Payment Models Work Group Meeting Agenda 1-16-15

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

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Don George	Y – Approve minutes	Attachment 1: Meeting Minutes
2	1:10-1:25	Updates	Kara Suter	N	
3	1:25-2:15	Medicaid Yr 2 Gate and Ladder	Kara Suter and Alicia Cooper	Y- Approval of G&L proposal	Attachment 3a: Memo from QPM to PMWG Re Targets and Benchmarks Attachment 3b: Proposed Changes to Year 2 VMSSP Gate and Ladder
4	2:15-2:50	Blueprint for Health – P4P model	Craig Jones and Kara Suter	N	Attachment 4: TBD
5	2:50-2:55	Public Comment		N	
6	2:55-3:00	Next Steps and Action Items		N	Next Meeting: Monday, February 23, 2015 1:00 pm – 3:00 pm EXE - 4th Floor Conf Room, Pavilion Building 109 State Street, Montpelier

Attachment 1 - Payment Models Work Group Minutes 12-01-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Monday, December 1, 2014 2:00 PM – 4:30 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Notes	Next Steps
1	Kara Suter called the meeting to order at 2:01pm, announcing that Steve Rauh has resigned his co-chairship, and that Anya Rader-Wallack and Georgia Maheras are recruiting for a replacement. Joelle Judge called the roll. There was not a quorum to approve the minutes of the November meeting.	
2	Kara Suter presented attachment 2. Alicia Cooper summarized the comments received from members of both the PMWG and QPM workgroups regarding the Year 2 Medicaid SSP Gate & Ladder methodology. Discussion in the QPM workgroup on targets and benchmarks for Year 2 Payment measures will continue during their December 22nd meeting. After QPM makes recommendations about targets and benchmarks, a proposal regarding the Year 2 Medicaid SSP Gate & Ladder methodology will be shared with this workgroup, hopefully during the January 16th meeting. • Abe Berman had a question about the process. Kara and Alicia clarified that QPM will be focusing on Targets & Benchmarks, while PMWG will be focusing on the Gate & Ladder methodology to link performance on Payment measures to shared savings eligibility. Any recommendations developed by PMWG regarding the Medicaid Gate & Ladder methodology for Year 2 will then be considered by the Steering Committee and Core Team. Once at the Core Team level, any approved Yr 2 changes will be added to the Yr 2 VMSSP contract amendment and be incorporated into current methodology	
3	Richard Slusky commented that there were discussions with the ACOs and payers, and a recommendation was made that there be no change made in Yr 2 for the Gate & Ladder methodology for the commercial SSP. The gate is already higher for commercial than Medicaid at 55%, and they feel this is still appropriate – especially as there is no data available yet. • Julie Wasserman asked about the definition for meaningful improvement. Richard said they have not looked at this yet as it will not be an issue until 2016. • Kara Suter said that comments on this topic are still welcome. Comments may be submitted	

	through the close of business on Monday, December 8th..	
4	Kara Suter introduced Chris Tompkins and Cindy Thomas from Brandeis. Suggested reading through the memo on own as presentation today will not hit on all of the specifics the memo does. Chris Tompkins presented on attachment 4B, the following were comments or questions from the presentation and memo: • Heather Bushey asked what was in a PAC and if there was anything sent out to answer that. Will provide the HCi3 web link to workgroup to look through as each episode is different. Table C provides the PAC for each episode: http://www.hci3.org/content/ecrs-and-definitions • Richard Slusky asked about how to read slide 6. Chris Tompkins responded that variation increases from left to right. • Kara Suter clarified that pregnancy episode includes both vaginal delivery and delivery by C-section, along with prenatal services during pregnancy (while the vaginal delivery episode and the C-section episode include only the delivery event). • Richard Slusky asked if any cost for pregnancy included child, or just mother. Kara Suter did not believe a child was included in calculations. Chris Tompkins suggested there might be a child involved with total cost of a pregnancy. Michael Bailit said other states are starting to include the child, but this data does not appear to include the child. • Bard Hill asked if Richard Slusky felt the child should be included or not – Richard felt it made sense to include a child in the calculation of PAC • Cecelia Wu asked how hypertension is defined. It is a condition, triggered by a diagnosis, and all relevant services are included for a 12 month period. High variation in hypertension is often associated with other illnesses and health issues that come from this disease and patients are going to vary dramatically. Also important to note this data is not risk adjusted for severity. • Richard Slusky asked if a patient is diagnosed with hypertension but has a stroke, which one will the patient costs be associated to? Kara Suter responded that the cost would likely be under both episodes. Chris Tompkins further explained that it can be all rolled into hypertension if using the highest level of inclusion. • Susan Aranoff asked how to count chronic conditions, especially if it started before data was collected? A calendar year is used for EOC purposes. • Cindy Thomas asked why the scale is different from Commercial and Medicaid. Commercial	

