Meeting #2

Date: August 17, 2015 2:30 PM

Location: School of Public Health, 1 University Place, Rensselaer NY

Attendees:

TD II Meeting 2 Attendance_8.17.201

Overview

This was the second meeting in a series of meetings for the Technical Design II Subcommittee (SC). The purpose of the meeting was to discuss the topics and draft recommendations (see agenda below), introduce new topics and raise any questions or concerns.

The specific agenda for this meeting included the following:

1. Welcome and Introductions
2. Deep Dive and Draft Recommendations:
    1. What activities/services should remain Fee-for-Service (FFS) and be considered VBP?
    2. How will technical assistance be provided to those providers that run into performance challenges in VBP arrangements?
3. Introduction to New Topics:
    1. Should certain services or providers be excluded from VBP?
    2. What should be the criteria and policies for the VBP Innovator Program?
4. Next Steps and Action Items

Key Discussion Points (Reference slide deck "Technical Design II Subcommittee Meeting #2")

1) Deep Dive #1: What activities/services should remain FFS and be considered VBP?

The co-chairs opened the discussion and identified the need to review this topic once again to bring more structure to the dialogue on which activities and services should remain FFS.

The Subcommittee (SC) reviewed the insights that had emerged during the first meeting. The goal of the discussion was to further define the recommendations (i.e. which services should be paid FFS in a VBP structure and how these services should be measured) and reach consensus on a proposed approach. The group was reminded that the recommendations must be well-defined in order for the Centers for Medicare & Medicaid Services (CMS) to approve them.

The SC walked through several examples highlighting how preventive care services are incentivized within different payment structures, and clarifying when preventive services might best be paid on a FFS basis potentially with a quality measure attached to it. It was largely agreed that preventive care service are already sufficiently incentivized in the primary care setting (through incentive payments, etc). Two service examples provided to the SC, the prescription of long-acting reversible contraception (LARC) and pre-exposure prophylaxis (PrEP), spurred conversations as to how they might best be included within certain bundles or subpopulations. For example, though it had been suggested that PrEP utilization could be tracked as a quality measure in the HIV/AIDS subpopulation, it was noted that the individuals for whom PrEP is recommended would not be classified as part of this group (i.e. HIV negative). There are significant challenges defining that subpopulation based on the data available. It was agreed that while PrEP is not the best example, preventive services such as LARC portray how they can be incentivized through including their quality measures in the bundles/subpopulations, when paid on FFS basis.

Another suggestion for FFS payment basis was high-cost medication and potentially highly expensive devices used in treatments. With a potential to be completely excluded from VBP, it was suggested to table this suggestion and discuss it again later in the meeting when the "Exclusions from VBP" topic was going to be addressed. Please see Section 3 below.

The discussion also focused on how these services should be measured, given that preventive services are diverse and require varied levels of effort on both the part of the member and provider. Several individuals pointed out that it will be crucial to track whether services are actually delivered versus offered, in order for these efforts to lead to improved population health outcomes. It was noted that outcomes of pediatric services should be tracked differently than those provided to adults, as it may take longer to measure impact. Several in the group stated that volume measures would be helpful, in order to promote public health initiatives for which a return on investment is not immediate. A suggestion was also made to support implementation of quality measurement, particularly given the varied use of electronic health record systems (EHRs) among providers and the work required to add tracking mechanisms to each respective system.

It was decided that a draft recommendation on this topic could be drafted based on the discussion and distributed to the SC. The members would then have an opportunity to review the content and provide written feedback.

2) Deep Dive #2: How will technical assistance be provided to those providers that run into performance challenges in VBP arrangements?

The SC was presented with slides detailing a draft recommendation on this topic, which was formed based on discussions in the first subcommittee meeting. The information presented included an overview of the technical assistance that providers will require prior to entering a VBP arrangement and following implementation. It was clarified that the Social Determinants of Health and CBOs Subcommittee will be concentrating on the communication and information-sharing needs associated with a transition to VBP, while the role of the Technical Design II Subcommittee is to think through the support needed after providers have entered into a value-based payment arrangement. The SC recommendation was that at this point no standard or guideline or specific State action required; MCOs, providers and the State will

collectively monitor whether action or additional guidelines may become necessary in the future. Providers experiencing performance challenges should receive assistance from their MCO, given the potential financial benefit to both parties and the framework that is already in place based on the contractual MCO/provider relationship.

Building off of this dialogue, a draft recommendation on technical assistance will be distributed to the SC for members to review and provide written feedback on the topic.

3) Introduction to New Topic #1: Should certain services or providers be excluded from VBP?

The goal of the conversation around exclusion was to think about creating a narrow, well-defined list of services and providers who should not be included in calculations of state-wide VBP participation. The SC deliberated on three specific topics: high-cost drugs, financially challenged providers, and out of network providers. As it relates to high-cost drugs, the group wished to narrow down the definition of high-cost, to better understand the threshold for when such costs would have a significant financial impact. The current impact of Sovaldi, a high cost prescription medication used to treat Hepatitis C, was an example that was mentioned. Several SC members did note that transplants and certain medical devices should also be considered in this high-cost service category. For financially challenged providers, the SC was reminded that this category of exclusion would likely only pertain to a very small number of providers and for a limited period of time: for example, if providers were going through bankruptcy or major restructuring. Several members of the SC requested that this category be further defined. The members agreed that out of network providers should include out of network emergency rooms, as those visits cannot be monitored.

As with the other topics discussed in Meeting #2, the Subcommittee will receive a draft recommendation and be asked to review and provide written feedback.

4) Introduction to New Topic #2: What should be the criteria and policies for the VBP Innovator Program?

The SC was asked to consider the design components of the Innovator Program, with focus on criteria for provider participation. There was only a very limited period of time available to delve into this topic, and SC members have been asked to provide any comments via email. A briefing paper with more information on the Innovator Program will also be distributed in advance of the next meeting for SC members to review. The design components of the Innovator Program will then be further discussed in Meeting #3.

Materials that have been distributed during the meeting:

#	Document	Description
1	Technical Design II Subcommittee Meeting #2  TD II Meeting 2_Presentation Slide	A presentation deck providing an overview of the following four topics: FFS as VBP, technical assistance for providers, VBP exclusions and the VBP Innovator program.

Key Decisions

Subcommittee members will receive several draft recommendations and a briefing paper on the VBP Innovator Program via email and be asked to provide written comments prior to the next meeting, which will be taking place at the MetLife Building in Manhattan at 1:00 pm on September 29, 2015. Consensus decisions will then be finalized during that session. Subcommittee members will be notified if any changes in meeting schedule or logistics occur.

Conclusion

In the next meeting the SC will review and finalize the recommendations made on the above topics, review the VBP Innovator Program in more depth, and be introduced to the following two new topics:

1. Should a special status be created for financially challenged providers?
2. What will be included in the planned assessment of the progress made in VBP participation and market dynamics?