Payment Models Work Group Meeting Agenda 7-07-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday July 7, 2014 2:00 PM – 4:30 PM.
EXE – 4th Floor Conf Room, Pavilion, Montpelier
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	2:00 – 2:05	Welcome and Introductions Approve meeting minutes	Don George and Steve Rauh	Attachment 1: Meeting Minutes
2	2:05 – 2:10	Update on Other Work Groups	Georgia Maheras	
3	2:10 – 2:50	Review ACO SSP Quality Measure Recommended Changes for Year 2	Cathy Fulton, Co-Chair QPM work group	Attachment 3A: Process for Review and Modification Attachment 3B: Payment Measures Criteria Attachment 3C: Adopted Measure Selection Criteria Attachment 3D: Proposed Measure Overview and Benchmarks
4	2:50-3:00	Review of Payment Models Integration Goals	Richard Slusky	
5	3:00 – 4:15	Presentation: *Medical Homes, Community Health Teams and Networks* from Blueprint for Health	Craig Jones	Attachment 5A: Blueprint Presentation Attachment 5B: Questions to Consider
6	4:15 – 4:20	Update on EOC	Kara Suter	
7	4:20 – 4:25	Public Comment	Don George and Steve Rauh	
8	4:25 – 4:30	Next Steps and Action Items	Don George and Steve Rauh	Next Meeting: Monday, August 4, 2014 2PM–4:30PM

				312 Hurricane Lane, Large Conf Room, Williston

Attachment 1 - Payment Models Work Group Minutes 6-02-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting: Monday June 2, 2014, 2:00 PM – 4:30 PM, DVHA, 312 Hurricane Lane, Large Conference Room.

Attendees: Don George, Stephen Rauh, Co-Chairs; Georgia Maheras, AoA; Kara Suter, Amanda Ciecior, Cecelia Wu, Bradley Wilhelm, Kimberly McNeil, Connie Harrison, Nancy Hogue, Craig Jones, Erin Flynn, Alicia Cooper, Amy Coonradt, Carrie Germaine, DVHA; Michael Curtis, Washington County Mental Health Services; Paul Harrington, Vermont Medical Society; Heather Bushey, Planned Parenthood; Julie Wasserman, Carolynn Hatin, Diane Cummings, AHS; David Martini, DFR; Richard Slusky, Ena Backus, Pat Jones, Spenser Weppler, GMCB; Marlys Waller, VT Council of Dev. and MH Services; Jen Woodard, DAIL; Kelly Lange, BCBS; Abe Berman, OneCare; Brendan Hogan, Michael Bailit, Bailit Health Purchasing; Chris Thompkins, Brandies University; Lila Richardson, VT Legal Aid; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Don George called the meeting to order at 2:03 pm. Phone participants were asked to email their attendance to members of the Project Management team. Heather Bushey moved to approve the minutes and Kelly Lange seconded. The motion passed unanimously.	
2. Introduction of Speaker	Kara Suter introduced François de Brantes, Executive Director of the Health Care Incentives Improvement Institute (HCI3). François' biography was included in the materials packet (attachment 2). The team from Brandeis is working with HCI3 on VT specific data analytics.	
3. Presentation: Episodes of Care, Experience from the field.	*Lessons from the Growing Field (attachment 3):* • Most initiatives have upside risk only. What drives the collapse? Multi-payer initiatives: right of veto, tension between providers and payers on who's going to lose out. • Low Medicaid cost is a barrier for participation: it can have implications on employees and benefit design. Collective bargaining and provider-payer bargaining do not have to be linked. Example:	

Agenda Item	Discussion	Next Steps
	Arkansas is able to work with providers in that state to change the unit of analysis. If you move away from fee for service, you change it to something greater than the individual service (total care). • Best to first consider which functions you are trying to drive and then create incentives based on that. • Chris Tompkins made the following observations: o Regarding efficiency: getting lab data on the chronic patients is difficult. You create a teachable moment between physician and patient if they can get the lab test completed at the time of a visit. Need to identify gaps and root cause analysis and what you can do to close those gaps. o Discharge planning is developed before the day the patient is expected to be discharged. o Think about how to give frontline awareness in a way that is relevant to your staff so all persons are aware of and working toward a common goal, not just Executives. Other points noted: • Dealing with each organization separately makes it easier to handle downside risk, and provides for accountability. • The rate of healthcare expenditures needs to stay at or below the rate of inflationary measures. • There are areas where you can reduce costs without taking it from the providers, minimizing some inefficiency. • CEO must play a key role in implementing new goals; changing compensation, reporting systems, etc. • Individual organizations can reduce episodes if they are efficient in their work. • The Payment Models work group is meant to evaluate a framework to base incentives and coordinate efforts so there is one point of leadership. • Episodes are clinically meaningful, and we can target where we see specific opportunities in VT. • Driving market share is not going to create market pressure. • Each plan uses different ways to measure quality. Relying on clinical records is the best gauge. • Small marginal shifts in the health of a population can make a big difference in overall savings.. • Episodes are constructs that help the managers and line clinicians achieve the results. This can be considered a management tool.	
4. Update on Shared Savings Programs	Kara welcomed the following new staff: Cecelia Wu – Healthcare Project Director (ACO); Bradley Wilhelm – Senior Policy Advisor; Amanda Ciecior – Health Policy Analyst; Kimberly McNeil –Payment Reform Policy Intern.	

Agenda Item	Discussion	Next Steps
	Kara presented the VMSSP Update (attachment 4). Lila asked about descriptions of classifications used in the VMSSP presentation for BD Child and ABD Adult. Kara will clarify these descriptions in the future. Richard Slusky gave the following update on the Commercial SSP**:** Analytics contract is currently in negotiations and going well. They are collecting data from payers and ACOs on expenditures, targets, whether savings were earned and looking at performance scores. On Friday they submitted the State's scope of work to CMMI for approval. The target is for a July 1 contract start. Regarding delays in attribution numbers - payers were focused on enrollment verses assignment of patients to a PCP. 20% of total enrollees only can be attributed. Blue Cross and OneCare have achieved the attribution threshold. VCP and CHAC don't have sufficient numbers yet, but given total number of enrollees that may change and they have until June 30th to update. Minimum number of covered lives is 5,000 with one ACO or 3,000 each with two ACOs. Richard is still optimistic we will meet those numbers.	
5. Update on Other Work Groups	Georgia Maheras gave the following updates: • Work groups will begin using a different phone system by the next meeting. • Core Team is looking at the provider grant program and will be opening for another round of applications in late July. Several work groups are making suggestions for improvements or changes. • Population Health and DLTSS work groups made recommendations for the year two ACO SSP measures. • QPM work group is reviewing all measures and will present to Payment Models at the end of summer. • Workforce work group is focused on proposal recommendations to the Governor and demand side modeling. • CMCM work group is looking at care management standards and will present to Payment Models later this summer. • HIE work group focused on telehealth criteria for RFPs and the Health Information Strategic Plan and how it relates to their work. • Steering Committee is canceled this month and will meet in July and August for substantial review of work group recommendations.	**Participants should contact Georgia if they are interested in working on this topic.**

Agenda Item	Discussion	Next Steps

6. Review of Criteria and Draft Survey	Kara reviewed attachments 6a *Criteria for Evaluating Episodes of Care* Data and 6b, the draft clinician survey:
	
	• Paul Harrington recommended adding the words "Provider Interest" to the first column.
	• **Next steps:**
	  o Chrissy will send an email to participants containing a word version of attachment 6b and solicit feedback. Feedback is due Monday June 9th.
	  o Development of an RFI and/or focus groups to gather in depth information to discuss how the payment model might be set up.
	  o Kara will follow up with key personnel and provider leadership so providers can expect to receive the survey.	