	payments vary in cost, whereas Medicaid has a set cost – makes sense for a difference in scale. • Cindy Thomas asked about identifying absolute dollars – this would have to be pulled from the tableau files or is found in data book previously distributed.	
5	Kara Suter presented on attachment 5, and suggested the formation of an EOC sub-group to continue this work in more detail. The following were comments or questions on the presentation. • Chris Tompkins clarified that HCi3 data does have risk adjustment model in place if chosen • Richard Slusky commented that most interest will likely come from the providers, they will want to more fully understand the potential of this information and have detail for specific episodes. This sub-group will be led by staff to drill down on existing questions with sub-group members. Staff will start analytic work, with RFP to continue and expand on work done by sub-group. Much of the specific information on episodes is in the Tableau files that the staff has access to. • Bard Hill asked if Medicare will also be included in this advancement of work, as it might be beneficial to have the full spectrum of patients to analyze. Kara Suter replied that this level of detail is something that the sub-group will work on, and make recommendations on – possibly down to payer level. • Purpose of Episodes in going forward? Kara Suter responded that this will most likely inform peer to peer learning and care delivery transformation instead of a new payment model construct at this time. • Comments and recommendations to Amanda.ciecior@state.vt.us by December 15	
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7	January's meeting will approve previous two months of PMWG meeting minutes.	Next Meeting: Friday, January 16, 2015 DVHA Large Conference Rm 312 Hurricane Lane, Williston

VHCIP PM Work Group Participant List

Attendance: 12/1/2014

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

First Name	Last Name		Organization	Pymt Models
April	Allen		AHS - DCF	X
Susan	Aranoff	[signature]	AHS-DAIL	X
Carmone	Austin	✓	MVP Health Care	M
Ena	Backus		GMCB	X
Melissa	Bailey	Melissa Bailey	VT Care partners / VT care network	X
Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	X
Susan	Barrett		GMCB	X
Anna	Bassford		GMCB	A
Abe	Berman	phone	OneCare Vermont	X
Susan	Besio		SOV Consultant - Pacific Health Policy Group	X
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Heather	Bushey	✓ phone	Planned Parenthood of Northern New England	M
Gisele	Carbonneau		HealthFirst	A
Amanda	Ciecior	[signature]	AHS - DVHA	S
Lori	Collins		AHS - DVHA	X
Amy	Coonradt	Amy Coonradt	AHS - DVHA	X
Alicia	Cooper	Alicia Cooper	AHS - DVHA	S
Michael	Counter		Visiting Nurse Association & Hospice of VT & NH	X
Diane	Cummings	✓ ✓	AHS - Central Office	M
Michael	Curtis	✓	Washington County Mental Health Services Inc.	M
Danielle	Delong		AHS - DVHA	X

Mike	DelTrecco		Vermont Association of Hospital and Health Systems	M
Michael	Donofrio		GMCB	X
Kathleen	Fish		MVP Health Care	X
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn		AHS - DVHA	S
Catherine	Fulton		Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Andrew	Garland		MVP Health Care	X
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	C
Carrie	Germaine		AHS - DVHA	X
Jim	Giffin		AHS - Central Office	X
Al	Gobeille		GMCB	X
Bea	Grause		Vermont Association of Hospital and Health Systems	MA
Lynn	Guillett		Dartmouth Hitchcock	M
Mike	Hall		Champlain Valley Area Agency on Aging	M
Heidi	Hall		AHS - DMH	M
Janie	Hall		OneCare Vermont	A
Thomas	Hall		Consumer Representative	M
Bryan	Hallett		GMCB	X
Paul	Harrington		Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Carolynn	Hatin		AHS - Central Office - IFS	X
Erik	Hemmett		Vermont Chiropractic Association	X
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	M
Churchill	Hindes		OneCare Vermont	X
Con	Hogan		GMCB	X
Nancy	Hogue		AHS - DVHA	X

Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones		GMCB	MA
Joelle	Judge		UMASS	S
Kevin	Kelley		CHSLV	X
Melissa	Kelly		MVP Health Care	X
Sarah	King		Rutland Area Visiting Nurse Association & Hospice	M
Kelly	Lange		Blue Cross Blue Shield of Vermont	M
Georgia	Maheras		AOA	S
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	MA
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Sandy	McGuire	Phone	HowardCenter for Mental Health	M
Todd	Moore		OneCare Vermont	M
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten		GMCB	X
Tom	Pitts		Northern Counties Health Care	M
Luann	Poirer		AHS - DVHA	X
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Lila	Richardson	Phone	VLA/Health Care Advocate Project	M
Howard	Schapiro		University of Vermont Medical Group Practice	M
Ken	Schatz		AHS - DCF	X
Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Julia	Shaw		VLA/Health Care Advocate Project	M
Tom	Simpatico		AHS - DVHA	X
Ted	Sirotta		Northwestern Medical Center	M
Richard	Slusky		GMCB	S/M
Jeremy	Ste. Marie		Vermont Chiropractic Association	M
Kara	Suter		AHS - DVHA	S/M
Beth	Tanzman		AHS - DVHA - Blueprint	X

