

Combined Meeting of The Blueprint Executive Committee and Blueprint Expansion, Design and Evaluation Committee

June 18, 2015

Attendees: D. Alsofrom; J. Batra; B. Bick; L. Bryan; S. Cartwright; P. Clark; A. Cooper; J. Donnelly; P. Farnham; C. Fulton; R. Gibson; M. Gilbert; D. Hawkins; M. Hazard; P. Jackson; C. Jones; J. Krulewitz; M. Lahiff; J. Le; T. Mable; E. McKenna; L. McLaren; M. Mohlman; M. Morse; H. Pallotta; J. Pelletier; J. Peterson; T. Peterson; H. Rabin; A. Ramsay; L. Ruggles; J. Samuelson; B. Tanzman; T. Tremblay; A. Wen; J. Wallace; R. Wheeler; M. Young; J. Zirena

By phone: A. Bart; P. Biron; S. Bruce; D. Charles; P. Cobb; W. Cornwell; C. Denis; E. Emard; J. Fels; P. Flood; E. Fuller; P. Harrington; R. Heintz; J. Hester; A. Jasinowski; P. Launer; J. Lord; S. Narkewicz; T. Reinertson; P. Reiss; J. Shaw; R. Slusky; J. Swayze; K. Turner; S. Winn;

The meeting opened at 8:00 a.m.

I. Opening Comments: Craig Jones, MD.

- The agenda and PowerPoint slide deck were distributed prior to this meeting.
- The purpose of today's meeting is to finalize the payment plan based on the legislative allocations. Given the budget challenge, we came up with a different budget model option, which we will review today. This new budget model, option #3, was remodeled from the payment model option #1. After committee discussion, ultimately we would like to make a set of recommendations today.

II. Review Option #3 for Payment Changes for FY2016

- Internal discussions took place with DVHA following our last meeting. Due to budget constraints, a new payment proposal was developed.
- Dr. Jones presented to the group the new budget model (Option 3).
 - Proposed highlights include:



1. CHT market share adjustment to start July 1, 2015. (Cigna and MVP plan to reduce CHT payments to market share levels as of 7/1/15. Without Medicaid and BCBS increases, these reductions result in an additional \$1,173,275 funding gap. \$1.19 million of Medicaid's CHT market share will be used to shore up the CHTs starting July 1. CHT funding would remain level set.
 2. Base PCMH payment for Medicaid only will also start July 1, 2015 and the cost will be \$1.2 million. A \$3.00 PPM base payment is the proposed amount for all eligible practices.
 3. Base payments of \$3.00 PPM from all remaining payers, and performance PCMH payments from all payers, will start January 1, 2016. The performance component can go up to \$.50, with an annual increase of \$1.5 million expected for Medicaid. After implementation of the performance component, the PCMH PPM is expected to average \$3.25 for Medicaid and commercial payers.
 4. On an annual basis, this will require an additional \$300,000 from Medicaid. The additional amount will likely have to be shifted out of other program expenditures. An example would be to adjust our Blueprint grant dollar amounts and put that money toward direct services instead. We will be reviewing our grants and contracts carefully looking for opportunities to cover the \$300,000 shortfall.
- Lou McLaren stated MVP supports the proposed PPM and market share adjustment. MVP is committed to Dr. Jones' proposal.
 - Bob Wheeler stated BCBS is supportive of the market share approach and increase payment model however, BCBS must receive Green Mountain Care Board approval through their rate review.
 - Allan Ramsey mentioned this discussion will also be held at the Green Mountain Care Board (GMCB) meeting today and everyone is invited to attend. A. Ramsey reminded everyone that all good things in the delivery system begin with the primary care providers. Changes in the delivery system cannot sustain itself unless there's a good payment system in place. He questioned how Dr. Jones came up with the proposed estimates for the medical home payment model. A. Ramsey also expressed concern about how the plan could be operationalized in such a short period of time. How quickly can the UCC's implement these changes? Dr. Jones responded that the proposal was based on budget discussions. Money will be disseminated and we will have time to set up a measurement recording and PCMH payment process by January 2016. Performance payments will be linked to service areas. This is intended to promote practices working together.
 - Elise McKenna also voiced concern regarding operationalizing the plan. Dr. Jones responded that is one of the reasons to start in January is so that we have time to set up the process. Four (4) core measures will be selected. A six (6) month lag time will

probably be used to determine payments. (e.g. In January, we will use July's results as the basis for the payments.)

