

Homes, Teams, and Networks: A Foundation for Vermont's Health Reforms

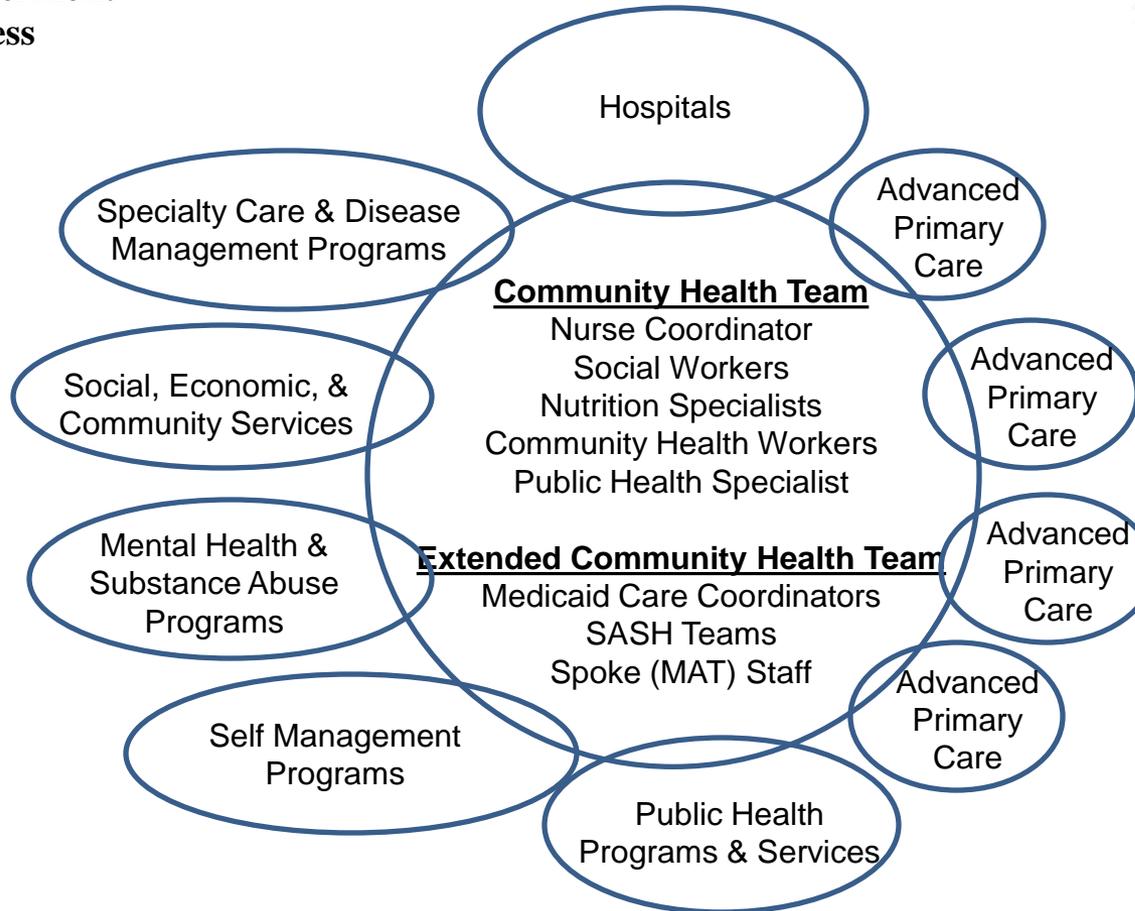
Blueprint Semi-Annual Meeting

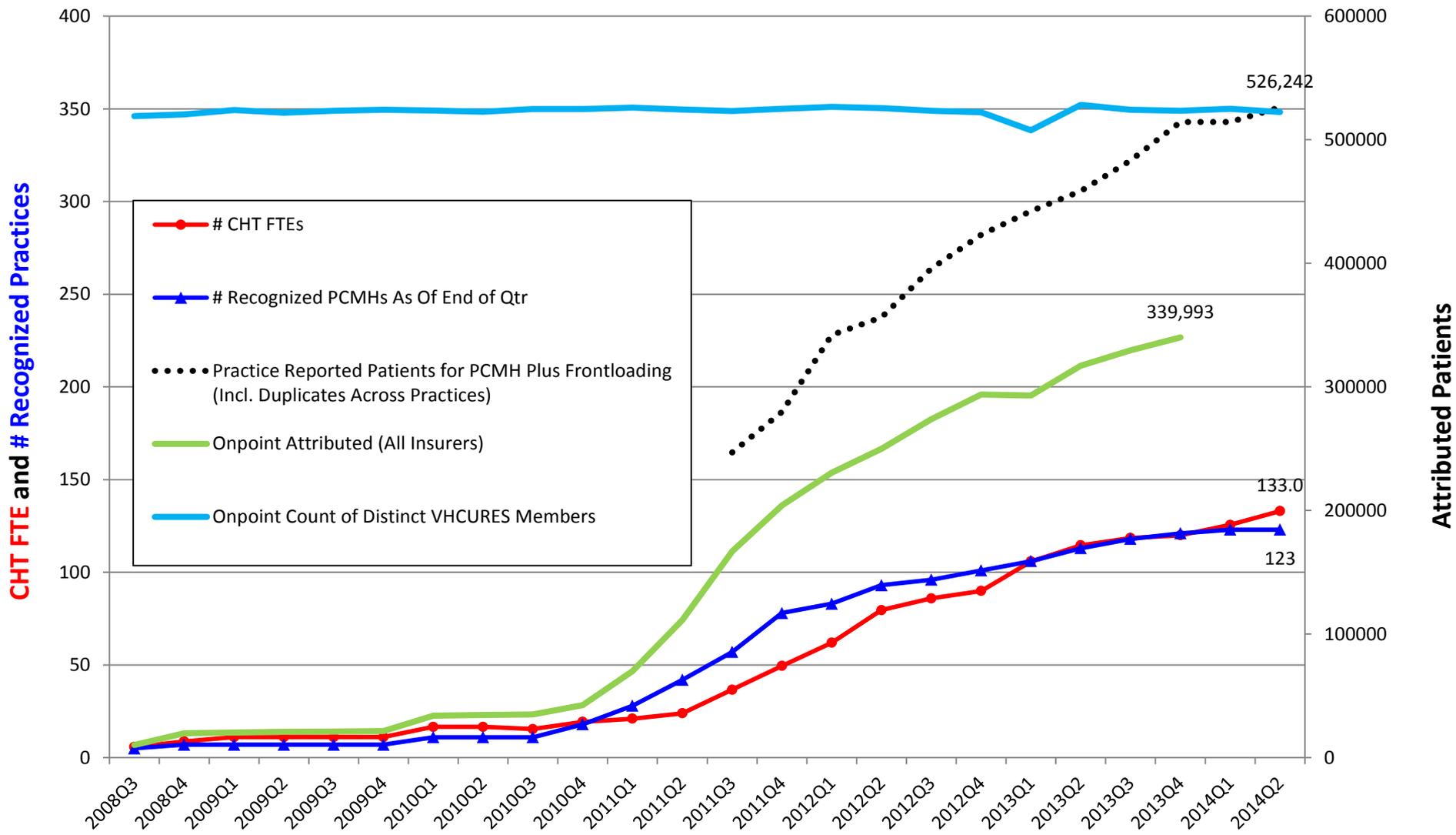
October 20, 2014

Agenda

1. Program Update
2. Unified Community Health Systems
3. Payment Modifications
4. Solicit input for strategies & implementation

