

Department of Vermont Health Access
Division of Health Care Reform
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**Combined Meeting of
Blueprint Executive Committee Meeting and
Blueprint Expansion, Design and Evaluation Committee
Minutes of
September 17, 2014
8:30 – 10:00**

Attendees: D. Andrews, P. Cobb, N. Eldridge, J. Evans, M. Hazard, P. Jackson, C. Jones, J. Krulewitz, C. MacLean, S. Maier, C. McLean, T. Moore, C. Oliver, A. Ramsay, P. Reiss, J. Samuelson, C. Schutz, K. Suter, B. Tanzman, C. Thomas, T. Tremblay, C. Thomas, K. Hentcy, M. Young

Attendees via Phone: J. Andersson-Swayze, P. Biron, J. Fels, S. Frey, A. Garland, B. Grause, P. Harrington, J. Hester, L. McLaren, E. Medved, S. Narkewicz, D. Noble, T. Peterson, K. Suter, T. Voci, R. Wheeler

The meeting opened at 8:32 a.m.

1. General Update:

Dr. Jones provided a quick update for the group.

- As of July, 2014 there are 123 practices in Vermont operating as Medical Homes
- Onpoint attribution as of December, 2013 = 347,489 patients vs. Practice Report attribution of 514,035. 644 Unique primary providers.
- In countries such as the UK and Netherlands, practices specifically ask patients to identify their PCP and their responses then get entered into a registry. This method appears to be more accurate as opposed to what claims show on attribution algorithms.
- To the degree that any insurer has a product where members must choose a PCP, it is recorded in the system. Attribution algorithm then only applies to patients who do not have an insurer package where they must choose a PCP.
- Eric Medved stated that at Gifford there are hundreds of patients who have not identified providers and he is not sure if these patients are getting attributed anywhere.

- Jean Anderson Swayze (HealthFirst) wanted to discuss the future of the Blueprint since the new Medicare G-codes for chronic care will force many practices to choose between Blueprint and Medicare G-codes to reimburse practices. The chronic care management fee will begin in January if a practice meets certain eligibility requirements. Dr. Jones responded that all 8 states in the MAPCP Demonstration have looked into this. If eligibility requirements are met for targeted subpopulations, then the numbers work out to \$42.00 PPPM. When most of the sites ran the numbers, it was quite different than the medical home payments because the fee doesn't apply to all Medicare patients in the practice. If Blueprint payments are increased as we are requesting, practices will actually make more by being a Medical Home. Every practice should look very carefully at the math.

2. **Draft Recommendation to the Legislature:**

- A Draft Recommendations document was distributed prior to this meeting. (Attachment A) The Blueprint has been asked to provide the legislature with Blueprint payment increase recommendations in context of a greater plan to continue advancements and stimulate health. We believe the future is moving toward a population health approach. Therefore, the focus of the report will be a proposal to stimulate systems and recommendations to take steps to strengthen community health systems, ACO's, and to build a foundation for Green Mountain Care.
- What can be done to strengthen the foundation for community systems of health, ACO, and Green Mountain Care? During the transition period, we can take steps to strengthen the foundation. The intent is to set a common game plan and create a platform for all. Opportunities include:
 - Unify operations in each community
 - Shared governance – one in each community
 - Unified performance reporting and dashboards
 - Sharing resources such as evaluation and data sets
 - Administrative simplification
 - Engaging specialists and strengthening the medical neighborhood
 - Strong foundation for primary care, preventative services and community oriented services.
 - Increases in payments that result in a more unified transition period.
- Craig Jones – There will be a strong emphasis on local ownership and leadership, we don't want to come up with a scripted structure but instead take input from all

communities to put together a thoughtful plan that recognizes the interests of all players involved.

- It is important to increase the capacity of PCMHs and CHTs during the transition phase as well as to maintain participation and to strengthen the foundation. We are not talking about pulling money away but instead we are talking about strengthening the investment.
- None of the insurers have voluntarily agreed to any increases.
- This is going to be a journey by coalition of the willing partners who believe in this approach. The transition period will define the role of the Blueprint, OneCare and ACOs moving forward. Now is the time to explore how to build a permanent infrastructure with shared resources in addition to funding full-capacity practices that are doing more with less every year in primary care practices. Payments remain the same today as they did six years ago which is not financially sustainable.
- The finished report is due on October 1st. Alan Ramsey stated that the Green Mountain Care Board wants to hear from stakeholders. Do you feel the proposed changes and recommendations are indeed the right kind of changes to implement moving forward? Will the changes lead to better outcomes?

With no further business, the meeting adjourned at 10:15 a.m.