- Wendy Cornwell stated she is concerned that the measurements will be looked at by Health Service Areas. Taking incentives away, would drive private practices out of the Blueprint. Dr. Jones responded that measurements would be linked to health service areas. The ACOs and providers work together in each area. Mark Young pointed out that everyone, independent as well as hospital owned practices, are all included in each health service area UCC. Dr. Jones reflected this is a stage of evolution. The intent is to promote greater collaboration and interaction between practices.
- Patrick Flood stated he agreed and is in full support of this new model.
- Jennifer Fels reminded everyone of the value of the Blueprint and the savings that have resulted from our combined work.
- Susan Bruce asked about the dollar amount that is tied to the funding gap. Dr. Jones stated that we can look into how the gap divides between each different service area.
- Dr. Jones stated one of our priorities after this model is implemented is to approach the business community (self-insured) who are currently not investing in but are benefiting from our efforts. There is enough evidence now that we should push forward to make a value case to the business community. We will need to work on identifying who the key businesses are. This should be the focus for the next year.
- L. McLaren questioned which Committee is eligible to vote. Dr. Jones responded both groups – the Blueprint Executive Committee and the Blueprint Expansion, Design and Evaluation Committee. DVHA's legal counsel, Howard Pallotta, nodded that Dr. Jones is correct.
- Jean Swazy-Andersson expressed significant reservations regarding the unified collaboratives. She voiced opposition to continuing with any NCQA PCMH program. Are there ways to modify the NCQA scoring process for the independent practices? Dr. Jones responded that both the new NCQA requirements as well as the new renewal process would be less cumbersome. NCQA will begin a new pilot process this summer in Vermont. This pilot may help streamline the scoring process moving forward. Dr. Jones cautioned that if a practice drops out of the NCQA process it will be even more arduous trying to rejoin.
- Paul Reiss stated HealthFirst is not comfortable with the proposed \$3.00 base PCMH payment. Their practice can no longer afford this and it is not nearly enough for their practice to move forward. Dr. Jones clarified the proposed \$3 base payment is modified from the Option #1 proposal. This proposal will help set things up for a better payment in FY17. It would not make sense from a program point of view to undo the medical homes, the collaborative structures in communities, and step backward.

III. Recommendations

There were a total of 64 attendees: 39 attendees in person and 25 attendees by phone. The following voted to not recommend moving forward with option #3:

- Jean Andersson-Swayze – voted for exception
- Hannah Rabin – voted for exception
- Bob Bick – abstain
- Jose Zirena – abstain

The committee recommends moving forward with option #3; to start both CHT market share and new PCMH payment model on July 1, 2015.

The meeting adjourned at 9:41 am.