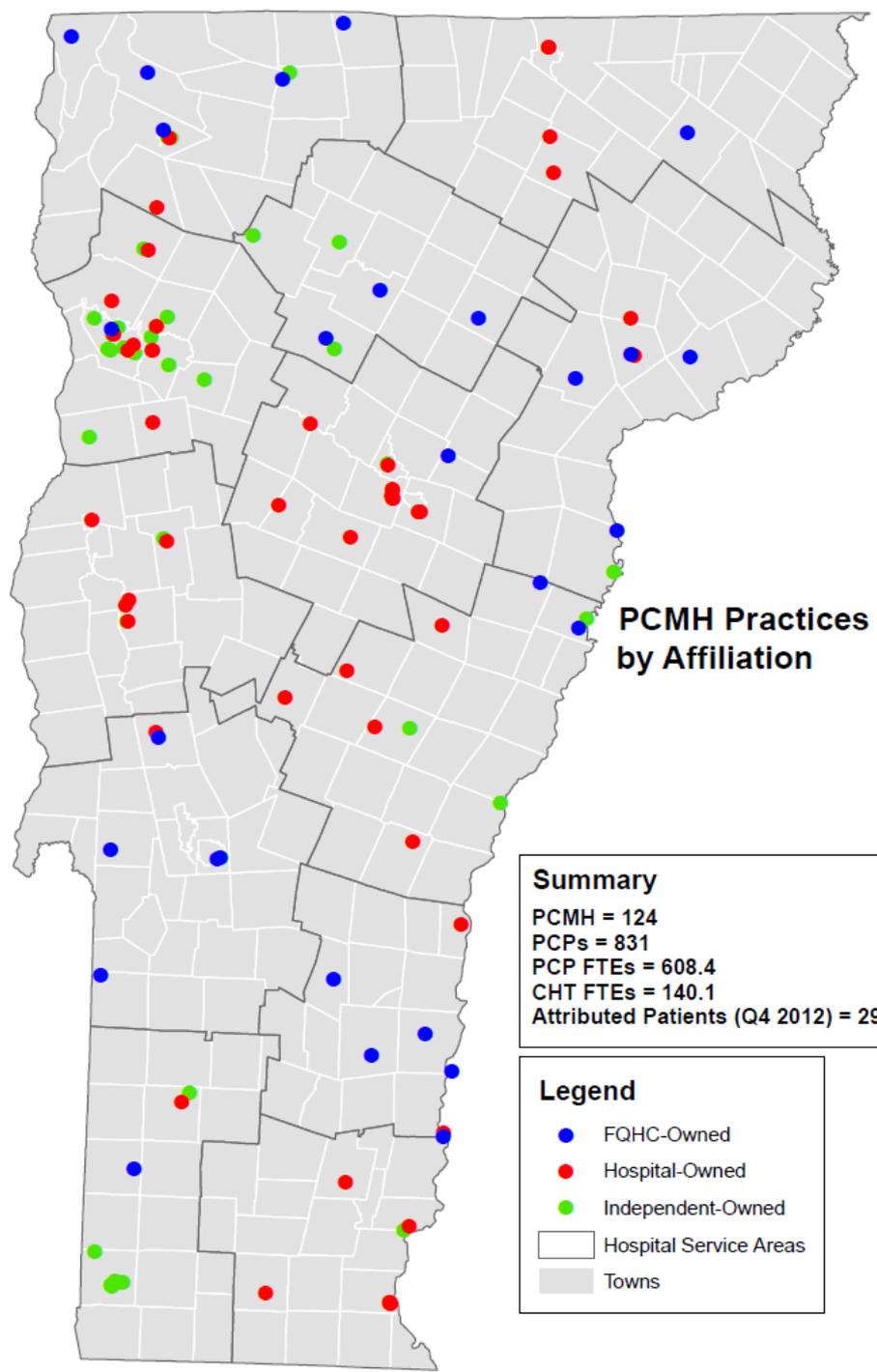
Program Update





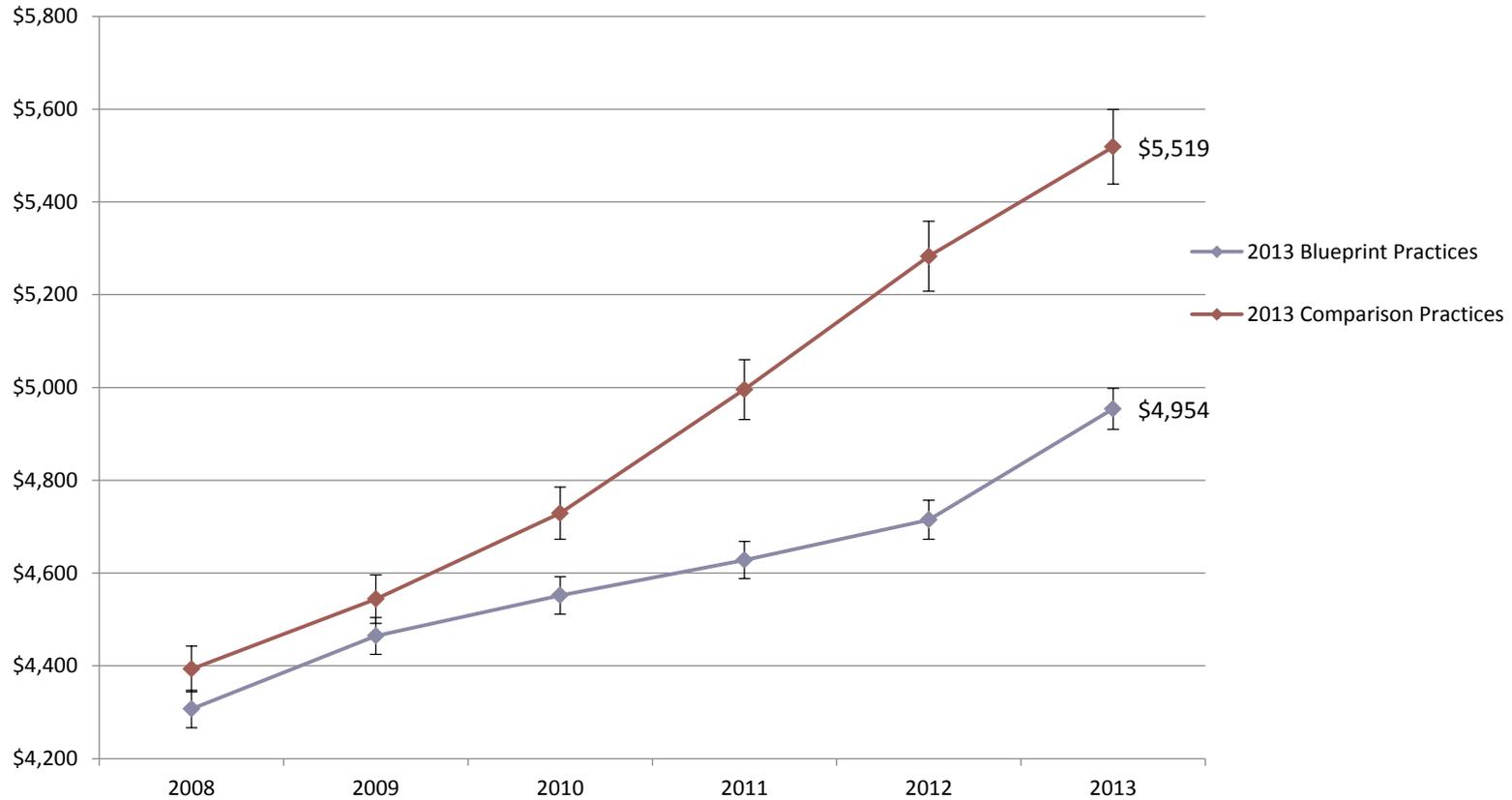
Health Services Network

Key Components	July, 2014
PCMHs (active PCMHs)	123
PCPs (unique providers)	644
Patients (Onpoint attribution) (12/2013)	347,489
CHT Staff (core)	218 staff (133 FTEs)
SASH Staff (extenders)	60 FTEs (48 panels)
Spoke Staff (extenders)	47 staff (30 FTEs)