5. Public Comment	No further public comments were offered.	
6. Next Steps and Action Items	**Next Meeting:** Monday July 7, 2014 2:00 PM – 4:30 PM, EXE- 4th Fl Executive Conference Room, Montpelier. Review of some data at the July meeting though it may get pushed to August. The agenda for the July meeting would then include presentations from other work groups and more information on the Shared Savings Programs.	

Attachment 3A: Process for Review and Modification

VHCIP Quality and Performance Measures Work Group
Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs
Work Group Recommendation (Approved February 10, 2014)

Standard:

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national x^{th} percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the

support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

Attachment 3B: Payment Measures Criteria

VHCIP Quality and Performance Measures Work Group
ACO Shared Savings Program Year 2 Payment Measure Selection Criteria
As of July 2, 2014

Criterion	Description
Relevant benchmark available	The measure has been selected from NQF-endorsed measures that have relevant benchmarks whenever possible.
Selected from the commercial or Medicaid Core Measure Set	The measure can only be selected from the available commercial or Medicaid core measure sets.
Presents an opportunity for improvement	The measure offers opportunity for performance improvement to achieve high-quality, efficient health care.
Focused on outcomes	The measure assesses outcomes; i.e., improving this measure will translate into improvements in quality outcomes, and take cost into account if applicable.
Representative of the array of services provided and beneficiaries served	The overall measures set will be representative of the array of services provided, and of the diversity of patients served.
Focus on prevention and wellness by patient, physician and system*	Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
Focus upstream to include risk and protective factors*	The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

*** These final two criteria from the Population Health Work Group were adopted by the QPM Work Group at its June 2014 meeting.**

Attachment 3C: Adopted Measure Selection Criteria

VHCIP Quality and Performance Measures Work Group
Adopted Criteria for ACO Shared Savings Programs – Year 2 Overall Measure Selection
As of July 2, 2014

Criterion	Description
Valid and reliable	The measure will produce consistent (reliable) and credible (valid) results.
Representative of the array of services provided and beneficiaries served	The overall measures set will be representative of the array of services provided, and of the diversity of patients served.
Uninfluenced by differences in patient case mix	Providers serving more complex or ill patients will not be disadvantaged by comparative measurement. Measures will be either uninfluenced by differences in patient case mix or will be appropriately adjusted for such differences.
Not prone to random variation, i.e., sufficient denominator size	In order to ensure that the measure is not prone to the effects of random variation, the measure type will be considered so as to ensure a sufficient denominator in the context of the program.
Consistent with state's goals for improved health systems performance	The measure corresponds to a state objective for improved health systems performance (e.g., presents an opportunity for improved quality and/or cost effectiveness).
Not administratively burdensome, i.e., feasible to collect	The measure can be implemented and data can be collected without undue administrative burden.
Aligned with other measure sets	The measure aligns with national and state measure sets and federal and state initiatives whenever possible.
Includes a mix of measure types	Includes process, outcome and patient experience (e.g., self-management, perceptions, PCMH CAHPS®) measures, including measures of care transitions and changes in a person's functional status.
Relevant benchmark available	The measure has been selected from NQF endorsed measures that have relevant benchmarks whenever possible.
Focused on outcomes	To extent feasible, the measure should focus on outcomes, i.e., improving this measure will translate into significant changes in outcomes relative to costs, with consideration for efficiency.
Limited in number	The overall measure set should be limited in number and include only those measures that are necessary to achieve the state's goals.
Population-based/focused	The overall measure set should be population-based so that it may be used not only for comparative purposes, but also to identify and prioritize state efforts. Recognizes population demographics; gives priority to aging population and other ages; considers geographic community and not just patient population; consistent with State Health Improvement Plan.

The following criteria from the Population Health Work Group were adopted by the QPM Work Group at its June 2014 meeting:

Focus on prevention and wellness by patient,	Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on

physician and system	identifying and treating disease and illness.
Focus upstream to include risk and protective factors	The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

Attachment 3D: Proposed Measure Overview and Benchmarks

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
June 20, 2014

Additional Measures Proposed for 2015 Reporting:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-8	Developmental Screening in the First Three Years of Life (*currently in Medicaid measure set; proposed for commercial measure set*)	NQF #1448; NCQA (not HEDIS); and CHIPRA	Yes		Medicaid can use claims data, but provider coding for commercial payers is not currently reliable, so the commercial measure could require data from clinical records.	CMS has analyzed data from five states (AL, IL, NC, OR, TN) that reported the measure for FFY12 consistently using prescribed specifications. CMS reports that 12 states reported in FFY13, and 18 intend to do so in FFY14. Best practice is in IL, which reported rates of 77%, 81%, 65% in Years 1-3; the five-state median was 33%, 40%, 28%.	• Vermont Legal Aid • Population Health WG • DLTSS Work Group
Core-30	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS)	Yes	Changes in HEDIS specifications for 2014: • Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.	For HEDIS purposes in 2014, both commercial and Medicaid plans could use the hybrid method which requires data from clinical records.	HEDIS benchmark available (for HEDIS 2015; no benchmark for 2014). Historical Performance HEDIS 2013 (PPO) • BCBSVT: 72%; CIGNA: 71%; MVP: 71% • National 90th percentile: 78%; **Regional 90th percentile: 82%** • National Average: 74%; Regional Average: 78%	• Population Health WG
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)			HEDIS rates are collected using the hybrid method, using claims data and clinical records.	Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO): • BCBSVT: 94%; CIGNA: 74%; MVP: 95% • National 90th percentile: 96%; **Regional 90th percentile: 96%** • National Average: 81%; Regional Average: 82% Postpartum Care Historical Performance (PPO): • BCBSVT: 83%; CIGNA: N/A; MVP: 84% • National 90th percentile: 86%; **Regional 90th percentile: 90%** • National Average: 70%; Regional Average: 70%	• Population Health WG
Core-35/ MSSP-14	Influenza Immunization	NQF #0041; MSSP	Yes		Requires clinical data or patient survey to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at	Medicare MSSP benchmarks available from CMS.	• Population Health WG • DTLSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
					public health events)		
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. This measure is in use in other states and HRSA and CDC publish benchmarks, so additional benchmarking feasible if there is interest in adoption.	• Population Health WG • DLTSS WG
Core 37	Transition Record Transmittal to Health Care Professional	NQF #0648/#2036 (paired measure – see below)	Yes		Clinical records	None identified	• DTLSS WG
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	Yes	Guideline change: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of hypertension: • Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. • Keep the BP treatment goal for patients 18–59 at <140/90 mm Hg. Changes in HEDIS Specifications for 2015: Proposed changes to HEDIS specifications in 2015 to align with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age-related BP thresholds. The total rate will be used for reporting and comparison across organizations.	Clinical records	HEDIS benchmark currently available, but with measure likely to change, there is a possibility that there won't be a benchmark for 2015. Historical Performance HEDIS 2013 (PPO) • BCBSVT: 61%; CIGNA PPO: 62%; MVP PPO: 67% • National 90th percentile: 65%; **Regional 90th percentile: 78%** • National Average: 57%; Regional Average: 63%	• Population Health WG • DLTSS WG
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP			Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. However, this measure is in use by other states so it may be possible to identify benchmarks.	• Population Health WG • DLTSS WG
Core-44	Percentage of Patients with Self-	Not NQF-endorsed	No. Need to develop measure		Clinical records	This measure is used by some PCMH programs in other states. Benchmarks could be obtained from	• Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
	Management Plans		specs based on the NCQA standard, or borrow from a state that uses this measure.			those states.	• DLTSS WG (*see Core-44 ALT)*
Core-44 (ALT*)	Transition Record with Specified Elements Received by Discharged Patients	NQF #0647/#2036 (paired measure - see above)	Yes		Clinical records	None identified	• DTLSS WG
Core-45	Screening, Brief Intervention, and Referral to Treatment	Not NQF-endorsed	No, but a form of the measure is in use by Oregon Medicaid		Could potentially use claims or data from clinical records. If claims-based, could involve provider adoption of new codes.	None available, but a form of the measure is in by Oregon Medicaid, so benchmark rates could be available if the same measure was adopted.	• Population Health WG • DLTSS WG • Howard Center
New Measure	LTSS Rebalancing *(proposed for Medicaid measure set)*	Not NQF-endorsed	DAIL has proposed specifications		DAIL collects statewide and county data from claims; potential to collect at ACO level.	None available	• DLTSS WG
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management	Not NQF-endorsed	Questions have been developed; may require NCQA approval to add to PCMH CAHPS Survey		Could add to PCMH CAHPS Patient Experience Survey; might increase expense of survey.	None available	• DLTSS WG