Executive Committee Planning & Evaluation Committee

June 18, 2015

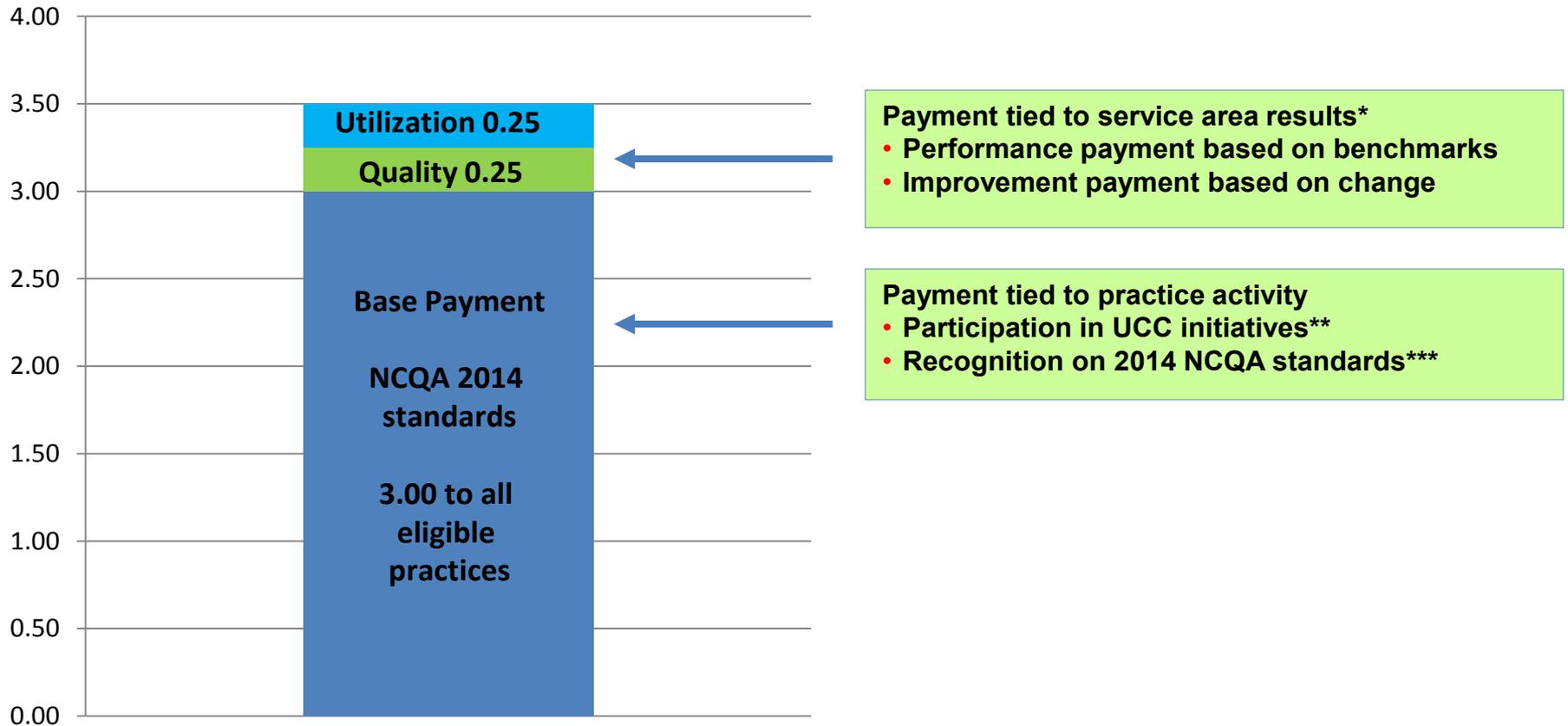
Agenda

- Review options for payment changes for FY2016
- Finalize recommendations for payment changes

Building a Community Health System

- Unified community collaborative (coordination, quality)
- Balanced leadership team (ACOs, VNAs, DAs, AAAs, Housers, Peds, others)
- New PCMH & CHT payment models
- Transformation support through Blueprint grants
- Comparative performance reporting to guide initiatives
- New NCQA scoring process

Medical Home Payment Model – Option 3



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

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

***Payment tied to recognition on NCQA 2014 standards with any qualifying score. Emphasize priority 'must pass' elements

Community Health Team Payment Based on Market Share

- Insurer market share has changed dramatically. In order for CHTs to be stable, CHT payments need to be based on market share and adjusted on a routine basis
- Cigna reduced CHT payments since 01/01/15, resulting in a 4.5% funding gap for total CHT payments (~\$400,000 per year). Cigna plans to reduce payments to market share levels (07/01/15)
- MVP plans to reduce CHT payments to market share levels (07/01/15)
- Without Medicaid and BCBS increases, these reductions (Cigna, MVP) will result in an additional \$1,173,275 funding gap (July to December 2015)

Decision Points

- Plan for best use of the new \$2,446,075 appropriation
- Objectives for 2016 transition year:
 - Stabilize CHT operations with market share based payment
 - Start new PCMH payment model (\$3.00 base + performance)
- Medicaid payment start dates
 - CHT market share adjustment starts July 1, 2015
 - Base PCMH payment starts July 1, 2015
 - Performance PCMH payment starts January 1, 2016

