

**VT Health Care Innovation Project  
 Payment Models Work Group Meeting Agenda  
 Monday, February 23, 2015 1:00 PM – 3:00 PM.  
 EXE 4<sup>th</sup> 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	1:10-1:25	Updates -CHAC TCOC -EOC Subgroup	Kara Suter and Alicia Cooper	N	
3	1:25-2:10	Blueprint for Health – P4P Methodology Discussion	Craig Jones	N	Attachment 3a: BP ACO Integration Attachment 3b: Planning Document
4	2:10-2:50	Medicaid Yr 2 Gate and Ladder	Kara Suter and Alicia Cooper	Y- Approval of G&L proposal	Attachment 4: Proposed Changes to Year 2 VMSSP Gate and Ladder
5	2:50-2:55	Public Comment		N	
6	2:55-3:00	Next Steps and Action Items		N	Next Meeting: Monday, March 16, 2015 1:00 pm – 3:00 pm DVHA Large Conference Room 312 Hurricane Lane, Williston

# Attachment 1

Agenda Item	Minutes	Next Steps
Opening and Updates	<p>Don George called the meeting to order at 1:02pm and introduced the new co-chair Andrew Garland, VP of MVP Vermont. It was announced that Episode of Care sub-group still needs volunteers, and if interested, contact <a href="mailto:Amanda.ciecior@state.vt.us">Amanda.ciecior@state.vt.us</a>. Mike DeITrecco and Susan Aranoff volunteered.</p>	
Approval of the minutes	<p>Bard Hill made a motion to approve the December minutes, Kara Suter seconded. A roll call vote was taken. The motion carried.</p> <p>Georgia Maheras spoke about the changes to the work group membership requirements. If a current member has not attended for at least 3 consecutive months, nor has their alternate, they will be moved from member status to an interested party.</p>	
Medicaid Yr 2 Gate and Ladder	<p>Kara Suter introduced the VMSSP Gate and Ladder methodology proposal. Alicia Cooper spoke on attachments 3a and 3b. The following are comments and questions about the proposal</p> <ul style="list-style-type: none"> <li>• Paul Harrington asked if it was correct that we do not know if any of the ACOS will have Yr 1 savings or not, and Alicia confirmed that Year 1 savings calculations have not yet been completed. He also inquired about CMS' concerns about the rigor of the program, given that no Year 1 program data is yet available. Alicia Cooper responded that CMS was surprised to see that the gate was set so low at 35%, noting that it was set here because we had no baseline performance information when preliminary program decisions were made. At this time, data is available about performance on these measures for the VT Medicaid population, as well as for CY2013 for the ACOs' attributed Medicaid populations. These sources of information indicate that ACO performance will likely surpass the 35% gate currently in place. Kara Suter added that those at the Federal level are looking strictly at the quality portion of the program and would like to see a more rigorous quality threshold in place for subsequent program years. Paul also asked how significant change will be calculated under the proposed approach. Alicia responded that significance will be calculated using a t-test, the same methodology proposed for use by CMS for the Medicare Shared Savings Program and being used by CMS in the Medicare Advantage Star Rating system.</li> <li>• Julia Shaw asked why the maximum number of points is 30 if the total is up to 37 points. Alicia Cooper responded that CMS first put forth this methodology to encourage Medicare ACOs to earn bonus points, however, it is still not possible to earn more than 30 points. Alicia Cooper to follow up with Julia Shaw on the intricacies of CMS's point system</li> <li>• Abe Berman asked about the process for approving any recommendations about the Year 2 VMSSP Gate &amp; Ladder methodology that come from the Payment Models Work Group.</li> </ul>	

Alicia responded that there will first be a vote in the work group, then the recommendation will go to the Steering Committee and Core Team for approval. Georgia added that VHCIP recommendations are not legally binding, and that DVHA and the ACOs would need to agree on terms during the Year 2 contract amendment process. Don George asked how this work group process ultimately impacts the contracting parties during the amendment process. Kara responded that since all contracting entities are present, it is the expectation that decisions made in the multi-stakeholder work group process are in line with what the ACOs would agree to and will be followed through with a contract amendment.

- Kelly Lange responded that the commercial SSP is not proposing any Yr 2 changes as Yr 1 savings info is not yet available. This is the biggest deviation in contracts between commercial and Medicaid. They support looking at such a change in the future, but are holding off for now.
- Andrew Garland added that although MVP is not participating in the commercial SSP, the proposed strategy for the Medicaid SSP was in line with MVPs quality strategies for other initiatives.
- Don George shared his concern about sending a recommendation through the VHCIP process with the potential for the recommendation to be ultimately disregarded by contracting entities.
- Lila Richardson requested more information on Medicare’s proposal for using bonus points for improvement in MSSP. Specifically, she requested additional information about how statistical significance would be calculated and clarification on the 30 point maximum.
- Paul responded that Alicia had already addressed the question of calculating statistical significance. Alicia repeated the description of the significance calculations.
- Paul noted that the GMCB previously voted to recognize improvement in the commercial SSP, , and that this proposal seems to be a more rigorous approach to recognizing improvement, while making the Medicaid and commercial SSPs more similar in this regard.
- Kara noted that this proposal elevates the gate considerably (from 35% to 55%) , and the inclusion of improvement points gives ACOs another way to work toward meeting the higher quality threshold. Julia would like to see the data on how big of a jump in performance would be needed to achieve statistical significance. Kara responded that it is not possible to calculate this yet, as such a calculation would require assumptions about Year 2 ACO sample sizes for each measure.
- Abe noted that this program is designed to incent providers to do things in alignment to the triple aim. As we have no information about the magnitude of Year 1 savings yet, we need to be careful to not alienate the participants in the ACOs.
- Don asked if the group was comfortable voting on a recommendation at this time. Lila

	<p>made a motion to remove this as an action item. Todd Moore seconded.</p> <ul style="list-style-type: none"> <li>Paul asked about the ramifications of a delay. Kara responded that Medicaid will not commence the contract amendment process until this and other outstanding issues have been fully vetted. A roll call vote was taken. The motion carried. A vote on the Year 2 Gate &amp; Ladder methodology will be taken during the February meeting. Any additional questions about the methodology in the interim should be directed to Alicia Cooper.</li> </ul>	<p>Those with questions are to go directly to Alicia Cooper (alicia.cooper@state.vt.us)</p>
<p>Blueprint for Health Presentation</p>	<p>Kara introduced Craig Jones, Director of the Blueprint for Health. Craig Jones presented on attachment 4; the following are comments or questions about the presentation.</p> <ul style="list-style-type: none"> <li>Susan Aranoff asked for clarification on slide 2, and what the ‘SASH team’ component consists of. Craig said that those listed are getting money from Blueprint</li> <li>Kelly asked how detailed the practice profiles are, and who is receiving them. Craig responded that in addition to practice specific reports, there are also service area reports that show comparison data. Several Core ACO measures are included in the reports.</li> <li>Paul asked about the Governor’s budget speech, its implications for the Blueprint, and whether the GMCB may fall under GMCB oversight in future. Craig responded that Blueprint will work closely with the GMCB regardless, but was unable to comment on any such reorganization. He also noted that the Blueprint’s objectives are directly aligned with what the GMCB is tasked with accomplishing.</li> <li>Paul asked about the Blueprint details in the budget put forth by the Governor. Kara asked that this group keep the overall investment of the dollars in mind, but not to focus on the exact PMPM. Craig and Paul highlighted a potential error in FY 2016 budget with regard to the current Blueprint PMPMs .</li> <li>Don asked who will approve any payment increases. Craig said changes have to go through the legislature as part of the budget to get approved. Changes to commercial payments will go through Green Mountain Care Board.</li> <li>Susan asked for clarification around HSA-level interdependencies when some areas have all three ACOs and others do not.. Craig called attention to slide 4. Geographical areas allow ACOs to collaborate in a simplified structure, and use each other’s resources to address shared issues in a certain area and population. The proposed payment structure is intended to incentivize the collaboration needed, with primary care at the forefront.</li> <li>Don asked about opportunities for new health plans in the state. Craig responded that the State’s quality requirements for health plans are redundant and administratively difficult. Todd added that health plans and Blueprint need to continue to work together to ensure inclusion of Vermonters who are self-insured. Craig emphasized that this proposal is a step toward the all payer waiver in 2017.</li> <li>Kara commented on the proposal: 1) With 4 components for a payment and with fixed</li> </ul>	

	<p>resources, inevitably something will be underweighted –we should continue to think about if everything included is appropriately incentivizing what we want. 2) It may be difficult to justify allowing certain provider types to receive payments for participating in the UCCs but not others. 3) We may want to consider using some of the allocated money to fund a PMPM and provide a larger base payment (amplifying the role of the medical home). 4) If payments for NCQA re-certification are discretionary, it will be especially difficult to budget for that component.5) Using the HSA-level for quality calculations makes sense, as sample sizes at the practice-level are generally too small to be statistically significant. Kelly commented that she appreciated the synergies that this proposal would support, but was concerned that the proposal is too process based – not looking at clinical integration and outcomes. It may work as a transitional model to align work with ACOs, but may not reward the outcomes-oriented improvement in the longer term. Todd commented that there may be an ACO-specific requirement that participating practices be NCQA recognized in 2017 to assure everyone is heading in the right direction together. Michael Hall asked how to make sure those most contributing to success are being rewarded to do that. Craig agreed that this is a concern, and said that the program was still working on providing the right monetary incentives, adding that he envisions a series of steps to get the payments right.</p> <p>•</p>	
Public Comment	<p>Richard Slusky noted that the ACO Operations Group would begin discussions on Yr 3 downside risk for the Commercial Shared Savings Program in the coming months. Medicare is now proposing that ACOs do not have to accept downside risk in the fourth program year, and the Medicaid SSP has extended one sided model through 2017. Richard further noted that input from PMWG is welcome, but because the assumption of risk could significantly impact the ACOs, they will need to be very directly involved in this decision.</p>	
Next Steps and Action Items	<p>Next meeting:  Monday, February 23, 2015  1:00 pm – 3:00 pm  EXE - 4th Floor Conf Room, Pavilion Building  109 State Street, Montpelier</p>	