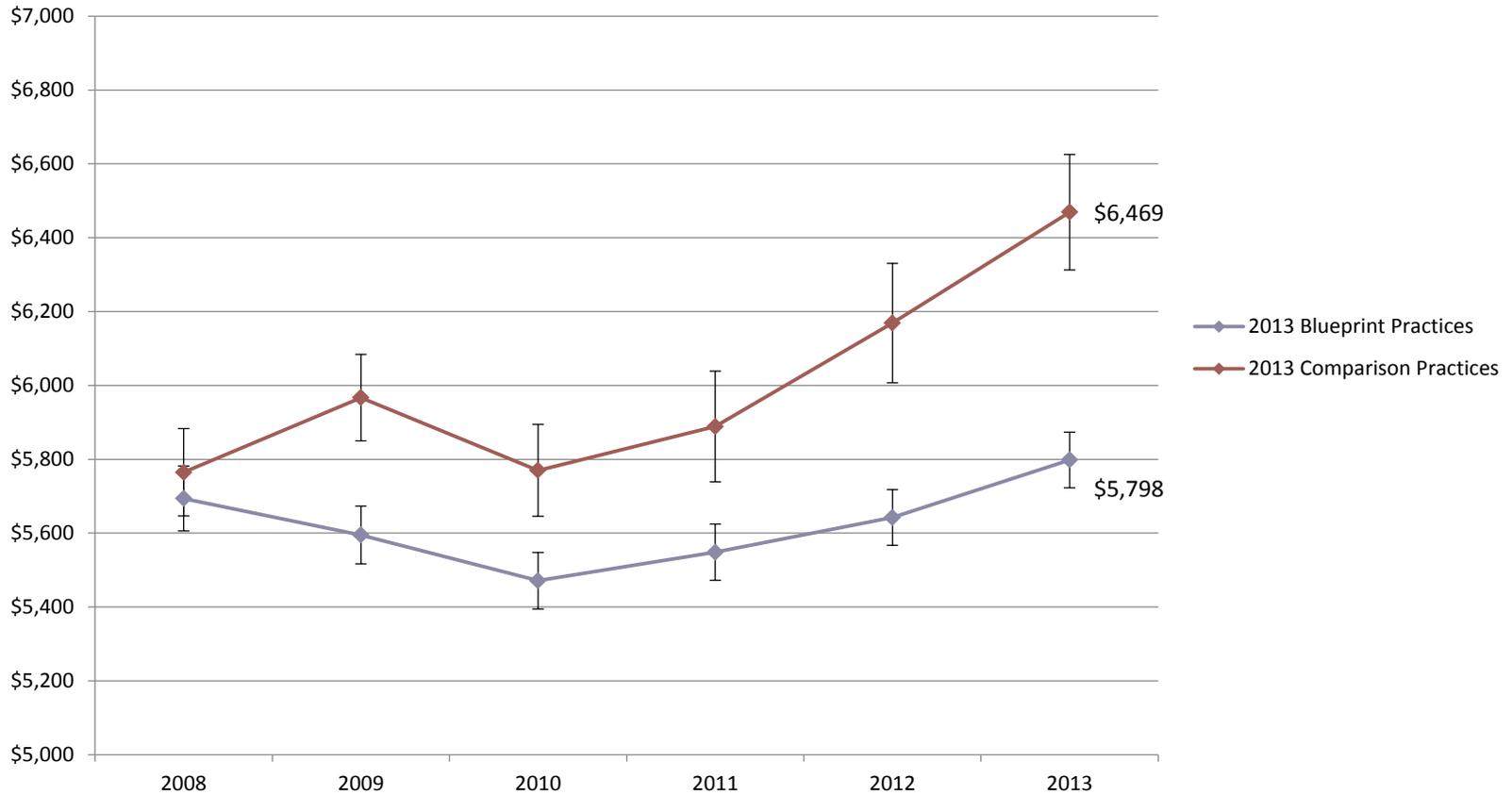


		Participant Practices Included in Evaluation	Commercial (Ages 18-64 Years)		Medicaid (Ages 18-64 Years)	
Year of entry into the program			Participant	Comparison	Participant	Comparison
2008	6	For each year of the evaluation, the participant population includes all people who received care in practices that would become medical homes by 2013* 	118,132	91,106	23,965	15,344
2009	6		136,445	89,452	30,362	15,851
2010	17		145,207	77,980	36,014	14,792
2011	76		156,695	68,281	40,245	12,980
2012	100		162,211	60,045	45,036	11,771
2013	123		160,350	59,402	44,385	12,247