Additional Measures Proposed for 2015 Payment:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-10 MSSP-9	Ambulatory Care-Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF# 0275; AHRQ PQI #05; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Not NQF-endorsed; AHRQ PQI #92; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA • DLTSS WG
Core-15	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1	Yes		Clinical	HEDIS benchmarks available from NCQA.	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		Vermont SSP Reporting Measure			records	This measure has three components: • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity BMI Percentile Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:63% • National 90th percentile: 65%; **Regional 90th percentile: 87%** National Average: 25%; Regional Average: 42% Counseling for Nutrition Historical Performance HEDIS 2012 (PPO) • CIGNA PPO: 73% • National 90th percentile: 69%; **Regional 90th percentile: 90%** National Average: 28%; Regional Average: 45% Counseling for Physical Activity Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:72% • National 90th percentile: 65%; **Regional 90th percentile: 86%** National Avg.: 26%; Regional Avg.: 42%	
Core-16 MSSP-22-26	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use	NQF #0729; MSSP; Year 1 Vermont SSP Reporting Measure	Yes. Measure steward (MCM) changed specs for 2014 and 2015.	Change to national LDL control guideline impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	• DLTSS WG
Core-17 MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) • BCBSVT: 41%	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						• National 90th percentile: 22%; **Regional 90th percentile: 18%** National Average: 28%; Regional Average: 34%	
Core-19 MSSP-18	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	Measure in use in some other states; we would have to review how implemented to see if benchmarks are available	• DLTSS WG
Core-20 MSSP-16	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	In use by HRSA so benchmark data may be available	• DLTSS WG
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP Monitoring and Evaluation Measure	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	• DLTSS WG

Attachment 5A -Blueprint Presentation

Medical Homes, Community Health Teams and Networks: An infrastructure for Preventive Health Services

Payment Implementation Workgroup

July 7, 2014

Vermont's Executive Branch and Legislature *Consistent Support for Health Reform*

2003 Blueprint launched as Governor's initiative

2005 Implementation of Chronic Care Model

2006 Blueprint codified as part of sweeping reform legislation (Act 191)

2007 Blueprint leadership and pilots established (Act 71)

2008 Community Health Team structure and insurer mandate (Act 204)

2010 Statewide Blueprint Expansion outlined (Act 128)

2011 Planning for "Single Payer" (Act 48)

Vermont Act No. 71 (2007) Page 7

The blueprint shall be developed and implemented to further the following principles:
(1) the primary care provider should serve a central role in the coordination of care and shall be compensated appropriately for this effort;
(2) use of information technology will be maximized;
(3) local service providers should be used and supported, whenever possible;
(4) transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to the blueprint model of health care delivery and payment;
(5) implementation of the blueprint in communities across the state should be accompanied by payment to providers sufficient to support care management activities consistent with the blueprint, recognizing that interim or temporary payment measures may be necessary during early and transitional phases of implementation; and
(6) interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior, the physical and social environment, and health care policies and systems.

Hospitals

Specialty Care & Disease Management Programs

Social, Economic, & Community Services

Mental Health & Substance Abuse Programs

Self Management Programs

Public Health Programs & Services

Advanced Primary Care

Advanced Primary Care

Advanced Primary Care

Advanced Primary Care

Community Health Team
Nurse Coordinator
Social Workers
Nutrition Specialists
Community Health Workers
Public Health Specialist

Extended Community Health Team
Medicaid Care Coordinators
SASH Teams
Spoke (MAT) Staff

Medical Homes & Community Health Teams
Operations based on NCQA PCMH Standards

Access During Office Hours	• Same day appointments • Timely clinical advice by phone • Timely clinical advice by electronic message
After Hours Access	• Access t routine & urgent care appointments • Continuity of medical record information for care & advice • Timely clinical advice by telephone
The Practice Team	• Roles for clinical & non-clinical team members • Regular team meetings & communication processes • Standing orders for services • Training & assigning teams to coordinate care
Evidence Based Guidelines	• The practice implements evidence based guidelines through point of care reminders for patients with 3 important conditions, plus high-risk or complex conditions. Third important condition related to unhealthy behaviors, mental health, or substance abuse.
Care Management	• Conducts pre-visit preparations • Collaborates with patient/family to develop an care plan including goals that are reviewed and updated • Gives patient/family a written plan of care • Assesses and addresses barriers when goals are not met • Gives patient/family a clinical summary • Identifies patients/families who might benefit from additional support • Follows up with patients/families who have not kept appointments

Medical Homes & Community Health Teams
Operations based on NCQA PCMH Standards

Medication Management	• Reviews & reconciles medications with patients/families • Provides information about new Rxs • Assesses patient response to medications & barriers to adherence
Support Self-Care Process	• Documents self-management abilities • Develops & documents self management plans & goals • Provides educational resources or refers to educational resources • Uses and HER to identify patient specific education resources
Test Tracking & Follow-up	• Tracks lab tests until results are available, flagging & following up overdue • Tracks imaging tests until results available, flagging & following up overdue • Flags abnormal lab results, bringing to attention of clinician • Flags abnormal imaging results, bringing to attention of clinician • Notifies patients/families of normal and abnormal lab and imaging results
Referral Tracking & Follow-up	• Giving consultant or specialist clinical reason & pertinent information • Tracking status of referrals, including timing for receiving report • Following up to obtain a specialists report
Continuous Quality Improvement	• Set goals & act to improve =>3 measures of clinical performance • Set goals and act to improve =>1 measure of patient/family experience
Continuity	• Expecting patients/families to select a personal clinician • Documenting patient/family choice of clinician • Monitoring % patient visits with selected clinician or team