Option 3: New PCMH & CHT Payment Models

1. Total appropriation = \$2,446,075
2. \$1,189,646 allocated to Medicaid CHT Market Share starting July 1, 2015
3. \$1,216,934 allocated to Medicaid PCMH Payment starting July 1, 2015
4. Requires an additional \$300,000 for Medicaid on an annual basis
5. The \$300,000 will likely have to come out of other program expenditures (e.g. grants)

Action	Year	Start	End	Additional Cost
PCMH Payment	1.0 FY16	07/01/2015	06/30/2016	\$1,216,933
CHT Market Share	1.0 FY16	07/01/2015	06/30/2016	\$1,189,646
Total				\$2,406,579

Option 3 – PCMH & CHT Market Share Start July 1, 2015

1. Total appropriation = \$2,446,075
2. \$1,189,646 allocated to Medicaid CHT Market Share starting July 1, 2015
3. \$1,216,934 allocated to Medicaid PCMH Payment starting July 1, 2015

Option 3 PCMH Payment Increases

	Start Date	Average PPM	Total FY16 Increase	Annualized Increase
Medicaid	07/01/15	\$3.25	\$1,508,409	\$1,508,409
BCBS	01/01/16	\$3.25	\$696,971	\$1,393,942
MVP	01/01/16	\$3.25	\$70,297	\$140,594
Cigna	01/01/16	\$3.25	\$9,575	\$19,150
Total			\$2,285,252	\$3,062,095

PCMH Payment Changes – Option 3

Payer	Current Annualized PCMH Costs Paid Based On PCMH Attrib Patients 2014-Q4	Count of Payer-Reported Claims-Based Blueprint PCMH Attrib Patients 2014-Q4	Market Share of PCMH Attrib Patients 2014-Q4	Increased Annualized PCMH Costs At \$3.25 Avg PPPM	Increased Annualized Cost Difference At \$3.25 Avg PPPM	Percent Change From Current Costs
BCBSVT	\$2,509,918.60	100,099	35.51%	\$3,903,861.00	\$1,393,942.40	55.54%
Cigna	\$30,965.36	1,285	0.46%	\$50,115.00	\$19,149.64	61.84%
Medicaid	\$2,433,867.00	101,084	35.86%	\$3,942,276.00	\$1,508,409.00	61.98%
Medicare*	\$1,619,289.88	67,568	23.97%	\$1,619,289.88	\$0.00	0.00%
MVP	\$321,322.32	11,844	4.20%	\$461,916.00	\$140,593.68	43.75%
Total	\$6,915,363.16	281,880	100.00%	\$9,977,457.88	\$3,062,094.72	44.28%

CHT Market Share Adjustments

Payer	Current Share of CHT Costs Paid	Current Annualized CHT Costs Paid Based On CHT Attrib Patients 2014-Q4	Count of Payer-Reported Claims-Based Blueprint CHT Attrib Patients 2014-Q4	Market Share of CHT Attrib Patients 2014-Q4	Market-Share Annualized CHT Costs	Market-Share Annualized Cost Difference	Percent Change From Current Costs
BCBSVT	24.22%	\$2,170,385.44	100,099	36.04%	\$3,327,290.76	\$1,156,905.32	53.30%
Cigna	13.66%	\$1,224,090.22	1,285	0.46%	\$42,713.40	-\$1,181,376.82	-96.51%
Medicaid	24.22%	\$2,170,385.44	101,084	36.40%	\$3,360,032.16	\$1,189,646.72	54.81%
Medicare*	22.22%	\$1,991,162.86	67,568	24.33%	\$2,002,715.52	\$11,552.66	0.58%
MVP	11.12%	\$996,477.54	7,672	2.76%	\$255,017.28	-\$741,460.26	-74.41%
Total	95.44%	\$8,552,501.51	277,708	100.00%	\$8,987,769.12	\$435,267.61	5.09%

Questions & Discussion