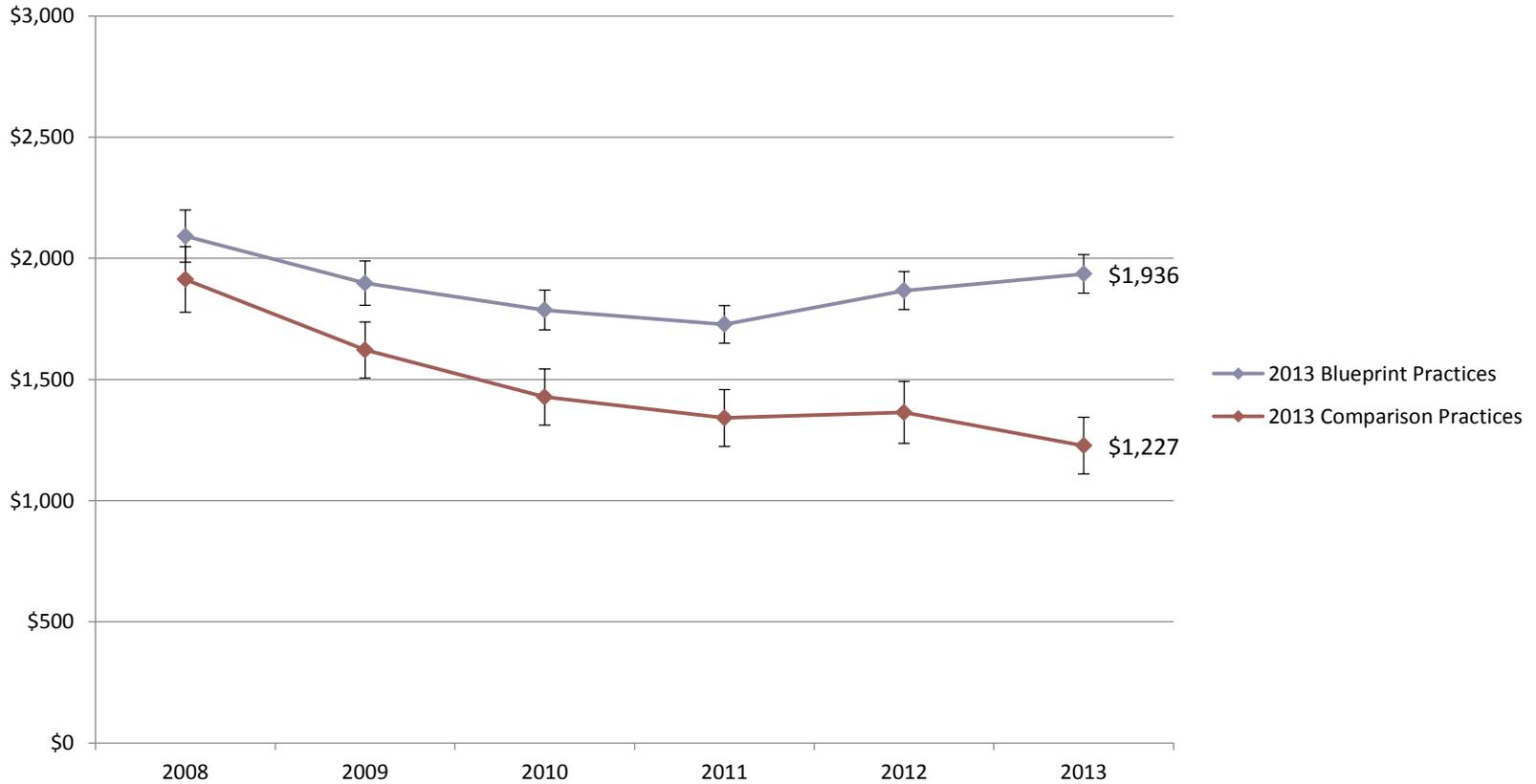
Total Expenditures per Capita 2008 - 2013 Commercial Ages 18-64 Years



Total Expenditures Excluding SMS per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years



SMS Total Expenditures per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years