# Attachment 3a

# **Blueprint ACO Integration, Community Health Systems, & Supportive Payment Modifications**

## **Payment Models Workgroup Vermont Health Care Improvement Program**

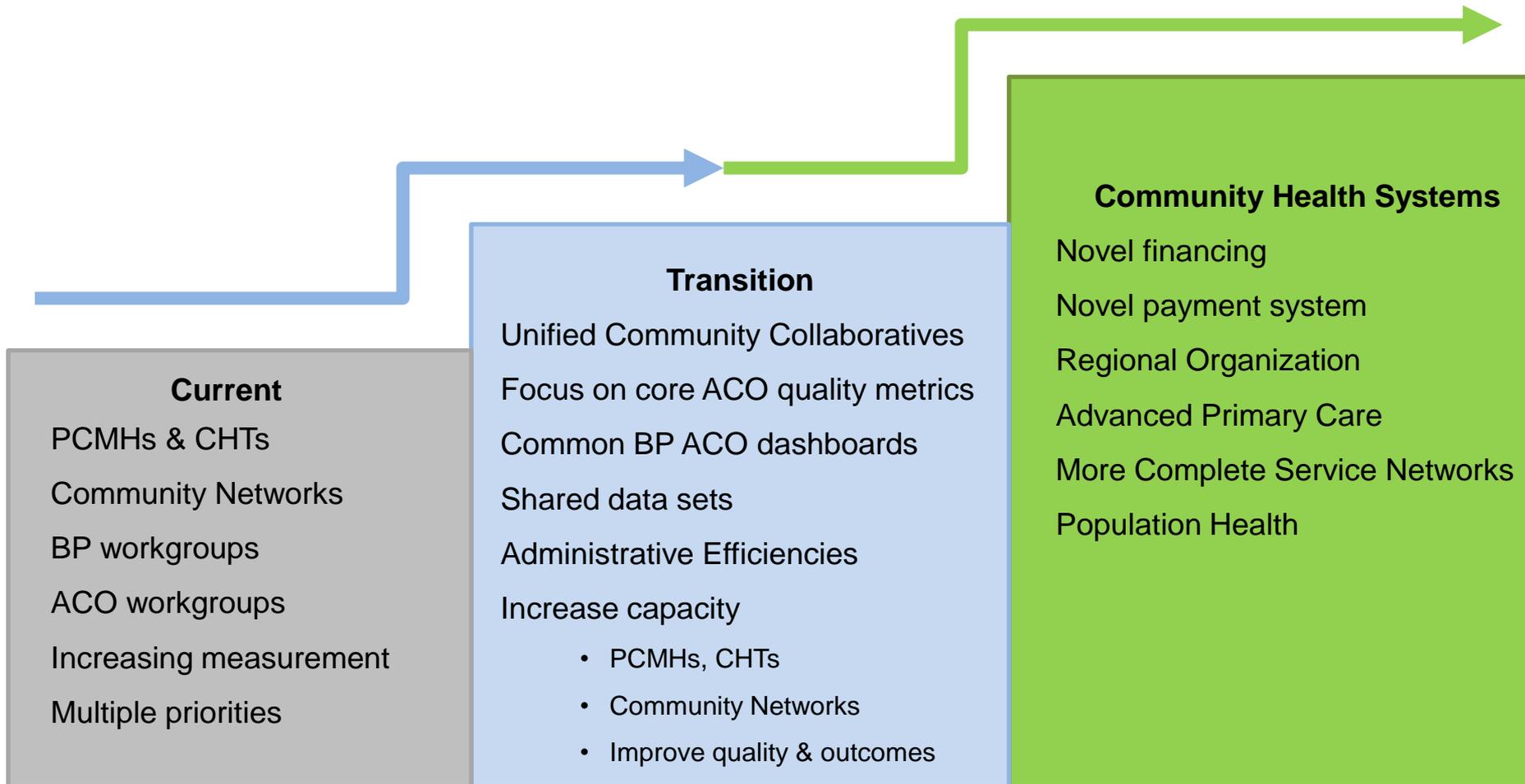
**February 23, 2015**

## Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & evolving community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Three ACO provider networks (OneCare, CHAC, HealthFirst)
- Opportunity to unify work, strengthen community health system structure



# Transition to Community Health Systems



# Strategy for Building Community Health Systems

## Design Principles

- Integration of medical, social, and long term support services
- Services organized at a community level into a cohesive system
- Services that improve population health thru prevention
- Enhanced primary care with a central coordinating role
- Coordination and shared interests across providers in each area
- Capitated payment that drives desired outcomes

# Strategy for Building Community Health Systems

## Action Steps

- Unified Community Collaboratives (quality, coordination)
- Unified Performance Reporting & Data Utility
- Increase support for medical homes and community health teams
- Novel medical home payment model
- Strengthen services using the health home model
- Administrative simplification and efficiencies

# Unified Community Collaborative (UCC)

## Overview

- Leadership Team (up to 11 member team)
  - 1 local clinical lead from each ACO (2 to 3)
  - 1 local representative from VNA, DA, SASH, AAA, Peds
  - Additional ad hoc members chosen locally
- Use measure results and comparative data to guide planning
- Planning & coordination for quality initiatives & service models
- Project managers provide support (convening, coordination)
- PCMHs & CHTs participate in quality initiatives

## Performance Reporting & Data Utility

### Reporting & Comparative Performance

- Profiles for each medical home practice
- Profiles for each Health Service Area
- Whole population results & breakouts (MCAID, MCARE, Commercial)
- Measures - Expenditures, utilization, quality (core ACO for HSAs)
- Improving with input from provider networks

# Practice Profiles Evaluate Care Delivery Commercial, Medicaid, & Medicare



**Practice Profile: ABC P**  
 Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Welcome to the 2014 Blueprint Practice Profile from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services. Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Demographics & Health Status	Practice	H.S.A.	St.
Average Members	4,081	84,070	2,925,000
Average Age	50.6	50.1	50.1
% Female	55.6	55.5	55.5
% Medicaid	14.5	13.0	13.0
% Medicare	23.7	22.2	22.2
% Maternity	2.1	2.1	2.1
% with Selected Chronic Conditions	50.1	38.8	38.8
Health Status (CRG)			
% Healthy	39.0	43.9	43.9
% Acute or Minor Chronic	18.8	20.5	20.5
% Moderate Chronic	27.9	24.5	24.5
% Significant Chronic	15.4	12.3	12.3
% Cancer or Catastrophic	1.4	1.3	1.3

Table 1: This table provides comparative information on the demographics & health status of your practice, all Blueprint practices in your Health Service Area (HSA) as a whole. Included measures reflect the types of information used to adjust rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial enrollment during the year. In addition, special attention has been given to Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's practice, percentage of membership in Medicaid, Medicare eligibility or end-of-stage renal disease status, and the member's receipt of special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of members through the claims data as having one or more of seven selected chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, co disease, hypertension, diabetes, and depression.

The Health Status measure aggregates 3M™ Clinical Risk Grouping (CRG) into the year for the purpose of generating adjusted rates. Aggregated risk class include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., amyotrophy, cystic fibrosis).



**Practice Profile: ABC Primary Care**  
 Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

**Total Expenditures per Capita**

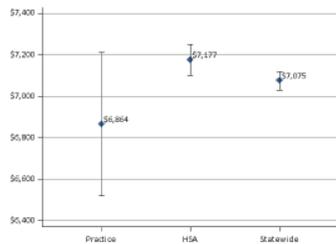


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

**Total Expenditures by Major Category**

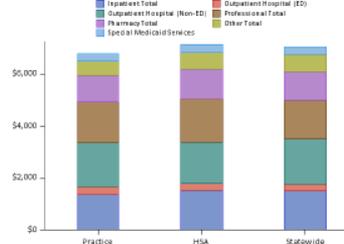


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

**Total Expenditures Excluding SMS**

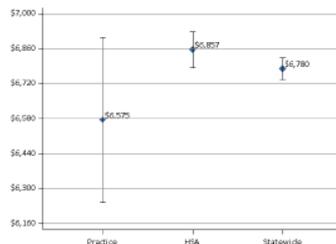


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medical Services, capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

**Total Resource Use Index (RUI) Excluding SMS**

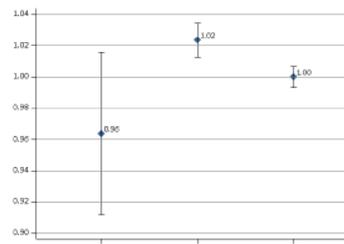
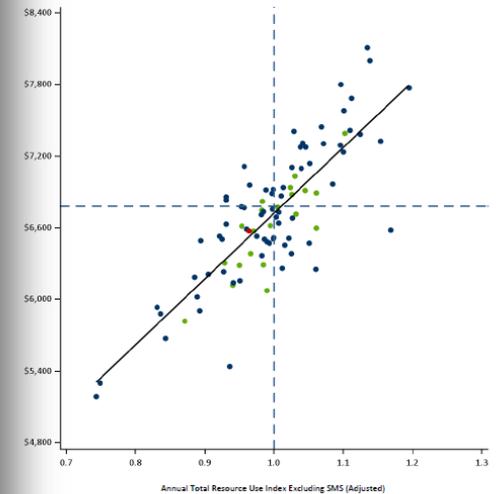


Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per resource varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects on aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medical Services. The practice and HSA are indexed to the statewide average (1.00).