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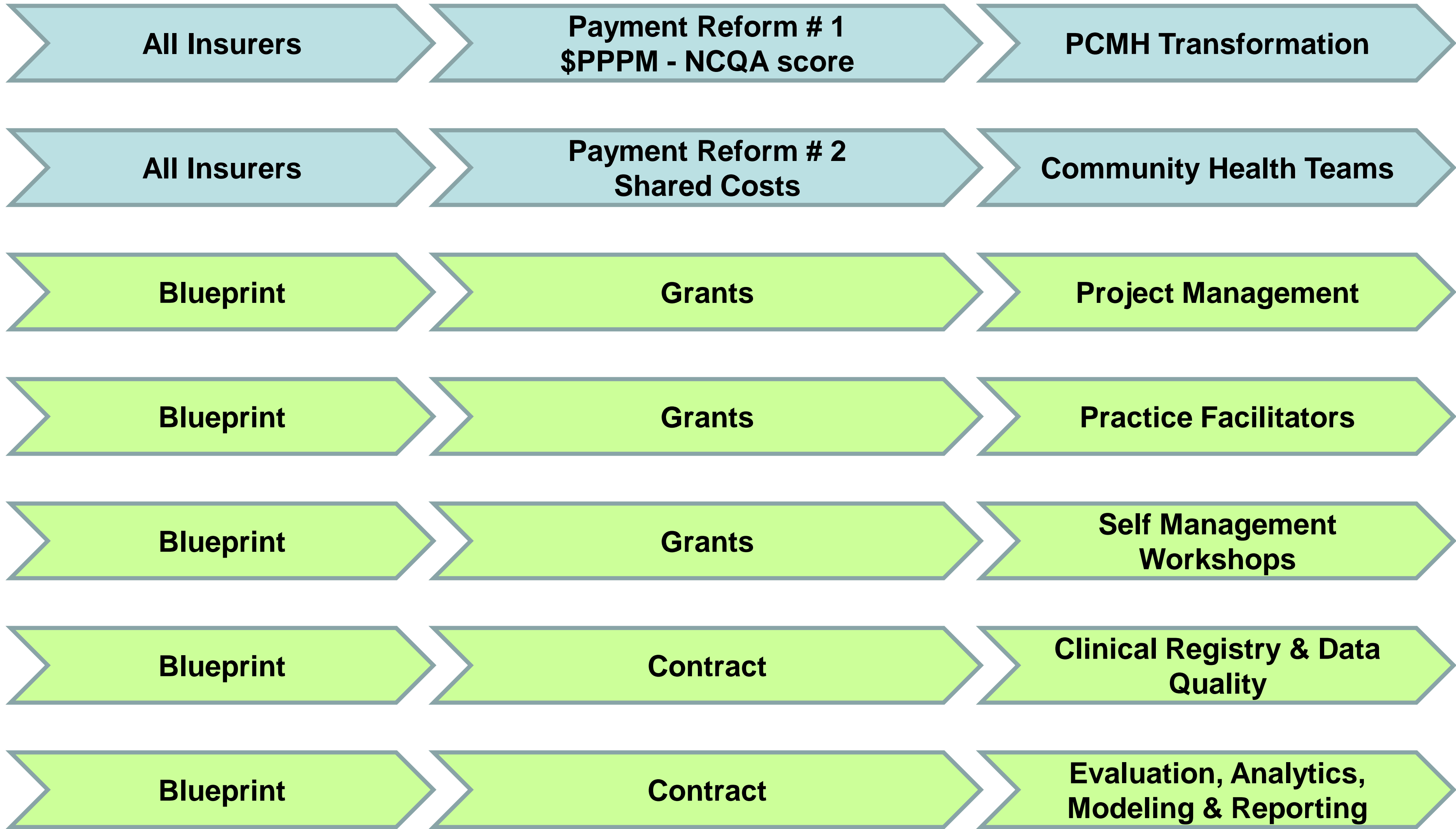

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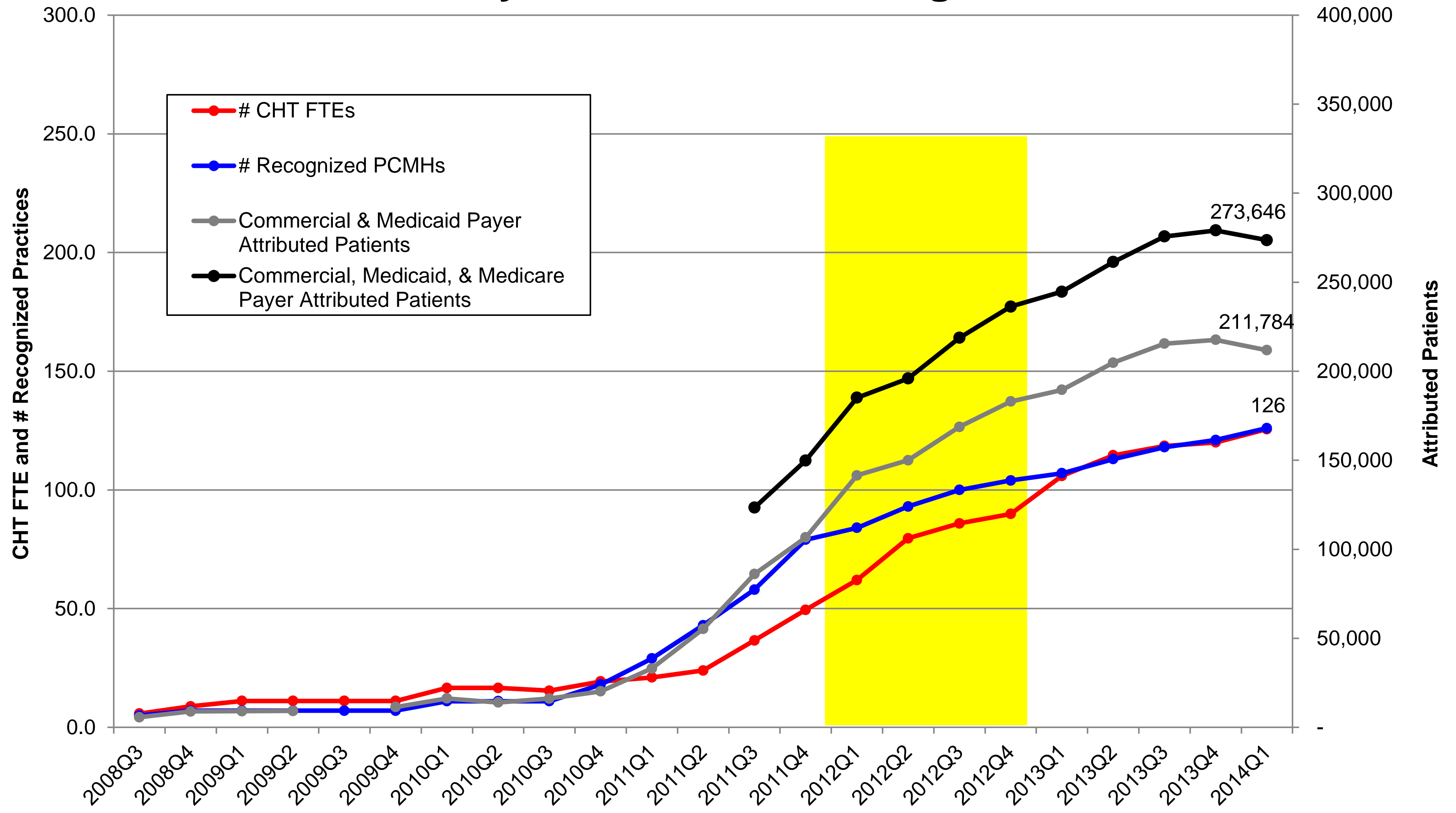
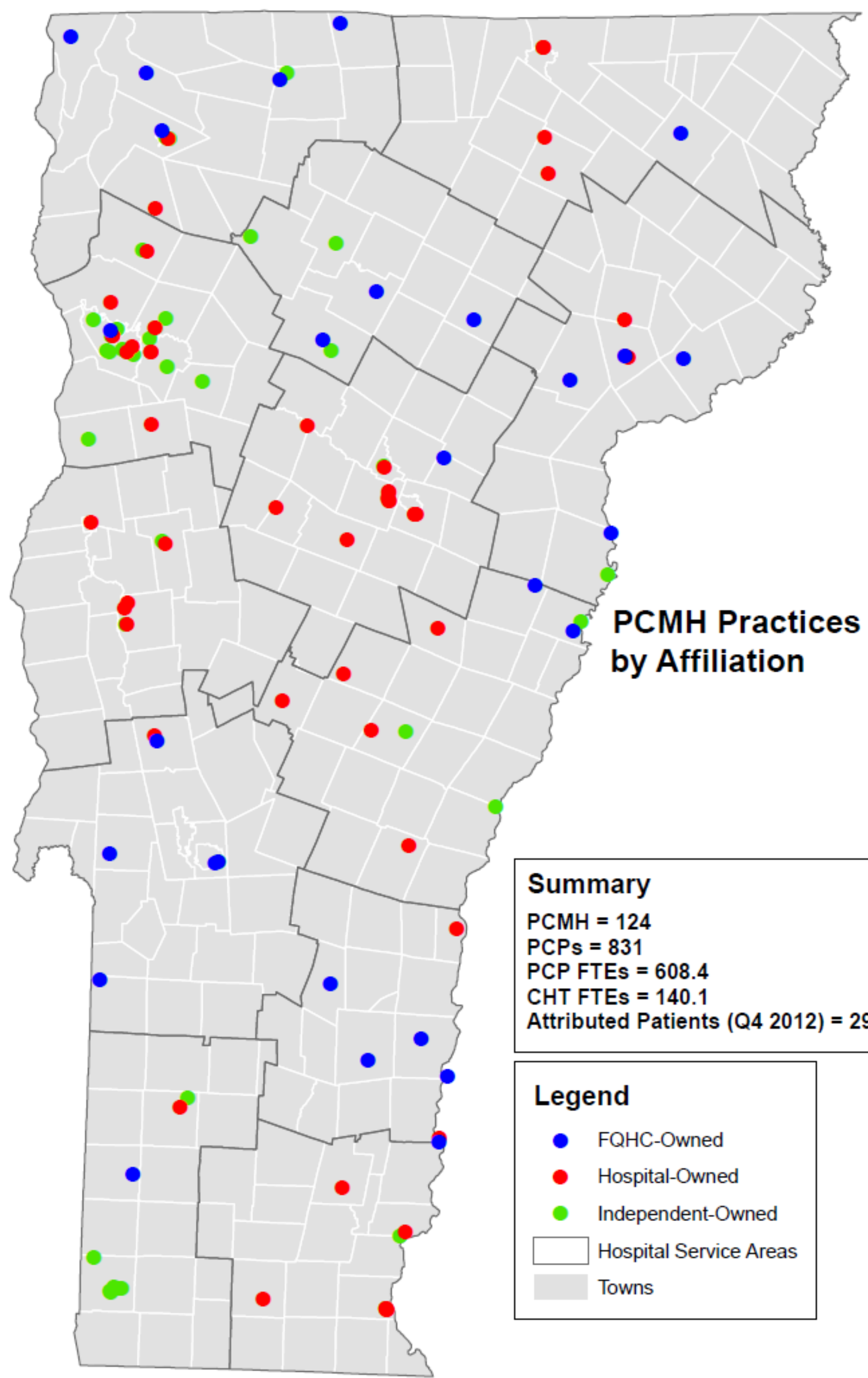
Patient Centered Medical Homes and Community Health Team Staffing in Vermont