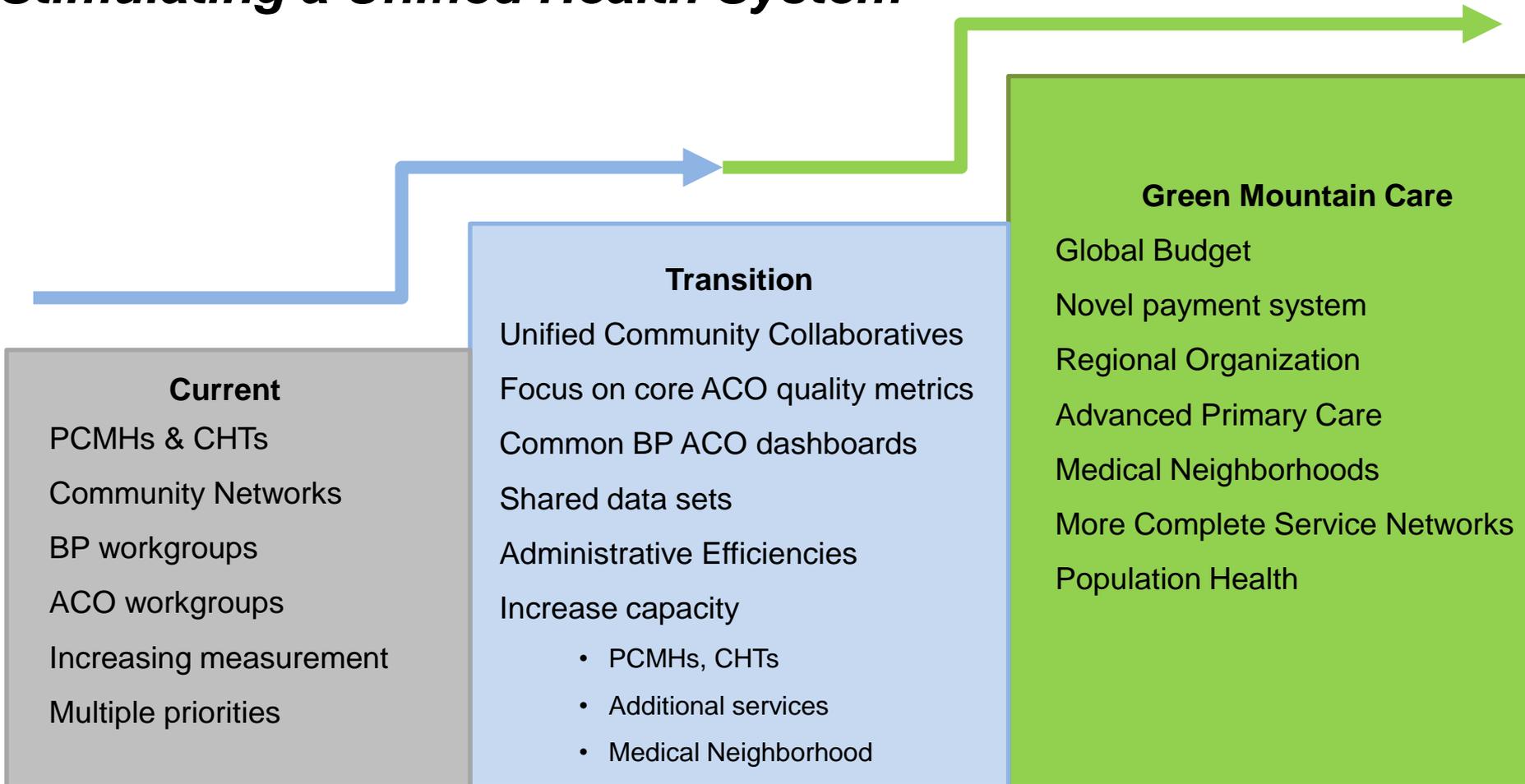


Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Essential delivery system foundation for Green Mountain Care
- Favorable trends over 6 years (utilization, expenditures, quality)
- Reduced expenditures that offset investment (PCMH & CHT payments)

Stimulating a Unified Learning Health System

Transition to Green Mountain Care *Stimulating a Unified Health System*



Strategy for the Transition to Green Mountain Care

1. Unified Community Health System Collaboratives
2. Unified Performance Reporting & Data Utility
3. Administrative simplification and efficiencies
4. Build the medical neighborhood
5. Implement new service models (e.g. ACE, ECHO)
6. Payment Modifications

Strategy for the Transition to Green Mountain Care

Unified Community Health System Collaborative

- Unified local quality collaboratives (blend BP & ACO groups)
- Focus on core ACO measures (add ACO measure dashboard)
- Review examples that are up and running
- Quarterly larger groups & leadership, Monthly workgroups
- Co-chairs including clinical leadership from ACOs
- Local groups adopt charter and select leadership

Strategy for the Transition to Green Mountain Care

Collaborative Performance Reporting

- Co-produce comparative profiles
- Include dashboard with results for ACO measures
- Possible thru a linkage of claims and clinical data
- Objective basis for planning & extension of best practices

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)

Demographics & Health Status

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

Table 1: This table provides comparative information on the demographics & health status of your practice, all Blueprint practices in your Hospital 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 disability or end-stage renal disease status, and the member required 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, coarctation, hypertension, diabetes, and depression.

The Health Status measure aggregates ICD-10 Clinical Risk Groupers (CRG) into the year for the purpose of generating adjusted rates. Aggregated risk class includes: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (dystrophy, cystic fibrosis).



Practice Profile: ABC Primary Care

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

Total Expenditures per Capita

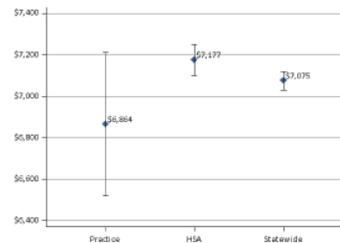


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

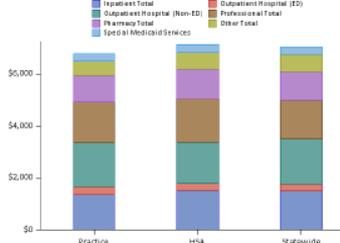


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

Total Expenditures Excluding SMS

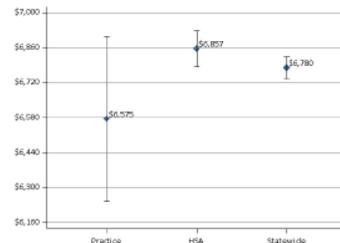


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medical Services, capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

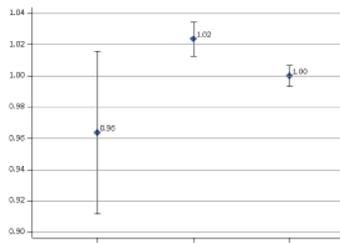


Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects on aggregated cost based on utilization and intensity of services across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

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

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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)

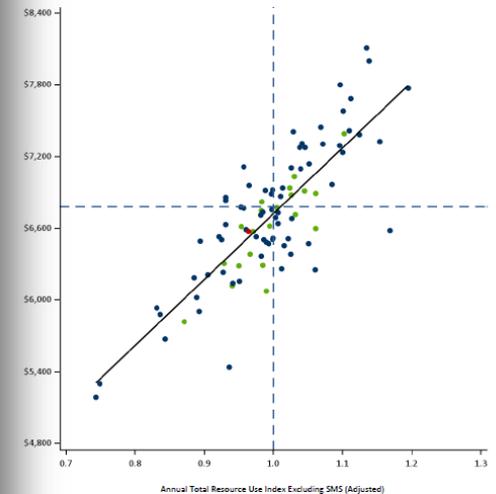


Figure 5: This graphic demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint 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 one 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 utilization had higher risk-adjusted expenditures.