**Practice Profile: ABC Primary Care**  
 Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

**Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)**

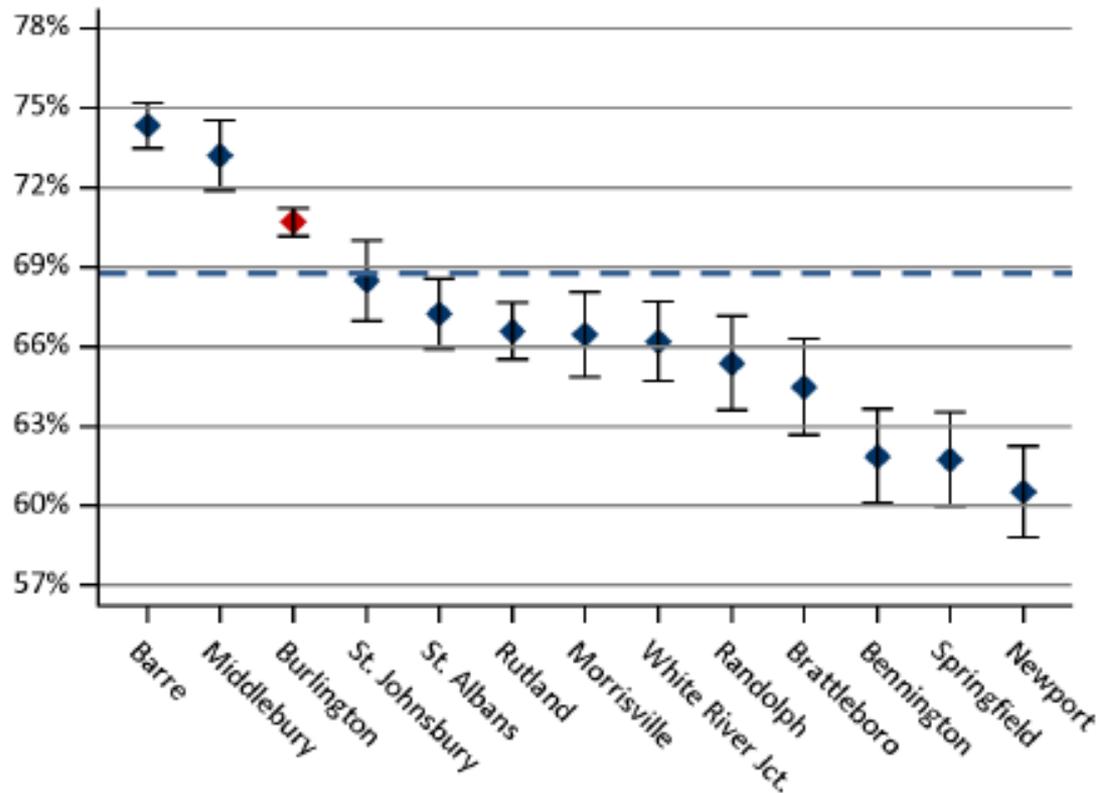


This graphic demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint practices (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI statewide (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand corner with lower expenditures and utilization are in the lower left-hand corner. An RUI value indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization. A trend line has been included in the graphic, which demonstrates that, in general, practices with a utilization had higher risk-adjusted expenditures.

Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

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## Claims Data – Cervical Cancer Screening (Core-30)



*Figure 14: Presents the proportion, including 95% confidence intervals, of continuously enrolled female members, ages 21–64 years, that received one or more PAP tests to screen for cervical cancer during the measurement year or the two years prior to the measurement year. The blue dashed line indicates the statewide average.*

## Claims Data – PQI Composite (Chronic): Rate of Hospitalization for ACS Conditions (Core-12)

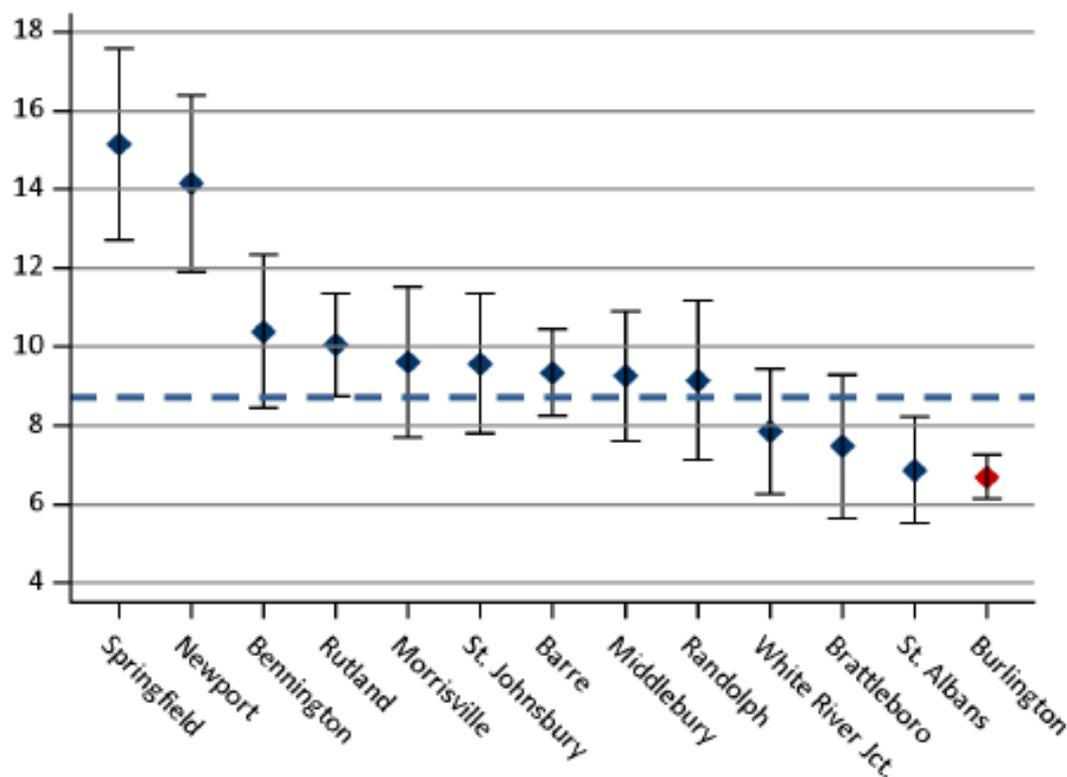
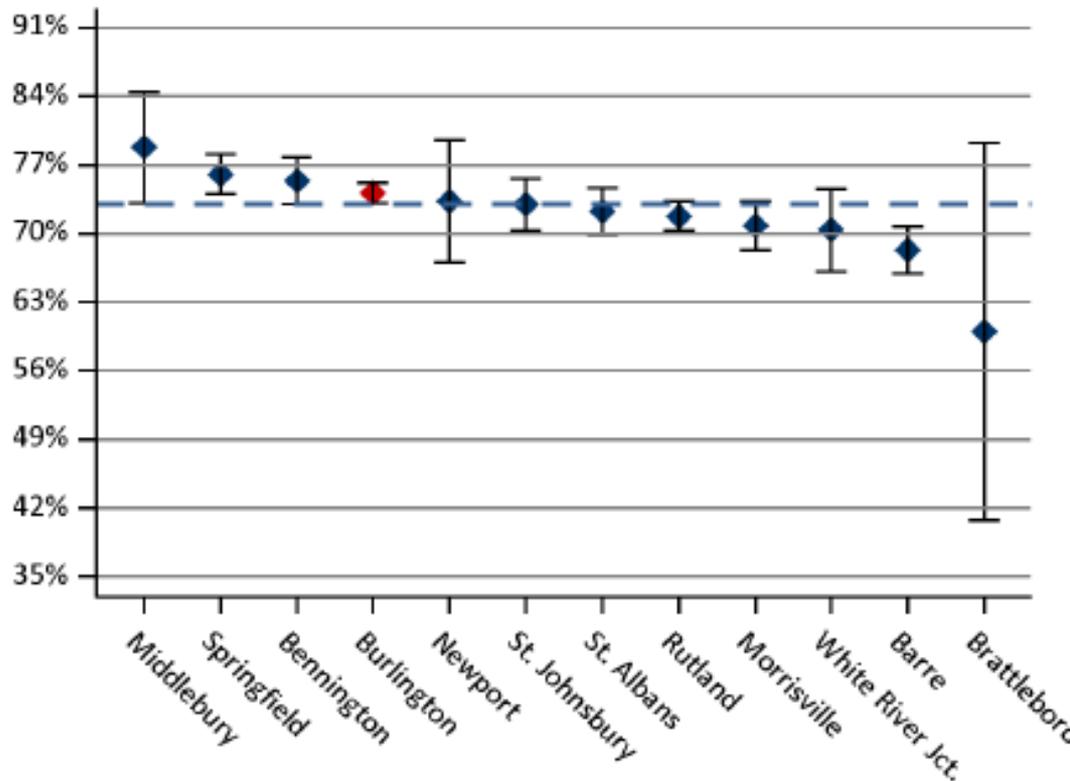


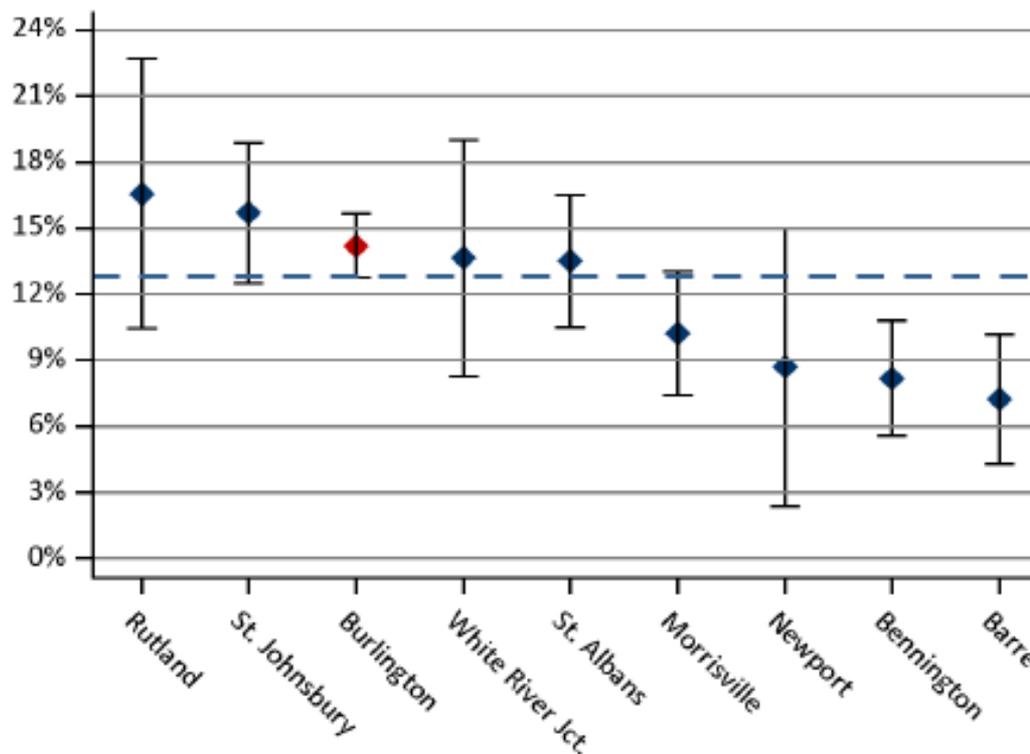
Figure 27: This Prevention Quality Indicator (PQI) presents a composite of chronic conditions per 1,000 members, ages 18 years and older. This measure includes admissions for at least one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The blue dashed line indicates the statewide average.