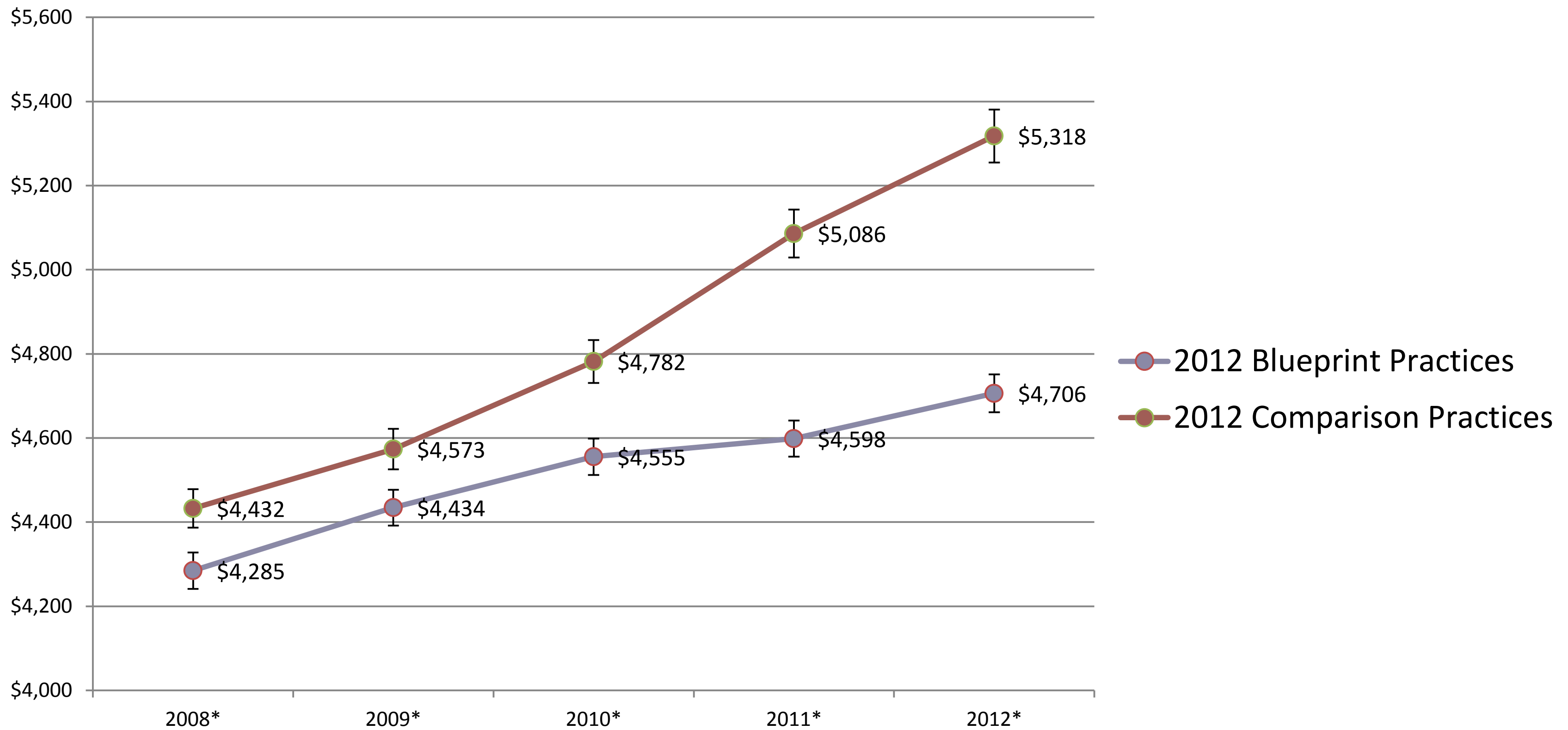
Summary

PCMH = 124
PCPs = 831
PCP FTEs = 608.4
CHT FTEs = 140.1
Attributed Patients (Q4 2012) = 293,862

