation ACOs with a monthly payment to support ongoing ACO activities
  - Allows flexibility in types of arrangements ACO enters into with its Providers/Suppliers

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## Appendix B: Payment Mechanisms

### Population-Based Payment Calculation

Example ACO	Amount	Description
# Aligned Beneficiaries	25,000	--
Benchmark (Projected Spending)	\$300,000,000 (\$12,000 PBPY = \$1,000 PBPM)	Benchmark calculated using model benchmark methodology.
Projected Spending by PBP participating providers/suppliers	75%	Using historic claims, CMS projects spending by providers participating in PBP.
FFS % Reduction	10%	Providers agree to reduction off base FFS rates.
PBPM to ACO	\$75	10% of 75% of \$1,000 PBPM
Monthly Payment to ACO	\$1,875,000	\$75 PBPM x 25,000 aligned beneficiaries
Annual Amount Paid to ACO	\$22,500,000	\$1,875,000 monthly payment x 12 months



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## Appendix B: Payment Mechanisms

- Capitation (beginning in 2017)
- Projected annual expenditures are paid to the Next Generation ACO in a PBPM payment with money withheld to cover anticipated care provided by non-ACO providers/suppliers.
  - Providers/suppliers submit claims to CMS as normal
  - ACOs are responsible for paying claims to its Provider/Suppliers and Capitation Affiliates
  - ACOs are not required to pay capitated providers 100% of FFS rates and may make other compensation arrangements
  - CMS will continue to pay normal FFS claims for care provided to beneficiaries from ACO providers and suppliers not covered by a Next Generation capitation agreement.
  - CMS may periodically update capitation amounts



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## Appendix B: Payment Mechanisms

### Capitation Conceptual Design

Example ACO	Amount	Description
# Aligned Beneficiaries	25,000	--
Benchmark (Projected Spending)	\$300,000,000 (\$12,000 PBPY = \$1,000 PBPM)	Benchmark calculated using model benchmark methodology.
Projected Spending by ACO Providers and Capitation Affiliates	75%	Using historic claims, CMS projects spending by providers participating in capitation.
Capitation PBPM	\$750	75% of \$1,000 PBPM
Monthly Payment to ACO	\$18,750,000	\$750 capitation PBPM x 25,000 aligned beneficiaries
Annual Amount Paid to ACO	\$225,000,000	\$18,750,000 monthly payment x 12 months