## Claims & Clinical Data – Hypertension: Blood Pressure in Control (Core-39, MSSP-28)



*Figure 34: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with hypertension, ages 18–85 years, whose last recorded blood pressure measurement in the DocSite clinical database was in control (<140/90 mmHg). Members with hypertension were identified using claims data. The denominator was then restricted to those with DocSite results for a blood pressure reading during the measurement year. The blue dashed line indicates the statewide average.*

## Claims & Clinical Data – Diabetes: Poor Control (Core-17, MSSP-27)



*Figure 33: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.*

# Payment Modifications

## Recommendations

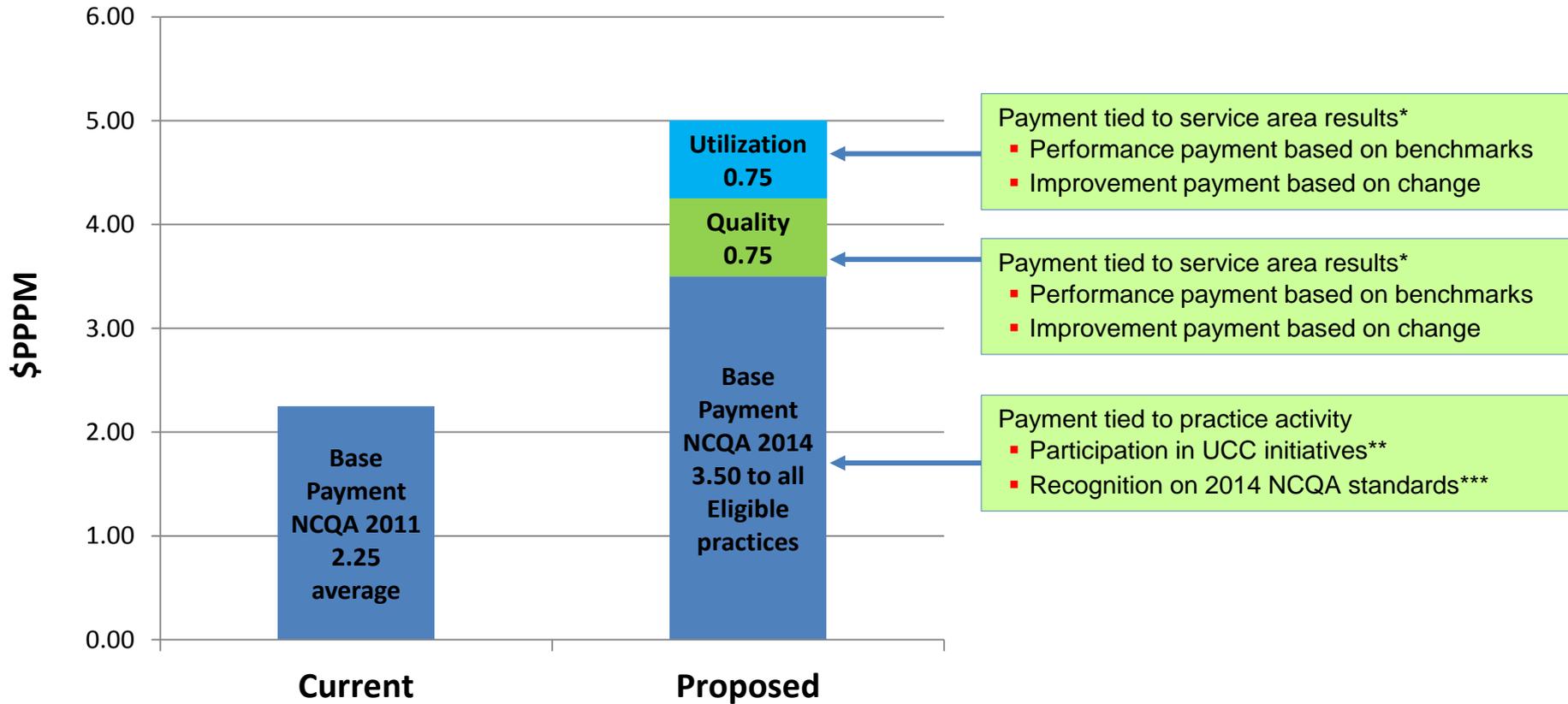
1. Increase PCMH payment amounts
2. Shift to a composite measures based payment for PCMHs
3. Increase CHT payments and capacity
4. Adjust insurer portion of CHT costs to reflect market share

## Payment Modifications

### Performance based medical home payment

- Total = Base (UCC, NCQA) + Quality + Utilization
- UCC participation, NCQA scoring – *practice control*
- Service area quality & utilization – *interdependencies*
- Stimulates work of UCCs (quality & coordination)

# Proposed Payment Modifications



\*Incentive to work with UCC partners to improve service area results.

\*\*Organize practice and CHT activity as part of at least one UCC quality initiative per year.

\*\*\*Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

## NCQA PCMH Standards

- Rigorous, measurable standards (process and quality)
- Grounded in research and expert opinion, updated regularly
- Widely adopted and tested across the US, and across VT
- Practices in VT scored independently and objectively (UVM VCHIP)
- Associated with improved cost & utilization outcomes in VT
- Cornerstone for NCQA Specialty Practice & ACO Standards
- Basis for a well coordinated healthcare system



## Proposed Modifications to CHT Payments

	Current Share of CHT Costs	Current Annual CHT Cost	Proposed Share of CHT Costs	Proposed Annual CHT Cost	Differential (annual)
		Based on \$1.50 PPM and current cost allocations	Based on percentages of attributed beneficiaries	Based on \$3.00 PPM for non-Medicare, and new cost allocations	
Medicare*	22.22%	\$2,150,229	22.22%	\$2,150,229	\$0
Medicaid	24.22%	\$2,343,768	35.66%	\$6,901,634	\$4,557,865
BCBS	24.22%	\$2,343,768	36.92%	\$7,145,494	\$4,801,725
MVP	11.12%	\$1,076,082	4.71%	\$911,573	-\$164,509
Cigna	18.22%	\$1,763,149	0.49%	\$94,835	-\$1,668,314
Total	100.00%	\$9,676,996	100.00%	\$17,203,763	\$7,526,767

\*Medicare share of CHT patient allocation remains unchanged at 22.22% and payment level remains unchanged at \$1.50 PPM.

## Community Oriented Health Systems



- Core measures & NCQA standards provide a statewide framework
- PCMH payment model incents quality & coordination
- Community collaboratives guide quality & coordination initiatives
- More effective health services & community networks
- Health System (Accessible, Equitable, Patient Centered, Preventive, Affordable)

# Attachment 3b

**Proposal for Delivery System Reforms:  
Integrating Vermont ACO and Blueprint  
Activities  
Phase II Payment Reforms**

**Vermont Blueprint for Health  
One Care  
CHAC  
Health First**

## Introduction

This proposal presents a plan for a next phase of delivery system reforms in Vermont to increase the capacity of primary care, provide citizens with better access to team based services, and strengthen the basis for a community oriented health system structure across Vermont. The suggested programmatic and payment changes are designed to establish a more systematic approach to coordinating local services and quality initiatives across the state. This will be achieved thru integration of Provider Network (ACO) and Blueprint program activities in a unified collaborative to guide quality and coordination initiatives in each service area; and, an aligned medical home payment model that promotes coordination and better service area results on core measures of quality and performance. The proposed changes represent a natural next phase for the evolution of health services in Vermont by building on delivery system advancements in each community, and on the administrative capabilities of medical provider networks that have formed to represent the business interests of similar provider types (hospital affiliated, health centers, independent providers). The structural, programmatic and payment changes proposed in this plan are designed to achieve the aim of providing citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services.

## Background

*Blueprint.* During the last six years, stakeholders across the state have worked with the Blueprint program to implement a novel healthcare model designed to provide citizens with better access to preventive health services, and to improve control over growth in healthcare costs. The statewide model includes:

- high quality primary care based on national standards for a patient centered medical home
- community health teams providing the medical home population with access to multi-disciplinary staff such as nurse care coordinators, social workers, and dieticians
- integrated health services workgroups to strengthen networks in each community and improve coordination between medical and social services and
- a statewide learning health system thru data guided quality initiatives at the practice, community, and statewide levels.

Implementation of the model has been supported by Multi-insurer payment reforms, as well as Blueprint grants to each area of the state that support project managers, practice facilitators, self-management programs, and assistance with health information technology and data quality. Results of a six year trend analysis demonstrate improvements in healthcare utilization,

healthcare expenditures, better linkage of Medicaid beneficiaries to social support services, and improvements in healthcare quality (HEDIS).