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

Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Clinical Outcomes



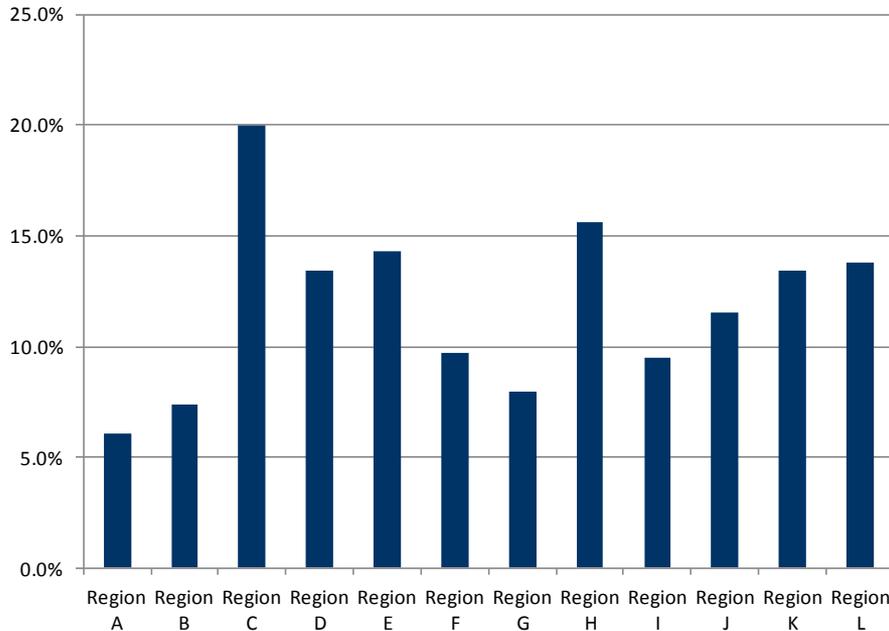
Examples of Patient Volume for Key Measures in 2013

Measure	Number of Patients with Data
Blood Pressure	93,230
Triglycerides	26,585
LDL-C	24,978
Tobacco Use	18,004
HbA1c	12,812

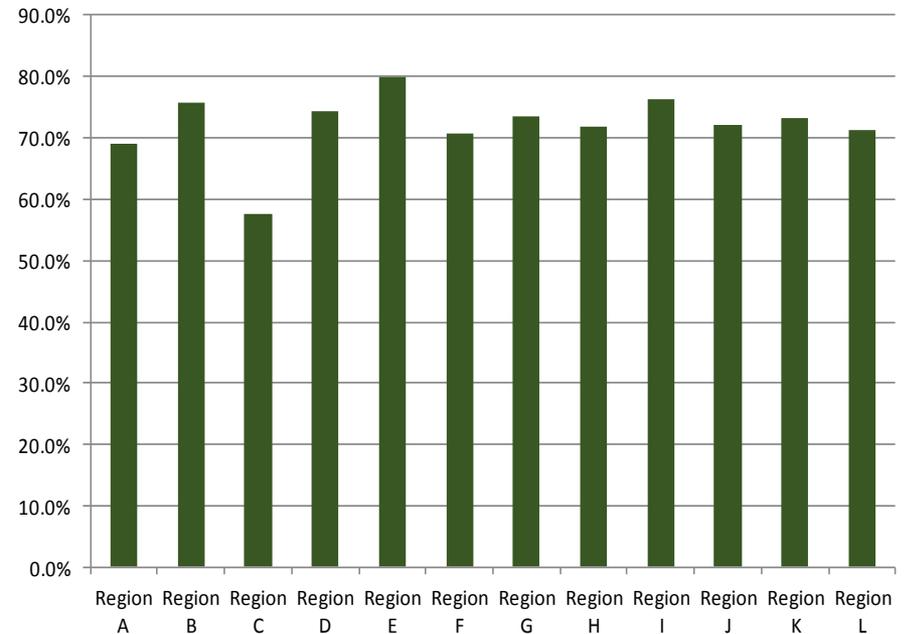
Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Outcomes Data

(ACO 27) % of Members with Diabetes, Glucose Not in Control (A1c >9%)



(ACO 28) % of Members with Hypertension, Blood Pressure in Control (<140/90 mm Hg)



Strategy for the Transition to Green Mountain Care

Data Utility

- Integration of diverse data sets for advanced measurement
- Produce analytic data sets to meet ACO measurement needs
- Share analytic data sets with ACOs
- Collaborative work with VITL and others to build data infrastructure

Strategy for the Transition to Green Mountain Care

Administrative Simplification, Efficiencies, & Cost Offsets

- Reduce insurer medical management programs (e.g. diabetes, hypertension)
- Insurer referrals to enhanced Community Health Teams
- BP participation meets insurer quality requirements for rule 9-03
- Approach NCQA regarding insurer requirements (quality, care management)
- Unified attribution process using VHCURES data