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# Attachment 4b

	Pioneer	Medicare Shared Savings Program	Next Generation	Vermont Medicaid Shared Savings Program	Vermont Commercial Shared Savings Program
<b>Attribution methodology</b>	Prospective alignment with year-end reconciliation: Beneficiaries will first be aligned with the group of primary care providers (same as MSSP, but including NPs and PAs) who billed for the plurality of primary care allowed charges during combined 3 year period. If a beneficiary had less than 10% of E&M allowed charges billed by primary care physicians (in or out of the ACO), alignment will be with the group of eligible specialists who billed for the plurality of allowed charges	Retrospective alignment in two steps: 1.) Assign a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. 2.) For beneficiaries who have not received primary care services from PCPs within the ACO, assign beneficiaries if they receive the plurality of primary care services from other ACO professionals within the ACO.	Prospective beneficiary alignment using Pioneer claims-based model and voluntary affiliation.	Retrospective alignment in two steps: 1) attributed through claims with qualifying CPT codes in performance year with Medicaid-enrolled primary care providers 2) eligible beneficiaries not assigned through claims, assign them to PCP they selected or were auto-assigned to in PY.	Retrospective alignment in two steps: 1) attribute to PCP if beneficiary selects one 2) if not assigned, look at claims in most recent 24 months for qualifying CPT codes of providers with internal medicine subspecialties 3) assign members to practice where they had greatest # of qualifying claims
<b>Minimum population</b>	15,000 non-rural /5,000 rural	5,000	10,000 non-rural/7,500 rural	5,000	5,000
<b>Benchmarking methodology</b>	Prospectively set: Based on weighted prior 3 year average of actual expenditures for each of ACO's aligned beneficiaries, most recent year weighted most heavily (60%, 30%, 10%). This baseline will be increased by average percentage growth rate (50%), and absolute dollar equivalent of growth rate (50%) for a national reference population ("matched cohort")	Retrospectively set: based on weighted prior 3 year expenditures of Medicare Parts A and B services, most recent year weighted most heavily (60%, 30%, 10%), trended forward to the third benchmark year by employing the national growth rate for those Part A and B services.	Prospectively set with four components: 1.) one year of historical baseline expenditures, 2.) applying a regional trend, 3.) risk adjustment 4.) applying a discount derived from a quality adjustment and two efficiency adjustments (regional and national ratios).	Retrospectively set: Expected TCOC PMPM calculated using calendar year claims for the attributed beneficiary population, trended forward two years using calculated CAGR and risk-adjustment. 3 benchmark years are used and rolled forward one year at the beginning of each performance year.	Retrospectively set: Years 1 and 2 benchmarks are based on Green Mountain Care Board-approved exchange premium (medical expense portion only)
<b>Base years (and how trended?)</b>	For Performance Years 1-3, base years are 2010, 2009, 2008. Base years updated for Performance Years 4-5 to 2013, 2012, 2011	For example, for ACOs starting in 2012, benchmarking years will be 2009, 2010, and 2011	For Performance Years 1-3, the base year will be 2015 and will remain static	For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years. Performance years continue to trend forward in this pattern.	N/A (XSSP target is premium-based)
<b>TCOC</b>	Medicare Parts A and B	Medicare Parts A and B	Medicare Parts A and B	All Medical Services in line with Part A and B	Most benefits offered through exchange insurance plans, with the following exceptions: 1.) services carved out by self insured employers, 2.) prescription retail (potential inclusion in expanded TCOC in Years 2/3), 3.) dental benefits (to be revisited when pediatric dental is mandated)
<b>MSR/MLR</b>	±1%	<b>Track 1:</b> +2% to +3.9% (depends on ACO size) <b>Track 2:</b> ±2%	none	+2% to +3.9% (depends on ACO size)	No MSR/MLR, instead expected spending and target spending amounts.
<b>Savings/Risk</b>	60 % of savings in the first year (70 % in the second year). ACOs have two other options from which to choose: one would increase the financial risk and reward, the other would decrease the risk and reward	Two risk arrangements: <b>Track 1</b> - share up to 50% savings with no downside risk and <b>Track 2</b> - up to 60% share in savings, with downside risk	Two risk arrangements: 1) 80% sharing rate for performance years 1 to 3 and 85% for performance years 4 and 5; 2) 100% risk for Part A and Part B expenditures in each year	2 risk arrangements (one-sided or two-sided model) for 3 performance years. 1-sided maximum sharing rate is 50%, two-sided is 60%. All VMSSP ACOs have selected one-sided model (upside risk only).	Upside risk only for 2 years and both upside/downside risk in Year 3 risk amount yet to be specified.
<b>Savings/Loss Caps</b>	10% savings/loss cap in PY1; 15% savings/loss cap in PY2	Savings caps: 10% in <b>Track 1</b> , 15% in <b>Track 2</b> ; loss caps ( <b>Track 2 only</b> ): 5% in PY1, 7.5% in PY2; 10% in PY3	15% savings/loss cap in all years	10% savings cap in all years	Savings cap of 10% in all years; loss cap between 3-5% in PY3 - specific cap yet to be specified
<b>Quality Metrics</b>	33 quality measures in four categories: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations	33 quality measures in four categories: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations.	The Next Generation Model will adopt the MSSP quality measure set, except for the electronic health record (EHR) measure (ACO-11: Percent of PCPs Who Successfully Meet Meaningful Use Requirements), for a total of 32 measures.	Currently 32 Payment and Reporting Measures, 8 of which are Payment Measures that impact shared savings	Currently 31 Payment and Reporting Measures, 7 of which are Payment Measures that impact shared savings
<b>Shared savings rate impacted by quality metrics</b>	Yes - Gate and Ladder methodology	Yes - Gate and Ladder methodology	Quality and performance to impact discount applied to benchmark	Yes - Gate and Ladder methodology similar to MSSP	Yes - Gate and Ladder methodology similar to MSSP
<b>Start date/ Program Length</b>	January 1st, 2012/ 3 performance years with 2 optional 1-year extensions	Multiple start dates in 2012-2014/ 5 yr with a 2 yr extension	Jan 1, 2016 and Jan 1, 2017/ 5 performance years (3 or 2 performance years with 2 optional 1-year extensions in 2019 and 2020).	January 1st, 2014/ 3 performance years	January 1st, 2014/ 3 performance years