*Provider Networks.* At the same time, Vermont's healthcare reform initiatives have continued to push forward on several fronts including implementation of an insurance exchange in alignment with the Affordable Care Act (Vermont Health Connect), and the introduction of shared savings programs designed to improve quality and control over health care costs (Accountable Care Organizations). As part of this process, medical providers have established three statewide networks based on common business interests and organization type. The three networks include OneCare (hospital affiliated providers), CHAC (providers working for health centers), and HealthFirst (independent providers). Each of the medical provider networks has established an administrative structure to guide participation in Vermont's healthcare reform processes including participation in shared savings programs. These new provider networks, and in particular their ability to organize initiatives and represent the interests of their constituents, adds important administrative capability to Vermont's healthcare landscape.

*Integration.* The three provider networks, each based on a common business identity and culture, can help to organize healthcare improvement priorities with their members (vertical organization). The Blueprint program with Community Health Teams and Integrated Workgroups has helped to organize coordination at a community level, across settings and provider types (horizontal). This plan blends these strengths and adds meaningful participation of additional provider types, in a formal collaborative structure that will improve services for citizens in each service area in Vermont. Modifications to current medical home payments are proposed which are integral to support coordination in each community, and to align medical home incentives with the quality and performance goals of the new collaboratives.

### **Programmatic Changes**

*Unified Community Collaboratives - Principles & Objectives.* Presently, an array of meetings focused on quality and coordination are taking place in communities across Vermont. Most areas have Blueprint integrated health services workgroups as well as workgroups for participants in the provider network shared savings programs (ACOs). The Blueprint meetings are oriented towards coordination of community health team operations and services across providers in the community (community, horizontal) while the ACO meetings are oriented towards meeting the goals of the participating provider network (organizational, vertical). The same providers may be participating in multiple meetings, with overlapping but distinct work on coordination of services and quality.

This proposal calls for development of a Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) in order to coalesce quality and coordination activities, strengthen Vermont's community health system infrastructure, and to help the three provider networks meet their organization goals. In many areas of the state the proposed collaboratives represent a

significant advancement in terms of the assortment of provider types who would participate in, and help lead, a unified forum. They build on a strong community oriented culture in the state with the underlying premise that the UCC structure, with administrative support and an aligned medical home payment model, will result in more effective health services as measured by:

- Improved results for priority measures of quality
- Improved results for priority measures of health status
- Improved patterns of utilization (preventive services, unnecessary care)
- Improved access and patient experience

*Unified Community Collaboratives – Activities.* As proposed, the UCCs will provide a forum for organizing the way in which medical, social, and long term service providers' work together to achieve the stated goals including:

- Use of comparative data to identify priorities and opportunities for improvement
- Use of stakeholder input to identify priorities and opportunities for improvement
- Develop and adopt plans for improving
  - quality of health services
  - coordination across service sectors
  - access to health services
- Develop and adopt plans for implementation of new service models
- Develop and adopt plans for improving patterns of utilization
  - Increase recommended and preventive services
  - Reduce unnecessary utilization and preventable acute care (variation)
- Work with collaborative participants to implement adopted plans and strategies including providing guidance for medical home and community health team operations

*Unified Community Collaboratives – Structure & Governance.* To date, Blueprint project managers have organized their work based on a collaborative approach to guiding community health team operations and priorities. In most cases, this has stimulated or enhanced local innovation and collaborative work. The three new medical provider networks have each established a more formal organizational structure for improving quality and outcomes among their constituents. The provider networks are looking to establish improved collaboration and coordination with a range of service providers in each community. The proposed collaboratives build from these complimentary goals and capabilities, enhance community coordination, and improve the ability for each provider network to achieve their goals. This is accomplished using a formal structure with a novel leadership team that balances the influence of the three medical provider networks, and the influence of medical, social, and long term providers.

We are proposing that the UCC in each HSA have a leadership team with up to 11 people based on the following structure:

- 1 local clinical lead from each of the three provider networks in the area
  - OneCare
  - CHAC
  - HealthFirst (not present in all HSAs)
- 1 local representative from each of the following provider types that serves the HSA
  - VNA/Home Health
  - Designated Agency
  - Designated Regional Housing Authority
  - Area Agency on Aging
  - Pediatric Provider
- Additional representatives selected by local leadership team (up to total of 11)

The proposal is for the leadership team to guide the work of the UCC in their service area with responsibilities including:

- Developing a plan for their local UCC
- Inviting the larger group of UCC participants in the local service area (including consumers)
- Setting agendas and convening regular UCC meetings (e.g. quarterly)
- Soliciting structured input from the larger group of UCC participants
- Making final decisions related to UCC activities (consensus, vote as necessary)
- Establishing UCC workgroups to drive planning & implementation as needed

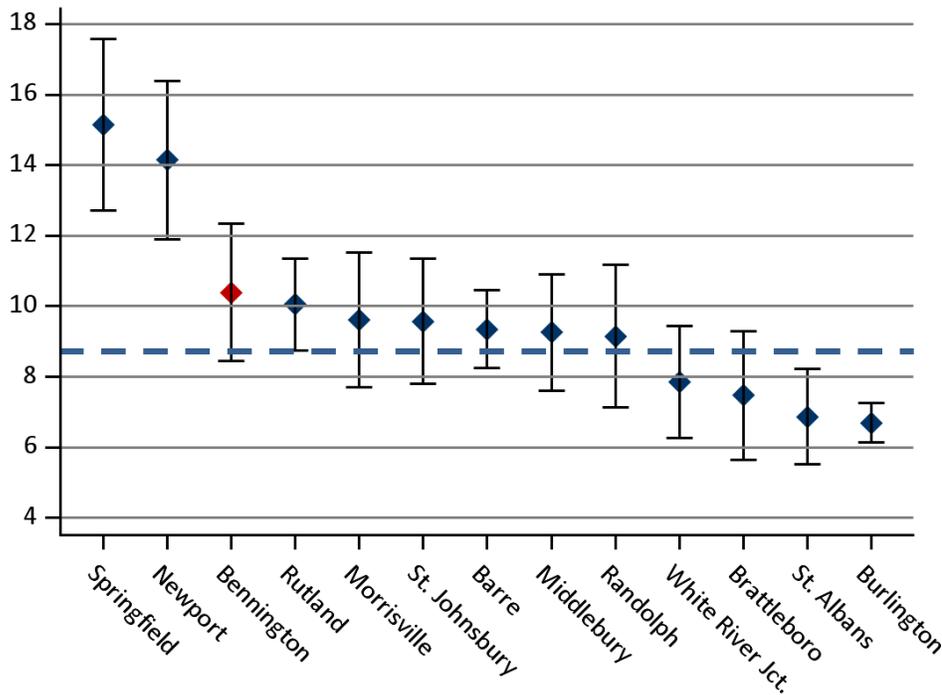
The UCC leadership team will be supported in their work with the following resources:

- Convening and organizing support from the Blueprint project manager
- Support on quality work from Blueprint practice facilitators
- Blueprint HSA grants structured to support the work of the UCC
- Collaboration between the Blueprint and UCC leaders on analytics & evaluation
- Profiles with comparative data including priority measures (practice, HSA levels)
- Ongoing programmatic collaboration (Blueprint, Provider Networks, UCC leaders, others)
- Modification to medical home payments to support provider networks and UCC goals

*Unified Community Collaboratives – Basis for Regional Health Systems.* As UCCs mature, they have the potential to emerge as governing and fiscal agents in regionally organized health systems. This could include decision making and management of community health team funds, Blueprint community grants, and ultimately budgets for sectors of health services (e.g. pre-set capitated primary care funds). In order to be effective an agent for cohesive regional systems, it is essential for UCCs to establish leadership teams, demonstrate the capability to engage a range of providers in sustained collaborative activity (medical, social, and long term support providers), demonstrate the capability to lead quality and coordination initiatives, and

demonstrate the ability to organize initiatives that tie to overall healthcare reform goals (e.g. core measures). Ideally, UCCs will demonstrate effective regional leadership to coincide with opportunities offered by new payment models and/or a federal waiver in 2017.

*Unified Community Collaboratives – Opportunity to Guide Improvement.* Current measurement of regional and practice level outcomes across Vermont highlights opportunities for UCCs to organize more cohesive services and lead improvement. When adjusted for differences in the population, there is significant variation in measures of expenditures, utilization, and quality. The variation across settings offers an opportunity for UCC leadership teams and participants to examine differences, and to plan initiatives that can reduce unnecessary variation and improve rates of recommended services. One example is the Prevention Quality Indicator (PQI) measuring the rate of hospitalizations per 1,000 people, ages 18 and older, for a composite of chronic conditions including: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The 2013 service area results for this indicator, which is included in Vermont’s core measure set for shared savings programs, highlights the variation that is seen with most core quality and performance measures.



Overall improvement in this measure, and reduction in variation across settings, is most likely with well-planned coordination across provider types including primary care, specialty care, and

community services that improve self-management capabilities for vulnerable populations such as seniors without adequate support. Hospitalization rates for these types of conditions are driven by complex life circumstances, often related to social, economic, and behavioral factors that influence the ability to engage in daily preventive care. While the measure is one of traditional healthcare utilization, outcomes will be better with cohesive integration of health and human services addressing non-medical as well as medical needs. The UCC, and the proposed leadership team, is designed to establish a structured forum to guide this level of integration. A coordinated effort to identify those at risk in the community, to assess the factors that limit effective management, and to organize a community team approach to prevention will have the greatest opportunity to improve outcomes.