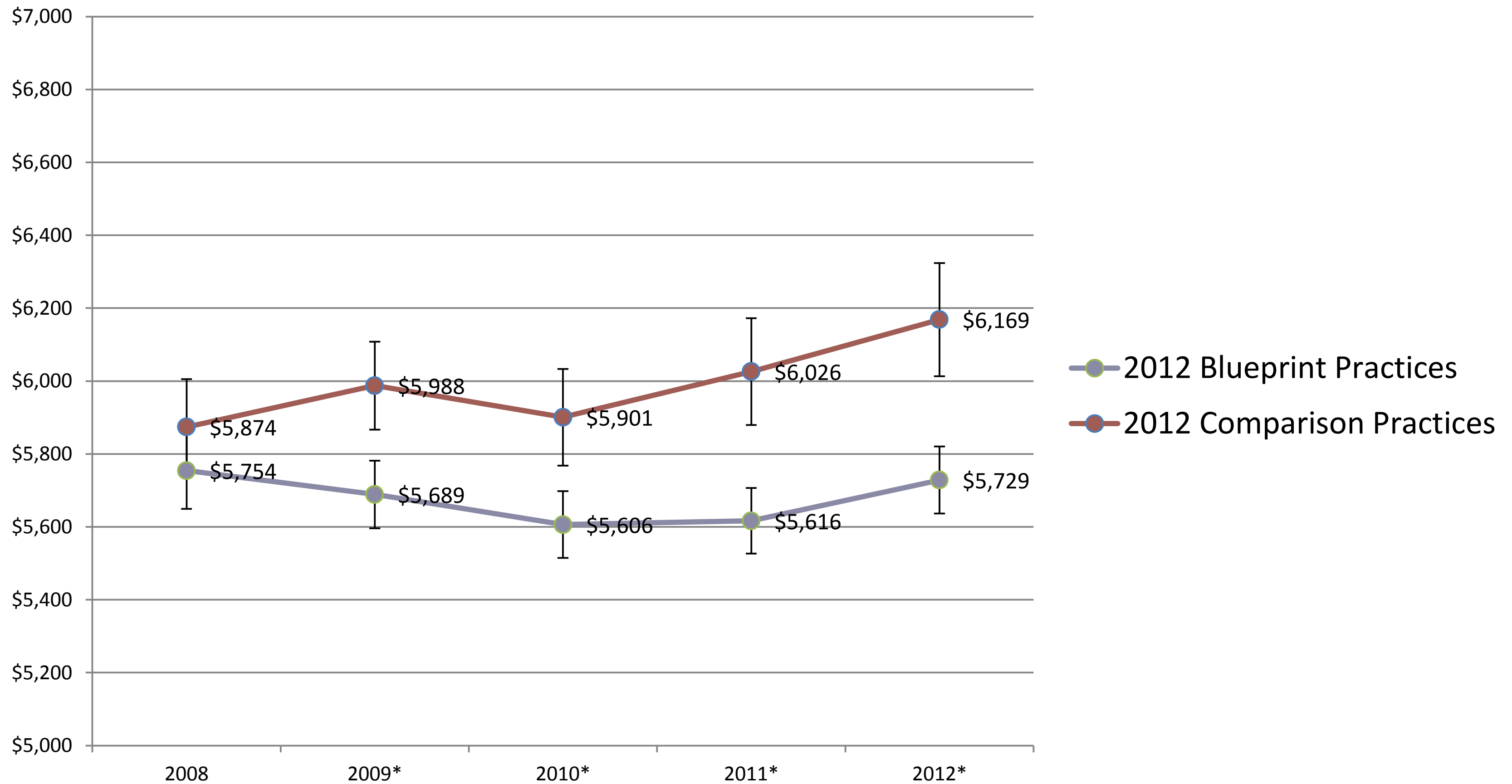
Study Groups by Age & Insurance Coverage

	Commercial (Ages 1-17 Years)		Commercial (Ages 18-64 Years)		Full Medicaid (Ages 1-17 Years)		Full Medicaid (Ages 18-64 Years)	
Demographic Measures	Blueprint 2012 Practices	Comparison 2012 Practices	Blueprint 2012 Practices	Comparison 2012 Practices	Blueprint 2012 Practices	Comparison 2012 Practices	Blueprint 2012 Practices	Comparison 2012 Practices
N								
2008	26417	32029	101919	105339	21714	19955	21417	17862
2009	29162	30675	117933	105811	24976	19515	27168	18993
2010	29260	27161	126593	95579	27562	18294	32313	18385
2011	29866	25082	135317	88880	29832	17189	35714	17321
2012	30632	22488	138994	83171	32812	15333	38281	16159

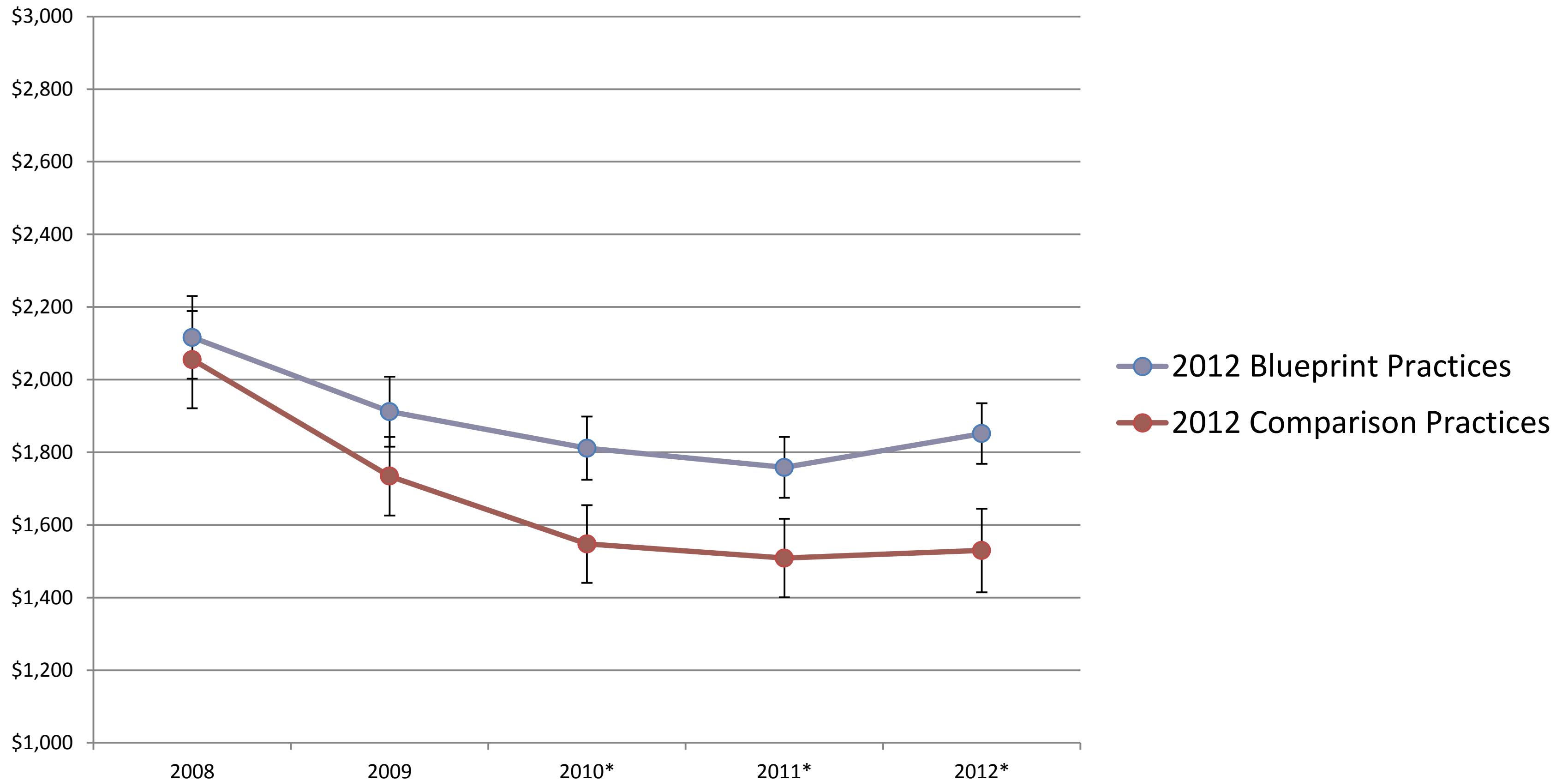
Total Expenditures Per Capita – Commercial Ages 18-64