Strategy for the Transition to Green Mountain Care

Medical Neighborhood

- Prepare and score specialty practices against NCQA standards
- Assures high quality care across the continuum (primary, specialty care)
- Establishes statewide foundation aligned with NCQA ACO standards
- Predicts improvement in quality, utilization, and expenditures
- Alternative thru primary care attestation (no measurement against standards)

Recommended Payment Modifications

Basis for Recommendations

- 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
- Strengthen foundation during transition to GMC

Options for Payment Modifications – Report to Legislature

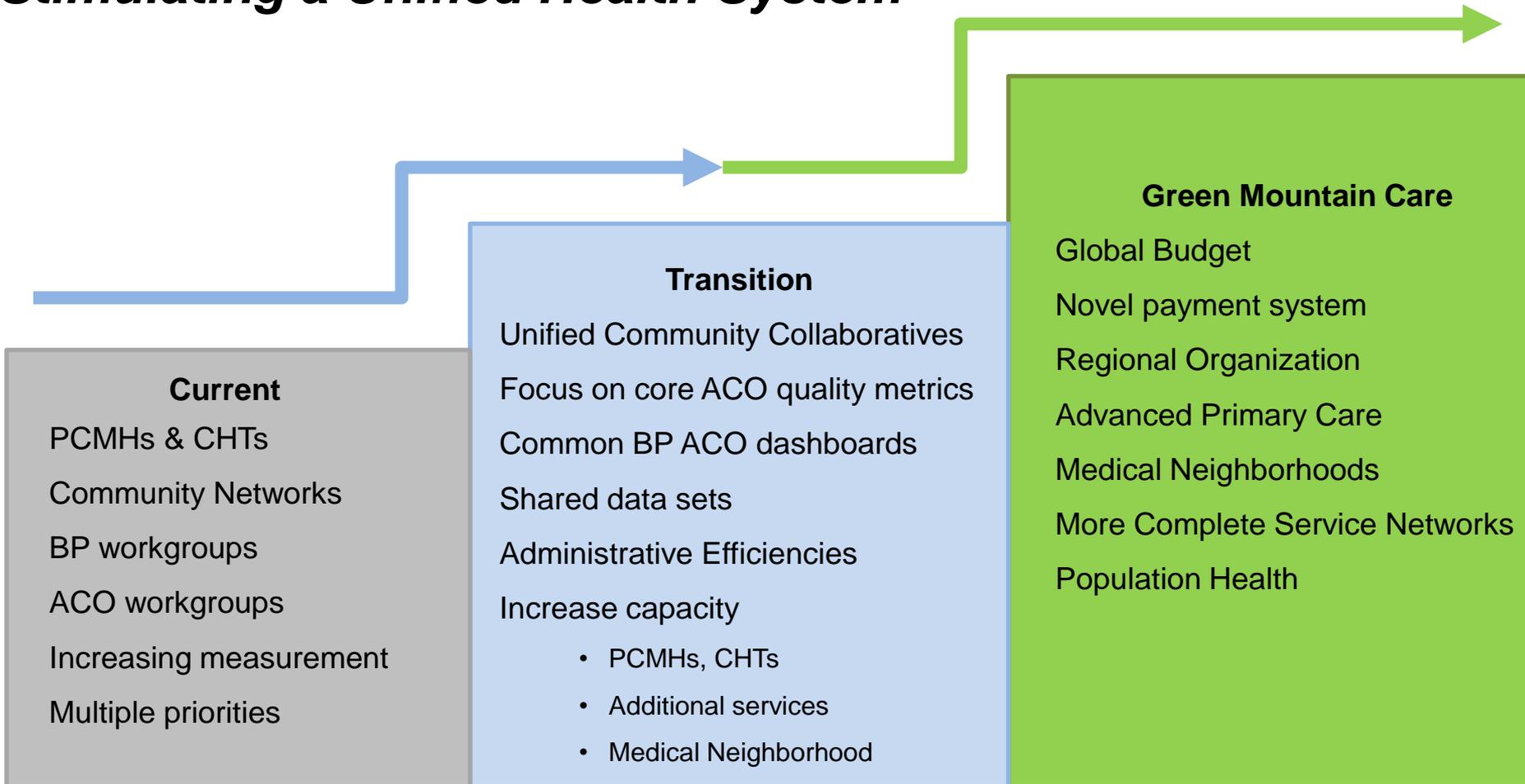
1. Adjust insurer portion of CHT costs to reflect market share
2. Increase CHT payments
 - From \$1.50 to \$2.00 PPPM
 - From \$1.50 to \$3.00 PPPM
 - Health Home Model (add capacity)
3. Increase PCMH payments
 - From an average of \$2.00-\$2.50 to \$4.00-\$5.00 PPPM
4. Increase CHT and PCMH payments
5. Test new models (e.g. fully capitated PC payment, Health Home)

Goals for the Transition to Green Mountain Care

- Assure that Vermonters have unhindered access to the highest quality primary care and team based services
- Stimulate unified cohesive networks of medical and non-medical services in each community
- Demonstrate measurable improvement in the quality of preventive services that Vermonters receive (core measures, additional measures)
- Demonstrate measurable improvement in key outcomes in each community (health status, experience, utilization, costs)
- Formalize a community oriented and data guided health system, ready to operate under Green Mountain Care.

Transition to Green Mountain Care

Stimulating a Unified Health System



Questions & Discussion