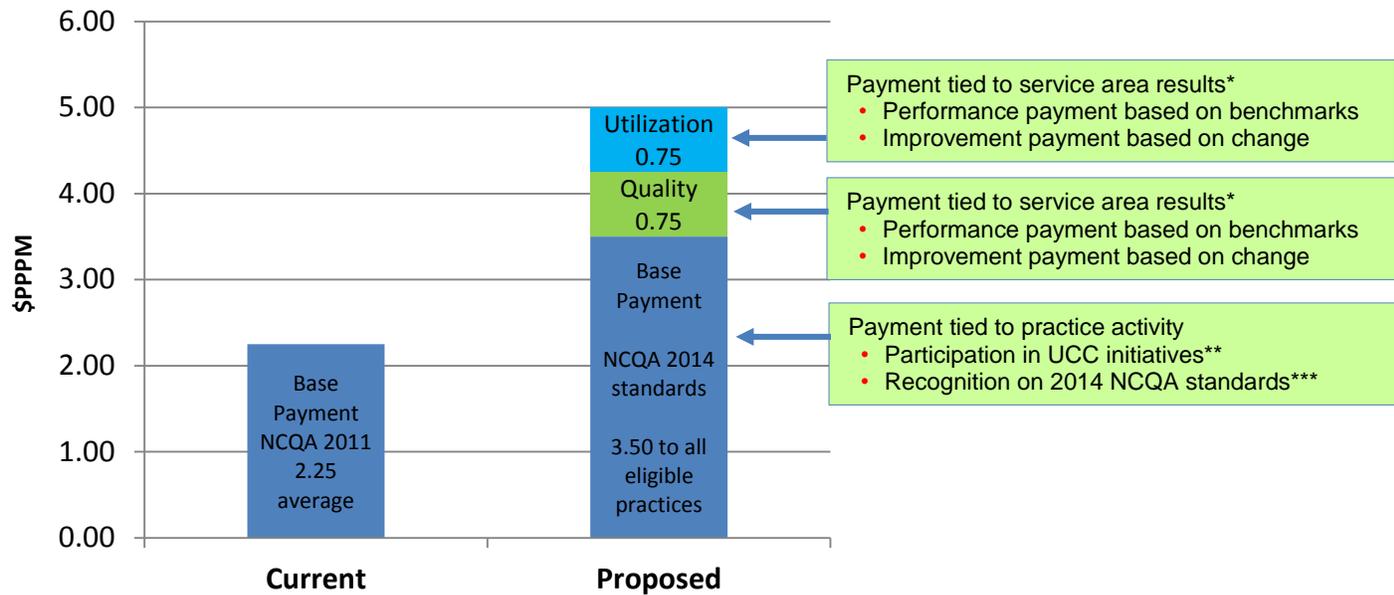
### **Payment Model**

*Current payment structure.* To date, two payments have been adopted by all major insurers to support the roll out and maturation the Blueprint program. The first payment is made to primary care practices based on their score on NCQA medical home standards. In effect, this represents a payment for the quality of services provided by the practice as assessed by the NCQA standards. The second is a payment to support community health team staff as a shared cost with other insurers. This represents an up-front investment in capacity by providing citizens with greater access to multi-disciplinary medical and social services in the primary care setting. Both are capitated payments (PPPM) applied to the medical home population. Although these two payments are relatively low compared to the overall revenue that primary care practices generate; when combined with the dedication of primary care practice teams and the Blueprint program supports, they have led to statewide expansion of medical homes and community health teams. There is growing evidence that medical homes and community health teams favorably impact healthcare expenditures, utilization, and quality. However, the medical home payments have not been increased in the last six years and are widely perceived as inadequate to support the effort required to comply with increasingly demanding NCQA standards. Some practices, particularly independent practices that don't have the administrative support that hospital affiliated practices and health centers have, may choose not to continue participating at the current payment levels due to the time and costs associated with medical home recognition and operations. Similarly, community health team payments have not kept up with the administrative costs that are required to operate the expanded program, or the salary and compensation costs to employ the workforce. In some cases, this has led to a reduction in the staffing that is available to patients as adjustments are made to accommodate administrative and staff salary pressures. Lastly, while these payments have stimulated successful program expansion, it is important to consider whether a modified medical home payment model can be used to support collaborative activity and the effectiveness of a community health system infrastructure.

*Proposed medical home payment structure.* The proposed medical home payment model is designed to more adequately fund medical home costs, and to directly align medical home incentives with the goals of the collaboratives and the ACO provider networks. The proposed payment changes anticipate multi-payer participation, a doubling of medical home payments, and a new performance component to the payment model. In this proposal, the total capitated payment to medical homes is based on a composite of medical home recognition, collaborative participation, and performance. The outcome measures driving the performance component include a Quality Index comprised of core ACO quality measures, and a Total Utilization Index. Improvement on these metrics, such as higher scores on the quality index and less variation on the utilization index, is directly aligned with the goals of Vermont's health reforms. The new medical home payment model includes the following elements:

- Base Component: Based on NCQA recognition & UCC Participation.
  - Requires successful recognition on 2014 NCQA standards (any qualifying score)
  - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
  - All qualifying practices receive \$3.50 PPPM
- Quality Performance Component: Based on HSA results for Quality Index.
  - Up to \$ 0.75 PPPM for results that exceed benchmark, or
  - Up to \$ 0.50 PPPM for significant improvement if result is below benchmark
- Utilization Performance Component: Based on HSA results for Utilization Index.
  - Up to \$ 0.75 PPPM for results that exceed benchmark, or
  - Up to \$ 0.50 PPPM for significant improvement if result is below benchmark
- Total Payment = Base + HSA Quality Performance + HSA TUI Performance
- Total Payment ranges from \$3.50 to \$5.00 PPPM

### **Comparison of current and proposed medical home payments**



\*Incentive to work with UCC partners to improve service area results.

\*\*Organize practice and CHT activity as part of at least one UCC quality initiative per year.

\*\*\*Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

The new payment model is designed to promote collaboration and interdependent work by linking a portion of each practice's potential earnings to measure results for the whole service area (HSA). It is also intended to more directly focus efforts on improved health outcomes and reduced growth in health expenditures. In theory, the combination of the UCC structure and decision making process, with the interdependent nature of the payment model, will lead to better organization and coordination across provider groups. In contrast, a medical home payment linked solely to practice quality is less likely to stimulate better coordination across a service area. Although fee for service is still the predominate payment, this suggested payment model is an important *step* towards a more complete capitated payment structure with a performance component that is anticipated for 2017. It will help to stimulate the culture and activity that is essential for a high value, community oriented health system. The implementation of this payment model is only possible with an increase in payment amounts to more adequately support the work that is required to operate a medical home and the multi-faceted payment structure. The incentive structure that is woven into the payment model includes:

- Requires active and meaningful participation in UCCs including: attention to variable and unequal outcomes on core measures; and, coordination with collaborative partners to improve services.
- Requires that practices maintain NCQA recognition, however shifts the emphasis to the most important Must Pass elements in the medical home standards and de-emphasizes the intensive documentation that is required to achieve the highest score.

- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization)
- Rewards coordination with UCC partners to achieve better results on service area outcomes for a composite of core quality measures (directly links incentives for medical homes to statewide healthcare reform priorities)
- Rewards coordination with UCC partners to achieve better service area results for the total utilization index (case mix adjusted), which has a predictable impact on healthcare expenditures (directly links incentives for medical homes to statewide healthcare reform priorities)

*Opportunity to improve care and reduce variation.* It is important to note that across Vermont there is significant variation in the results of quality and utilization measures, after adjustment for important differences in the populations served. Unequal quality and utilization, for comparable populations with comparable health needs, provides an opportunity to examine differences in regional health services, and to plan strategies that improve the overall quality of healthcare that citizens receive. The Blueprint currently publishes Profiles displaying comparative measure results for each participating practice and for each service area. The profiles include the results of core quality measures which have been selected thru a statewide consensus process. The objective display of the variation that exists across service areas, and across practices within each service area, can support the work of the UCCs including identification of opportunities where quality and utilization should be more equal, and implementation of targeted strategies to reduce undesirable variation.

*Proposed changes for community health team payments.* Currently, community health team payments average \$1.50 PPM. This proposal calls for an increase to \$3.00 PPM to increase ancillary support services available to medical home patients, and to more adequately support salary and administrative costs for a community team infrastructure. In addition to the increase, the proposal is to adjust each insurer's share of community health team costs to reflect their proportion of attributed medical home patients in the Vermont market. This will be calculated by applying each insurer's percentage of the attributed medical home population to the total community health team costs. Total community health team costs will be based on the total number of unique patients reported by medical home practices using a 24 month look back. Insurers proportion of the medical home population will be updated with a new attribution count twice yearly. Due to the terms in the current Multi-Payer Demonstration Program with CMS, Medicare's share will remain constant with a 22.22% share of community health team costs which is in close alignment with their market share. An example of the change to each insurer's share of costs, based on their current proportion of attributed medical home patients, is shown below.

**Market share basis for community health team costs.**

	Current share of CHT Costs	Proposed share of CHT Costs*
Medicare	22.22%	22.22%
Medicaid	24.22%	35.66%
BCBS	24.22%	36.92%
MVP	11.12%	4.71%
Cigna	18.22%	0.49%
Total	100.00%	100.00%

\*Each insurer's percentage of community health team cost is based on their attributed proportion of the total medical home population.

**Quality and Performance Framework**

*Design Principles.* This plan calls for use of Vermont's core performance and quality measures, in conjunction with comparative performance reporting, to help guide UCC activities and medical home payments. This approach ties the work of medical homes and UCCs directly to priorities for state led health reforms as reflected by the core measure set, which was selected using a statewide consensus process as part of the Vermont Healthcare Improvement Program (SIM). The three medical provider networks share a common interest in the results of the core measures which are used to determine whether network clinicians are eligible for payment as part of shared savings programs (SSP).

The proposal calls for use of a subset of these measures, which can be consistently reported using centralized data sources, to provide targeted guidance for the work of the UCCs. The intent is that UCCs will work to improve the results on some or all of the subset, depending on local priorities and the decisions made by each UCC. The subset of measures will be also be used to generate an overall composite result for the service area (quality composite). The composite result will be used to determine whether medical homes are eligible for a portion of their augmented payment (see payment model).

In addition to the subset of core quality and performance measures, this plan incorporates use of the Total Resource Utilization Index (TRUI), a standardized and case mix adjusted composite measure designed for consistent and comparable evaluation of utilization and cost across settings. Comparative results of the TRUI, adjusted for differences in service area populations, can be used in combination with more granular utilization measures to identify unequal healthcare patterns and opportunities for UCC participants to reduce unnecessary utilization that increases expenditures but doesn't contribute to better quality. Similar to the core quality and performance composite, the service area result for the TRUI will be used to determine whether

medical homes are eligible for an additional portion of their augmented payment (see payment model).