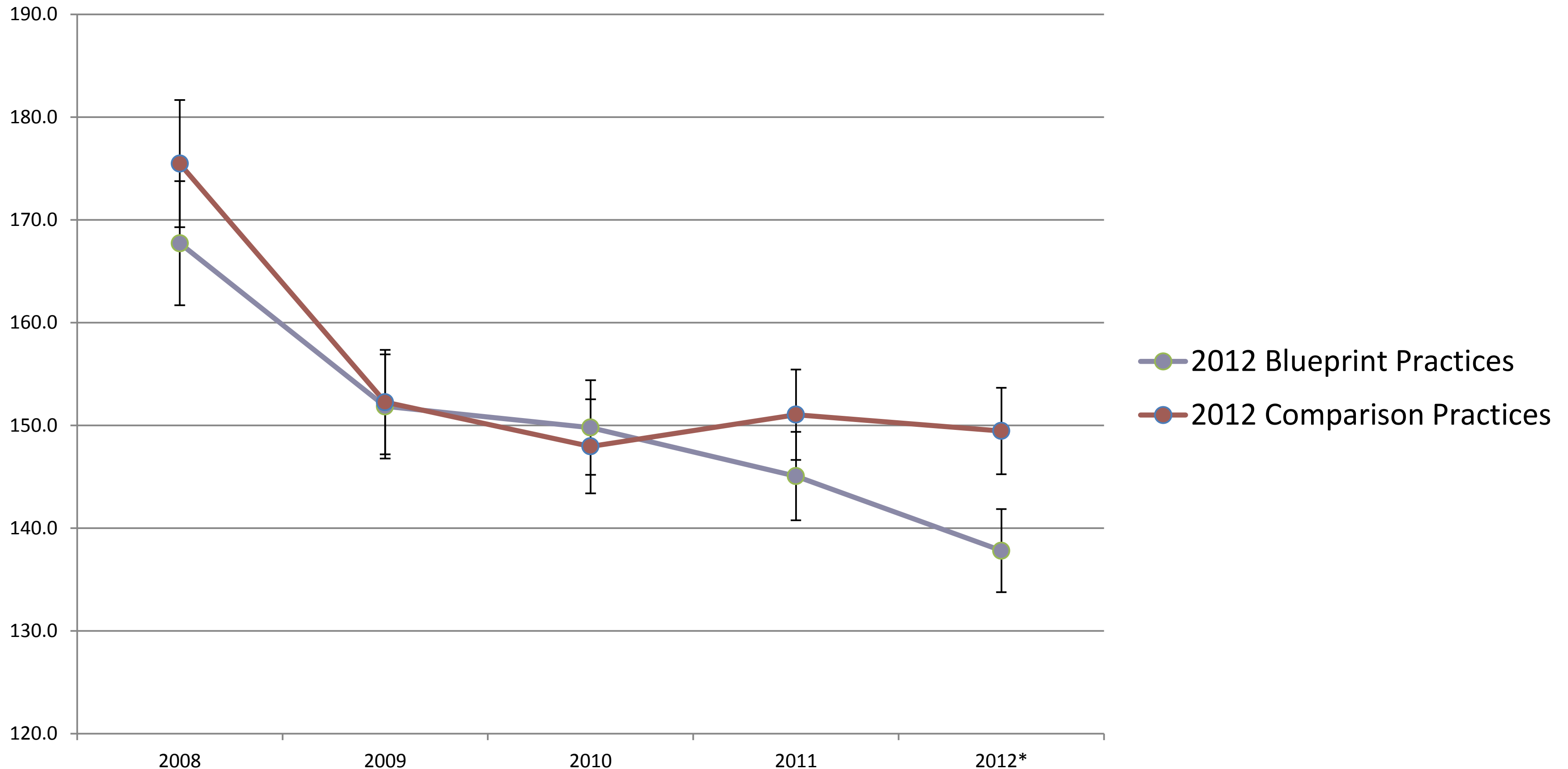
Total Expenditures Per Capita – Medicaid (minus SMS) Ages 18-64



Expenditures Per Capita on Special Medicaid Services Ages 18-64



Inpatient Discharges Per 1000 Medicaid Ages 18-64



Summary – Program Status in 2014

- Statewide model & transformation infrastructure
  - 124 PCMHs, 831 PCPs, 140 CHT Staff, 293,862 Patients
  - Organized based on NCQA Standards
  - Organized leadership network
  - Organized facilitator network
  - Organized self management network
  - Organized QI activities & learning forums

Summary – Foundation for newer reforms

- ACO partners lead the transformation infrastructure in each community:
  - Program Managers
  - Practice Facilitators
  - CHT leaders
  - Learning forums
  - Comparative evaluation

Summary – Foundation for newer reforms

- Work with ACO partners based on:
  - Target measures
  - Target populations
  - Target conditions
  - Common service models
  - Common care strategies & processes

Summary – Foundation for newer reforms

- Statewide infrastructure to support ACO & GMC implementation:
  - Identify targets (populations, utilization patterns, quality gaps)
  - Implement responsive services & care models
  - Use learning forums for dissemination of common strategies
  - Use facilitators to support implementation
  - Comparative data for ongoing improvement

Increasing PCMH & CHT Payments

Basis for Proposed Payment Model

- Current payments have stimulated substantial transformation
- Improved healthcare patterns, linkage to services, lower expenditures
- Reduced expenditures offset investments in PCMHs and CHTs
- Proposed payment modifications are needed to maintain participation
- Proposed payment modifications stimulate continued improvement
- PCMHs, CHTs, Networks - ingredients for a value based health system

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Increase PCMH & CHT Payments – No P4P

	ACTUAL 2012	PROJECTED 2013	2014	2015	2016
TOTAL COMMERCIAL AND MEDICAID PRACTICES	105	123	128	130	131
AVERAGE PATIENTS PER PRACTICE	1847	1853	1854	1857	1858
TOTAL COST- PRACTICE TRANSFORM (NCQA PAYMENTS) W OR W/O SMS:	$4,816,377	$5,661,037	$9,124,039	$12,567,214	$12,665,531
TOTAL COST- CAPACITY EXPANSION (CHT PAYMENTS) W OR W/O SMS:	$3,490,128	$4,102,200	$6,408,331	$8,693,023	$8,761,031
TOTAL COST- TUI P4P PROGRAMS	$0	$0	$0	$0	$0
TOTAL GAIN- ADULTS AND PEDIATRICS- WITH SMS	$74,126,608	$86,894,214	$90,440,771	$91,869,516	$92,578,828
TOTAL GAIN- ADULTS AND PEDIATRICS- WITHOUT SMS	$91,413,165	$107,256,739	$111,657,731	$113,487,941	$114,368,140
TOTAL PROGRAM COSTS (INVEST'S NCQA & CHT) W OR W/O SMS	$8,306,505	$9,763,237	$15,532,370	$21,260,237	$21,426,562
PAYBACK- GAIN AS A MULTIPLE OF COST- WITH SMS:	8.92	8.90	5.82	4.32	4.32
PAYBACK- GAIN AS A MULTIPLE OF COST- WITHOUT SMS:	11.01	10.99	7.19	5.34	5.34

Addition of Outcomes Based Payment (P4P)

Composite Payment Model

- Pay for *transformation* – based on NCQA PCMH score
- Pay for *capacity* – investment in CHT Staff
- Pay for *outcomes* - incentive to achieve goals (new component)
- *Composite PMPM = Transformation + Capacity + Outcomes*

Key Components of Payment Model

- Baselines are derived from existing data
- Impact estimates are conservative relative to existing trends
- Doubles $PPPM based on NCQA score (range $2.50 - $5.00 PPPM)
- Doubles $PPPM for CHTs (increase from $1.50 to $3.00 PPPM)
- Introduces P4P $PPPM based on TRUI (eligibility based on HEDIS)
    - Pay for current performance (Quartiles 1,2,3)
    - Pay for improvement (% change in TRUI since last measurement)