Anya	Wallack		SIM Core Team Chair	X
Marlys	Waller	[signature]	Vermont Council of Developmental and Mental Health Services	X
Julie	Wasserman	[signature]	AHS - Central Office	X
Spenser	Weppler	[signature]	GMCB	S
Kendall	West			X
Bradley	Wilhelm		AHS - DVHA	X
Sharon	Winn		Bi-State Primary Care	M
Cecelia	Wu	[signature]	AHS - DVHA	X
Erin	Zink		MVP Health Care	X
Marie	Zura		HowardCenter for Mental Health	MA
				91
James	Westrich	[signature]	AHS- DVHA	X
Sean	Skafelstad	✓	AHS	
Chris	Tompkins	✓	Brandeis	

VHCIP PM Work Group Member List

Roll Call: 12/1/2014

*Did not have a quorum = no vote

Member		Member Alternate		Minutes		
First Name	**Last Name**	**First Name**	**Last Name**			**Organization**
Carmone	Austin					MVP Health Care
Heather	Bushey ✓					Planned Parenthood of Northern New England
Diane	Cummings ✓					AHS - Central Office
Michael	Curtis					Washington County Mental Health Services Inc.
Mike	DelTrecco ✓	Bea	Grause			Vermont Association of Hospital and Health Systems
Catherine	Fulton ✓					Vermont Program for Quality in Health Care
Joyce	Gallimore ✓					CHAC
Lynn	Guillett					Dartmouth Hitchcock
Heidi	Hall					AHS - DMH
Mike	Hall					Champlain Valley Area Agency on Aging
Thomas	Hall					Consumer Representative
Paul	Harrington					Vermont Medical Society
Bard	Hill ✓					AHS - DAIL
Sarah	King					Rutland Area Visiting Nurse Association & Hospice
Kelly	Lange	James	Mauro			Blue Cross Blue Shield of Vermont
Sandy	McGuire ✓	Marie	Zura			HowardCenter for Mental Health

Todd	Moore					OneCare Vermont
Tom	Pitts					Northern Counties Health Care
Paul	Reiss					Accountable Care Coalition of the Green Mountains
Lila	Richardson √	Rachel	Seelig			VLA/Health Care Advocate Project
Howard	Schapiro √					University of Vermont Medical Group Practice
Julia	Shaw √					VLA/Health Care Advocate Project
Ted	Sirotta					Northwestern Medical Center
Richard	Slusky √	Pat	Jones √			GMCB
Jeremy	Ste. Marie	Jessica	Oski			Vermont Chiropractic Association
Kara	Suter √	Craig	Jones			AHS - DVHA
Sharon	Winn	Joyce	Gallimore			Bi-State Primary Care
	27		8			

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Attachment 3a - Memo from QPM to PMWG Re Targets and Benchmarks

MEMO

DATE: December 29, 2014
TO: VHCIP Payment Models Work Group
FROM: VHCIP Quality & Performance Measures Work Group
RE: Request for Input – Year 2 ACO Payment Measure Targets & Benchmarks

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In response to the Payment Models Work Group's request for input regarding the selection of benchmarks and the setting of performance targets for the Year 2 ACO Payment Measures used for the Commercial and Medicaid Shared Savings Programs, the Quality and Performance Measures Work Group members voted in favor (with 2 votes in opposition) of the following recommendations:

Year 2 Benchmarks:

- Use national HEDIS benchmarks for all measures for which they are available; use ACO-specific change-over-time improvement targets when national benchmarks are unavailable:

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

Year 2 Performance Targets

- Use the same methodology that was used in Year 1 for assigning points for performance, such that ACOs may earn a maximum of 3 points for each Payment measure:

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25th Percentile	1 Point	Statistically significant decline	0 Points
50th Percentile	2 Points	Statistically same	2 Points
75th Percentile	3 Points	Statistically significant improvement	3 Points

Attachment 3b - Proposed Changes to Year 2 VMSSP Gate and Ladder

Proposed Year 2 VMSSP Gate & Ladder Methodology

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

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

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

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

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

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

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

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

Example

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

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

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

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

Methodological Considerations

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

For each qualifying measure, the state or its designee would determine whether there was a significant improvement or decline between the performance year and the prior year by applying statistical significance tests[1], assessing how unlikely it is that the differences of a magnitude as those observed would be due to chance when the performance is actually the same. Using this methodology, we can be certain at a 95 percent confidence level that statistically significant changes in an ACO's quality measure performance for the performance year relative to the prior program year are not simply due to random variation in measured populations between years.

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

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

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