Used together, the two composite measures promote a balance of better quality (core quality and performance) with more appropriate utilization (TRUI). Linking payment to measure results for the whole service area establishes interdependencies and incentives for medical home providers to work closely with other collaborative participants to optimize outcomes. Routine measurement and comparative reporting provides UCCs with the information they need to guide ongoing improvement. In this way, the proposed measurement framework serves as the underpinning for a community oriented learning health system and helps UCCs to:

- Establish clear measurable goals for the work of the collaborative
- Guide planning and monitoring of quality and service model initiatives
- Align collaborative activities with measurable goals of state led reforms
- Align collaborative activities with measurable goals of shared saving programs

*Measure Set.* Implementation of this plan depends on selection of a subset of quality and performance measures from the full core measure set that was established thru VHCIP. The intent is for a *meaningful* limited set that can be measured consistently across all service areas, using centralized data sources that are populated as part of daily routine work (e.g. all payer claims database, clinical data warehouse). Ideally, measures will be selected that maximize measurement capability with existing data sources, prevent the need for additional chart review, and avoid new measurement burden for providers. At the same time, work should continue to build Vermont's data infrastructure so that more complete data sets and measure options are available. Vermont's full set of core measures are shown in Appendix A, with the subset that can currently be generated using centralized data sources shown below:

- Plan All-Cause Readmissions
- Adolescent Well-Care Visit
- Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)
- Follow-up after Hospitalization for Mental Illness, 7 Day
- Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Developmental Screening in the First Three Years of Life
- Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
- Mammography / Breast Cancer Screening
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite

- Appropriate Testing for Children with Pharyngitis
- Cervical Cancer Screening
- Influenza Vaccination
- Percent of Beneficiaries With Hypertension Whose BP < 140/90 mmHg
- Pneumonia Vaccination (Ever Received)
- Ambulatory Sensitive Condition Admissions: Congestive Heart Failure
- Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use - Adult
- Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) – Adult
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

*Process to select measures.* Given the importance of these measures, a stepwise process is recommended to select a subset that will be used to help guide the work of UCCs, and as the basis for a performance portion of medical home payments.

- Leadership from the three provider networks recommends a consensus subset. It is essential for medical home clinicians to help prioritize the subset since their payment is partly tied to service area results. This first step allows the primary care community to coalesce around a subset of measures, which are selected from an overall set that represents state level reform priorities (statewide consensus process).
- The consensus subset, recommended by the three provider networks, should be vetted thru key committees to assure that a balanced subset is selected (meaningful, practical, and usable). Committees to be considered include: VHCIP - Quality & Performance Measurement Workgroup, Payment Models Workgroup, Core Committee; BP - Executive Committee, Planning & Evaluation Committee.

Attributes that should be considered when selecting the subset include:

- Will improvement in these measures contribute in a meaningful way to the goals of Vermont's health reforms (e.g. quality, health, affordability)
- Is there a real opportunity for service areas to improve the results of these measures with better quality and coordination (UCC work, medical homes)?
- Is sufficient data currently available so that these measures can be measured in all service areas?
- Can measure results be generated and routinely reported, in a usable format, for use by UCC participants?
- Are regional and national benchmarks available for these measures?

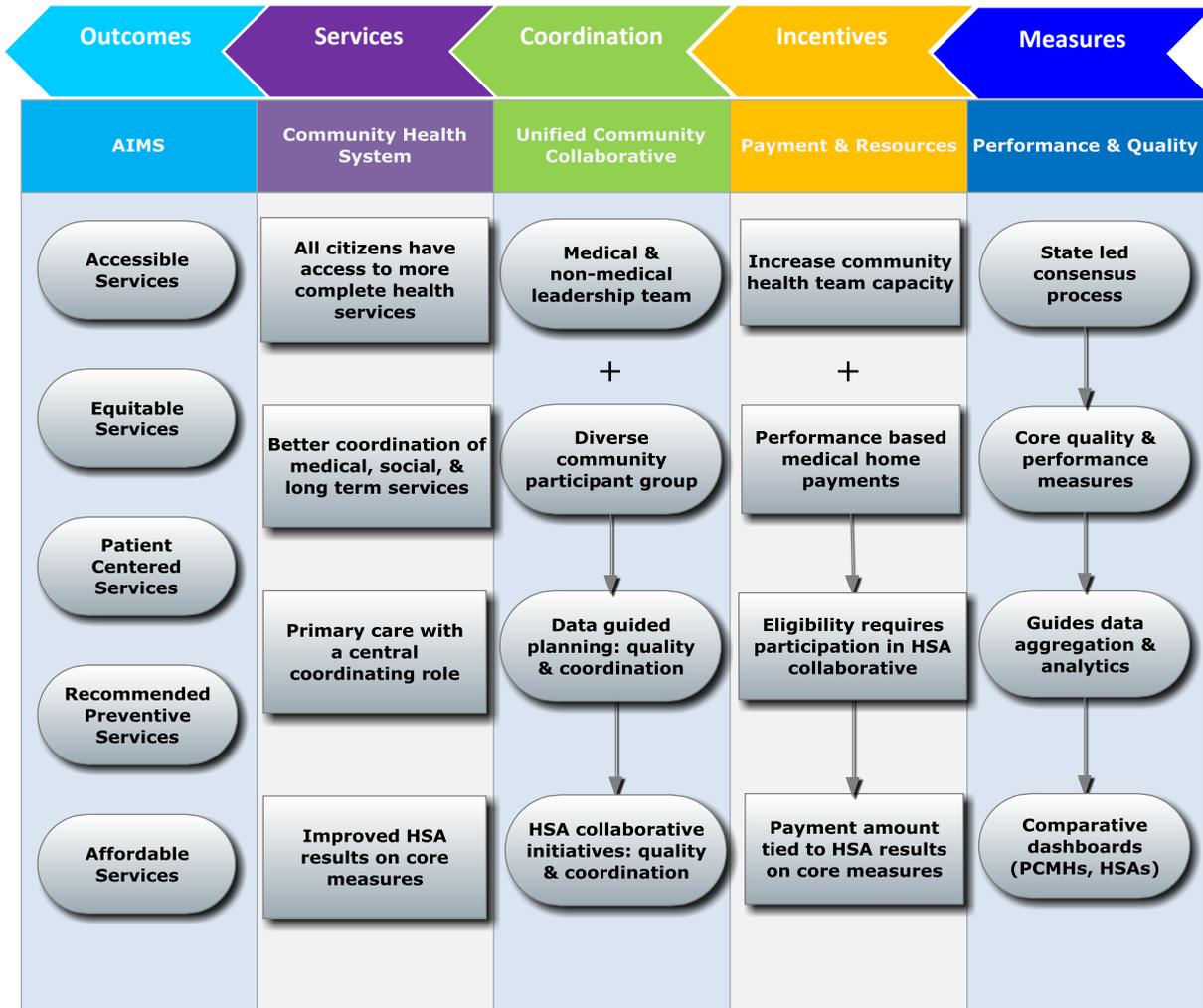
*Linking Healthcare & Population Health.* The most substantial improvement in results for these core performance and quality measures is likely to be achieved by addressing the medical, social,

economic, and behavioral components that converge to drive poor health outcomes. Although the core measures are oriented to the healthcare sector, the program and payment strategies outlined in this plan stimulate interdependency and coordination of a broader nature. The makeup of the collaborative leadership team, decision making process, and link between medical home payment and service area outcomes are all designed to assure that citizens have access to more cohesive and complete services. Collectively, the plan is a first step in using comparative measurement as a driver for a broader community health system. However, an important next step would be to incorporate measures that reflect non-medical determinants as part of the framework to guide community health system activities. As part of this plan, it is recommended that the VHCIP Population Health workgroup work with provider network leadership and other stakeholders to identify a subset of core population health measures that can be reliably measured and used in concert with the current core quality and performance measures.

### **Strategic Framework for Community Health Systems**

This plan is intended to provide Vermont's citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services. Strategically, the plan starts with Vermont's consensus based core performance and quality measures, and positions these measures as drivers for local community level learning health systems. Medical home financial incentives are in part tied to service area results for these core measures and to their participation in local collaborative initiatives. The collaboratives are designed to lead initiatives which will improve quality and performance, including the results of core measures, thru better coordination. Ultimately, data guided community initiatives, involving medical and non-medical providers, will provide citizens with direct access to more complete and effective services. The use of core measures as proposed, with detailed information on local variation and outcomes, is a substantial step towards a performance oriented community health system. Results to date in Vermont suggest that medical homes working with community health teams, and other local providers, will lead to a measurable increase in recommended preventive services and a reduction in unnecessary and avoidable services. The strategic framework to achieve the desired aims is outlined below.

**Strategic Framework.**



**Decision Points.**

Successful implementation of this plan depends on several key actions and decision points. First, the plan depends on an increase in medical home and community health team payment levels. As part of his budget proposal to the Vermont state legislature, Governor Shumlin announced his intention to increase Medicaid’s portion of these payments starting January 1, 2016. His proposal calls for a doubling of current amounts which will support the new performance based payment model, an essential ingredient to maintain primary care participation and to stimulate community health system activity across Vermont. To be effective, these increases need to be multi-payer, involving all major insurers in Vermont.

Second is the selection of a subset of Vermont’s consensus measures that will be used to comprise the quality index portion of the payment model. These measures are important since they will help set priorities for community improvement and medical home payment. They must be consistently measurable across all service areas with sufficient historical data so that

benchmarks for payment and improvement can be set. Pragmatically, the data should be available in Vermont's central data sources so that additional local data collection is not necessary.