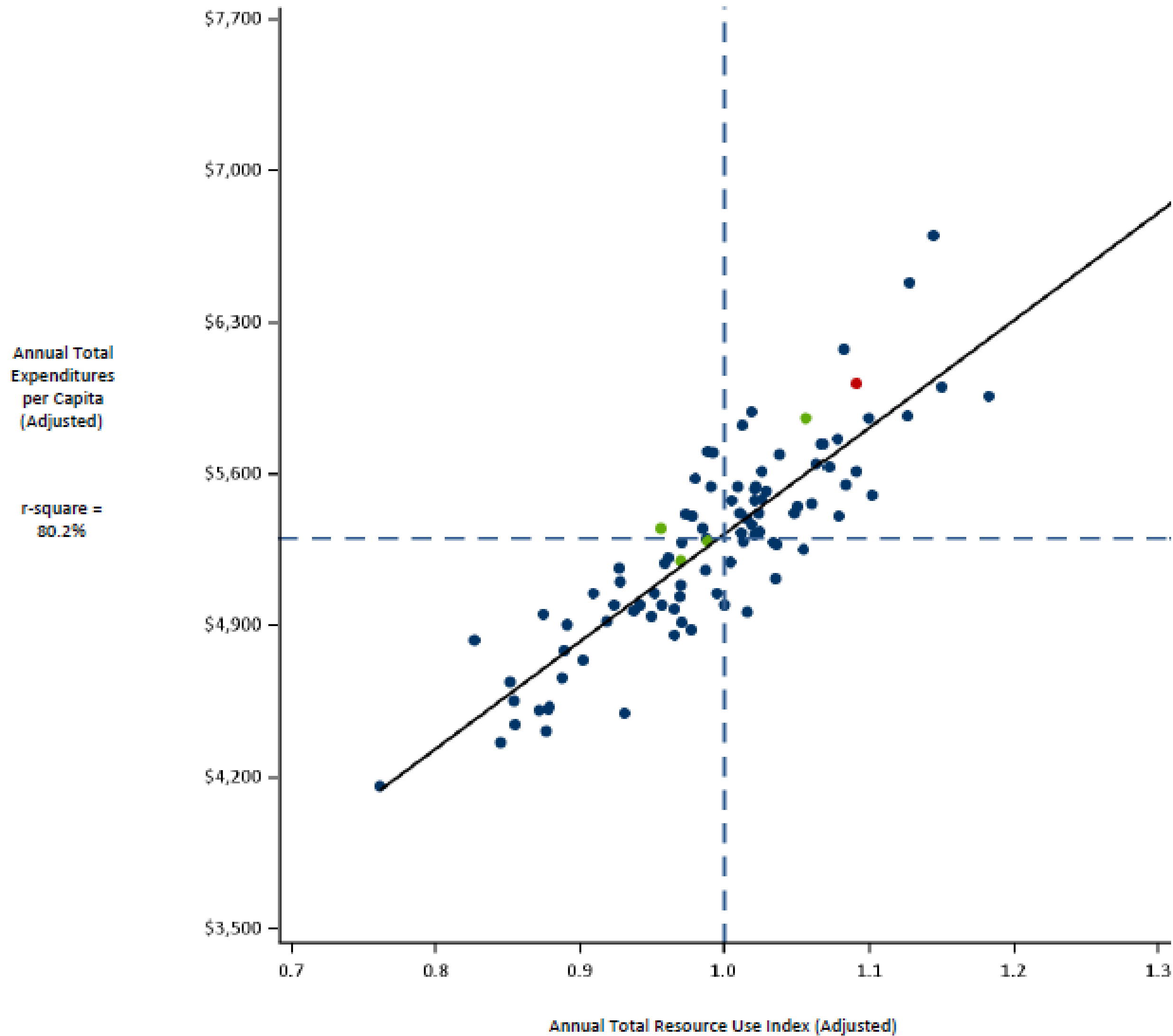
Quality Gateway – Year 1 Payment Measures (claims)

Commercial and Medicaid Shared Savings Programs:

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*

Medicaid Shared Savings Program:

- Developmental Screening in First 3 Years of Life


Annual Total Expenditures per Capita vs. Resource Use Index (RUI)
Annual Total Expenditures per Capita (Adjusted)
r-square = 80.2%
$7,700
$7,000
$6,300
$5,600
$4,900
$4,200
$3,500
0.7
0.8
0.9
1.0
1.1
1.2
1.3
Annual Total Resource Use Index (Adjusted)

Estimates for Models

Accomplishments to date

LOOKUP TABLE P4P COST- UTILIZATION		
TUI QUARTILE	PMPM	PMPY PAYMENT
1.00	$7.50	$90.00
2.00	$5.00	$60.00
3.00	$2.50	$30.00
4.00	$0.00	$0.00

Improvements since last measurement

LOOKUP TABLE P4P COST- CHANGE IN TUI		
CHANGE IN TUI INDEX	BONUS IN ADDITION TO PAYMENT/PATIENT	
	PMPM	PMPY
0.00	$0.00	$0.00
0.01	$1.00	$12.00
0.02	$1.50	$18.00
0.03	$2.00	$24.00
0.04	$2.50	$30.00
0.05	$3.00	$36.00
0.06	$3.50	$42.00
0.07	$4.00	$48.00
0.08	$4.50	$54.00
0.09	$5.00	$60.00
0.10	$5.50	$66.00

LOOKUP TABLE P4P GAIN- CHANGE IN TUI	
CHANGE IN TUI INDEX	ANNUAL GAIN PER PATIENT
0.00	$0
0.01	$49
0.02	$98
0.03	$147
0.04	$196
0.05	$245
0.06	$294
0.07	$343
0.08	$392
0.09	$441
0.10	$490

Increase PCMH & CHT Payments – Add TRUI Payment (P4P)

	ACTUAL		PROJECTED		
	2012	2013	2014	2015	2016
TOTAL COMMERCIAL AND MEDICAID PRACTICES	105	123	128	130	131
AVERAGE PATIENTS PER PRACTICE	1847	1853	1854	1857	1858
TOTAL COST- PRACTICE TRANSFORM (NCQA PAYMENTS) W OR W/O SMS:	$4,816,377	$5,661,037	$9,124,039	$12,567,214	$12,665,531
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TOTAL COST- TUI P4P PROGRAMS	$0	$0	$0	$14,488,372	$13,871,633
TOTAL GAIN- ADULTS AND PEDIATRICS- WITH SMS	$74,126,608	$86,894,214	$90,440,771	$91,869,516	$92,578,828
TOTAL GAIN- ADULTS AND PEDIATRICS- WITHOUT SMS	$91,413,165	$107,256,739	$111,657,731	$113,487,941	$114,368,140
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PAYBACK- GAIN AS A MULTIPLE OF COST- WITH SMS:	8.92	8.90	5.82	3.07	3.05
PAYBACK- GAIN AS A MULTIPLE OF COST- WITHOUT SMS:	11.01	10.99	7.19	3.67	3.66

Composite Payment Structure

Payment Type	Basis for Payment	Proposed Change
Transformation*		
PCMH	NCQA PCMH Score	Double $PPPM
Capacity		
CHT core	# PCMH Patients	Double $PPPM
Outcomes*		
Eligibility	HEDIS Quality Score (ACO measures)	Introduce
P4P	Total Utilization Index Score	Introduce

*Extension of Transformation & Outcomes payments to specialty practices establishes aligned model & shared interests

Questions & Discussion

Attachment 5B - Questions and Recommendations to Consider

1. Is the current work and proposed next steps for BP consistent with goals of ACO SSP programs? Why or why not?
2. Would the WG recommend that consideration of population based quality payments be deferred until the form of integration among ACOs, Blueprint and other reform initiatives is integrated and strategically defined?
3. Should efforts be focused on other areas besides moving from NCQA to outcomes based payments at this time? If yes, what should be those focus areas?
4. How will different approaches to quality payments impact different types of primary care practices like hospital-owned, versus FQHC, versus RHC, versus independent practicing? Should a P4P program be different for these providers?
5. Are there other priority providers or P4P opportunities that should be targeted either in addition to or in lieu of primary care focused program?
6. Does this approach indirectly support quality of the CHTs? Why or why not? How could an approach further strengthen CHTs?