Third is the structure of the payment model. This includes the number of components that are included in the composite payment structure, the weight of each component, and the use of service area results to drive a portion of the payments. This proposal calls for three components with the following weights; Base (\$3.50 PPPM for all eligible practices), Quality (up to \$0.75 PPPM based on performance), and Utilization (up to \$0.75 PPPM based on performance). It also calls for the use of service area results to determine whether practices receive the performance portions of the payment. This represents an increase in the base payment for all participating medical home practices while introducing performance based components with an incentive to coordinate closely with other local providers.

This structure is based on extensive discussion and input with the three ACO provider networks, Blueprint committees and local program participants, Vermont's insurers, and with VHCIP committees. While there is not unanimous agreement, this structure provides a strong consensus based plan with incentives that are designed to elevate community health system coordination and learning health system activity to a new level.

**Appendix A. VHCIP Core Quality & Performance Measures**

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-1		Plan All-Cause Readmissions	NQF #1768, HEDIS measure	Adult	For members 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.
Core-2		Adolescent Well-Care Visit	HEDIS measure	Pediatric	The percentage of members 12-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)	NQF #0075, NCQA	Adult	The percentage of members 18-75 years who were discharged alive for acute myocardial infarction, coronary artery bypass grafting, or percutaneous coronary intervention in the year prior to the measurement year or who had a diagnosis of Ischemic Vascular Disease during the measurement year and one year prior, who had LDL-C screening.
Core-4		Follow-up after Hospitalization for Mental Illness, 7 Day	NQF #0576, HEDIS measure	Adult	The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Core-5		Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement	NQF #0004, HEDIS measure	Adult	(a) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment within 14 days. (b) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and had two additional services with a diagnosis of AOD within 30 days of the initiation visit.
Core-6		Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	NQF #0058, HEDIS measure	Adult	The percentage of adults 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic.
Core-7		Chlamydia Screening in Women	NQF #0033, HEDIS measure	Adult and Pediatric	The percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-8		Developmental Screening in the First Three Years of Life	NQF #1448	Pediatric	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF, AHRQ (Prevention Quality Indicator (PQI) #5)	Adult	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
Core-11	MSSP-20	Mammography / Breast Cancer Screening	NQF #0031, HEDIS measure	Adult	The percentage of women 50-74 years who had a mammogram to screen for breast cancer in the last two years.
Core-12		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite	NQF, AHRQ (Prevention Quality Indicator (PQI) Chronic Composite)	Adult	Prevention Quality Indicators' (PQI) overall composite per 100,000 population, ages 18 years and older; includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.
Core-13		Appropriate Testing for Children with Pharyngitis	NQF #0002	Pediatric	Percentage of children 2-18 years who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.
Core-14		Childhood Immunization Status (Combo 10)	NQF #0038, HEDIS measure	No	The percentage of children 2 years of age who had each of nine key vaccinations (e.g., MMR, HiB, HepB, etc.).

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-15		Pediatric Weight Assessment and Counseling	NQF #0024	No	The percentage of members 3-17 years who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
Core-16	MSSP-22,-23,-24,-25,-26	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	NQF #0729 (composite)	Adult	(a) MSSP-22: Percentage of patients 18-75 years with diabetes who had HbA1c <8% at most recent visit; (b) MSSP-23: Percentage of patients 18-75 years with diabetes who had LDL <100 mg/dL at most recent visit; (c) MSSP-24: Percentage of patients 18-75 years with diabetes who had blood pressure <140/90 at most recent visit; (d) MSSP-25: Percentage of patients 18-75 years with diabetes who were identified as a non-user of tobacco in measurement year; (e) MSSP-26: Percentage of patients 18-75 years with diabetes and IVF who used aspirin daily -- Aspirin use was not included as part of the profile composite.
Core-17	MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059, NCQA	Adult	Percentage of patients 18-75 years with diabetes whose HbA1c was in poor control >9%.
Core-18	MSSP-19	Colorectal Cancer Screening	NQF #0034, NCQA HEDIS measure	No	The percentage of members 50-75 years who had appropriate screening for colorectal cancer.
Core-19	MSSP-18	Depression Screening and Follow-Up	NQF #0418, CMS	No	Patients 12 years and older who had negative screening or positive screening for depression completed in the measurement year with an age-appropriate standardized tool. Follow-up for positive screening must be documented same day as screening.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-20	MSSP-16	Adult Weight Screening and Follow-Up	NQF #0421, CMS	No	Patients 18 years and older who had BMI calculated during the last visit in the measurement year or within the prior 6 months. In cases where the BMI is abnormal, a follow-up plan must be documented during the visit the BMI was calculated or within the prior 6 months.
Core-21		Access to Care Composite	NCQA	No	NCQA Survey - percentage of patients who could get appointments or answers to questions from providers when needed.
Core-22		Communication Composite	NCQA	No	NCQA Survey - percentage of patients who felt they received good communication from providers.
Core-23		Shared Decision-Making Composite	NCQA	No	NCQA Survey - percentage of patients whose provider helped them make decisions about prescription medications.
Core-24		Self-Management Support Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about specific health goals and barriers.
Core-25		Comprehensiveness Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about depression, stress, and other mental health issues.
Core-26		Office Staff Composite	NCQA	No	NCQA Survey - percentage of patients who found the clerks and receptionists at their provider's office to be helpful and courteous.
Core-27		Information Composite	NCQA	No	NCQA Survey - percentage of patients who received information from their provider about what to do if care was needed in the off hours and reminders between visits.
Core-28		Coordination of Care Composite	NCQA	No	NCQA Survey - percentage of patients whose providers followed-up about test results, seemed informed about specialty care, and talked at each visit about prescription medication.
Core-29		Specialist Composite	NCQA	No	NCQA Survey - percentage of patients who found it easy to get appointments with specialists and who found that their specialist seemed to know important information about their medical history.
VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-30		Cervical Cancer Screening	NQF #0032, HEDIS measure	Adult	The percentage of females 21-64 years who received one or more PAP tests to screen for cervical cancer in the measurement year or two years prior to the measurement year.

Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #0068, NCQA	No	Percentage of patients 18 years and older with IVD who had documentation of using aspirin or another antithrombotic during the measurement year.
Core-35	MSSP-14	Influenza Vaccination	NQF #0041, AMA-PCPI	Adult	Patients 6 months and older with an outpatient visit between October and March who received an influenza vaccine.
Core-36	MSSP-17	Tobacco Use Assessment and Cessation Intervention	NQF #0028, AMA-PCPI	No	Percentage of patients 18 years and older who had a negative tobacco screen or positive tobacco screen with cessation intervention in the two years prior to the measurement year.
Core-38	MSSP-32	Drug Therapy for Lowering LDL Cholesterol	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and an outpatient visit in the measurement year whose LDL-C <100 mg/dL or LDL-C ≥100 mg/dL and who received a prescription of a statin in the measurement year.
Core-38	MSSP-33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and a LVEF < 40% or diagnosis of CAD and diabetes who received a prescription of ACE/ARB medication in the measurement year.
Core-39	MSSP-28	Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg	NQF #0018, NCQA HEDIS measure	Adult	Percentage of patients 18-85 years with hypertension whose BP was in control <140/90 mmHg.
Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	Not NQF-endorsed; MSSP	No	Percentage of patients 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
<b>VT Measure ID</b>	<b>Medicare Shared Savings Program Measure ID</b>	<b>Measure Name</b>	<b>Nationally Recognized/ Endorsed</b>	<b>Included in HSA Profile?</b>	<b>Measure Description</b>
Core-47	MSSP-13	Falls: Screening for Fall Risk	NQF #0101	No	Percentage of patients 65 years and older who had any type of falls screening in the measurement year.
Core-48	MSSP-15	Pneumonia Vaccination (Ever Received)	NQF #0043	Adult	Patients 65 years and older who had documentation of ever receiving a pneumonia vaccine.
	MSSP-1	CG CAHPS: Getting Timely Care,	NQF #0005, AHRQ	No	CMS Survey - Getting Timely Care, Appointments, and Information

		Appointments, and Information			
	MSSP-2	CG CAHPS: How Well Your Doctors Communicate	NQF #0005, AHRQ	No	CMS Survey - How Well Your Doctors Communicate
	MSSP-3	CG CAHPS: Patients' Rating of Doctor	NQF #0005, AHRQ	No	CMS Survey - Patients' Rating of Doctor
	MSSP-4	CG CAHPS: Access to Specialists	NQF #0005, AHRQ	No	CMS Survey - Access to Specialists
	MSSP-5	CG CAHPS: Health Promotion and Education	NQF #0005, AHRQ	No	CMS Survey - Health Promotion and Education
	MSSP-6	CG CAHPS: Shared Decision Making	NQF #0005, AHRQ	No	CMS Survey - Shared Decision Making
	MSSP-7	CG CAHPS: Health Status / Functional Status	NQF #0006 , AHRQ	No	CMS Survey - Health Status/Functional Status
	MSSP-8	Risk-Standardized, All Condition Readmission	CMS, not submitted to NQF (adapted from NQF #1789)	No	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
	MSSP-10	Ambulatory Sensitive Condition Admissions: Congestive Heart Failure	NQF #0277, AHRQ (Prevention Quality Indicator (PQI) #8)	Adult	All discharges with an ICD-9-CM principal diagnosis code for CHF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with CHF. This is an observed rate of discharges per 1,000 members.
	MSSP-11	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS EHR Incentive Program Reporting	No	Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.
	MSSP-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #0554	No	Percentage of patients 65 years and older who were discharged from any inpatient facility in the measurement year and had an outpatient visit within 30 days of the discharge who had documentation in the outpatient medical record of reconciliation of discharge medications with current outpatient medications during a visit within 30 days of discharge.
	MSSP-31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #0083	No	Percentage of patients 18 years and older with a diagnosis of heart failure who also had LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	NQF #0055, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received an eye exam for diabetic retinal disease during the measurement year.
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF #0062, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received a nephropathy screening test during the measurement year.

# Attachment 4

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

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 25<sup>th</sup> percentile to the national 25<sup>th</sup> 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 75<sup>th</sup> 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 tests<sup>1</sup>, 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.

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