

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

**September 16, 2015**

**Attendees:** S. Aranoff; J. Batra; B. Bick; P. Cobb; S. Constantino; T. Dolan; P. Farnham; K. Fitzgerald; J. Franz; A. French; V. Harder; J. Hester; B. Hill; C. Huang; C. Jones; J. Le; S. Maier; M. Mohlman; J. Peterson; J. Samuelson; M. Sheehey; B. Tanzman; T. Tremblay; S. Wepler; B. Wheeler

**By phone:** P. Biron; E. Emard; J. Fels; C. Foulton; J. Krulewitz; P. Launer; E. McKenna; S. Narkewicz; M. Shattuck; T. Voci; J. Wallace; M. Young

The meeting opened at 8:31 a.m.

I. Opening Remarks and Context: Craig Jones, MD.

- Today's agenda and PowerPoint slide deck were distributed prior to this meeting.
- Additional meeting materials were distributed in today's meeting and will be electronically distributed as well.
- The purpose of today's meeting is to catch up with everyone on the process and what's been going on in the past couple of months.

II. Published Results

- C. Jones informed the group of our first peer-reviewed paper, *Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care*, was published in the Journal Population Health Management.
- C. Jones reviewed slide #4 that includes Figure 2 from the report. The charts represents actual expenditures that have been paid for in the claims and includes VT residents ages 1 year and older. The chart reflects pre-year, implementation year, NCQA scoring year, post-year 1 and post-year 2 for 2008 – 2013. The impact of the ACOs will not be shown in this.
  - The results are favorable.

- The relative reduction is across the three insurers types. Reductions offsets what was paid to both the medical homes and community health teams. The results show an increase in Medicaid special services such as dental, transportation, and other services not typically covered by other payers. The interpretation of this finding is that medical homes and community health teams are better connecting their patients to social and prevention services relative to the comparison group.
  - Slide #15 gives an example of claims and clinical data linkage. C. Jones mentioned we are expanding our ability to link claims and clinical data. A new feature of the practice and Health Service Area profiles is a table showing percentages of patients linked clinical data on specific measures (e.g. blood pressure and BMI), and the percentages meeting criteria for chronic conditions (e.g. hypertension and obesity). There is no reason why other data, such as home, food, social, etc., can't be integrated.
  - Linked clinical data are getting to the actionable results. Treatment data can also be added. V. Harder stated this will be powerful for practices to see and what to treat.
  - C. Jones challenged the group to think creatively of where there are rosters (e.g. non-claims data) that can be flagged and linked.
- Before discussion moved onto the updates of Blueprint/ACO collaboration, J. Wallace requested an update about the Gobeille vs. Liberty Mutual case, whether claims data needed to be submitted for self-insured. C. Jones did not have a lot of information and heard the case will be heard before the Supreme Court this fall. If we lose the data on self-insured, we will be losing a lot. M. Mohlman reported the brief has been submitted and may be on the Green Mountain Care Board website. T. Tremblay mentioned the State attorneys have been looking at the work Blueprint has been doing and imagines that some of our work will be used in the hearing.

### III. Community Collaboratives

- Over the past nine months, the leaders of the three ACOs have been working with the Blueprint in forming decision making groups who will help guide the community level health structure. All the communities are in different stages in the state and are beginning to use priorities and projects.
- J. Samuelson acknowledged the ACO partners, Miriam Sheehey (OneCare Vermont), Patty Launer (CHAC), and Susan Ridzon (Health First). We have been working collaboratively to merge our resources and support.
- Twelve of the communities are actively participating in the Care Coordination learning collaborative that SIM is currently holding. This shows how different types of organizations and communities are working together.
- S. Aranoff hopes the community collaborative meetings will be open to all. J. Samuelson mentioned the need to balance transparency with the communities' needs to develop trust among the members and leadership groups within the community.
- M. Sheehey gave nods to a couple of teams around their efforts that include: Bennington, Burlington and Newport.

- C. Jones stated this is actual decision making, showing both ACOs and CHT supporting a real initiative. This is the operation on the ground of the Community Health Structure. C. Jones applauds all.
- J. Hester mentioned this is critical. He also noted that CMMI is finalizing an initiative supporting ACO/Population Health and will work like what is being discussed. It should be out by the end of this year. C. Jones asked if there will be any challenges for eligibility, such as Next Gen ACO. J. Hester responded he doesn't believe so.

#### IV. Payment Modifications

- As of July 1, 2015, all eligible practices have received the \$3 base payment for medical homes payment from Medicaid. Other insurers will join Medicaid on January 1, 2016. The performance component, which we have been working with the ACOs on, will be based on service area outcomes and will go into effect January 1, 2016.
- P. Cobb asked if the performance payments will be adjusted. C. Jones responded, yes, it will be twice a year, every 6 months.
- C. Jones went over slide #8, *Changes to the Payment & Eligibility Requirements*. In recognition to NCQA undergoing a change in their process for scoring, independent practices can defer to the end of 2016 until the NCQA process is underway. Most of the practices chose to rescore and have not dropped out yet. We're also piloting the new NCQA scoring process. Performance payment will be based on recognition and not score.
- Quality performance payment: M. Mohlman discussed the four ACO core measures that are tied to the performance payment and they include:
  1. Core-2: Adolescent well-care visit
  2. Core-8: Developmental Screening in the first three years of life
  3. Core-12: Rate of hospitalization for ACS conditions (PQI Chronic Composite)
  4. Core-17: Diabetes mellitus: hemoglobin A1c poor control (>9%)
- M. Mohlman stated the decision was to go with a point system and to use our State data. The HSA data have been adjusted to be comparable to the State. If an HSA is at or above the State average, the HSA will get one point for that measure. If an HSA is at or above the High Achiever (90<sup>th</sup> percentile), the HSA will get three points. If you are not in the High Achiever bracket, the HSA is eligible for improvement points: 1 point for maintaining, 2 points for achieving at least a minimum improvement. Total of 3 possible points for each measure; total of 12 possible points for all four measures. HSA scores will make practices eligible for one of three payment levels, up to \$0.25 for the quality performance payment. Utilization performance payment will be based on the Total Resource Use Index reported in the Blueprint HSA profiles.
- B. Bick questioned whether a more finely graduated performance payment system was desired, so that it would not be possible for a practice to get worse on a performance measure and still get the maximum payment. In contrast, other commenters supported the proposed approach, pointing out that it would be important to allow HSAs to focus on a subset of performance measures.

With no further time, the meeting adjourned at 10:17 am.

# Executive Committee Planning & Evaluation Committee

September 16, 2015

## Agenda

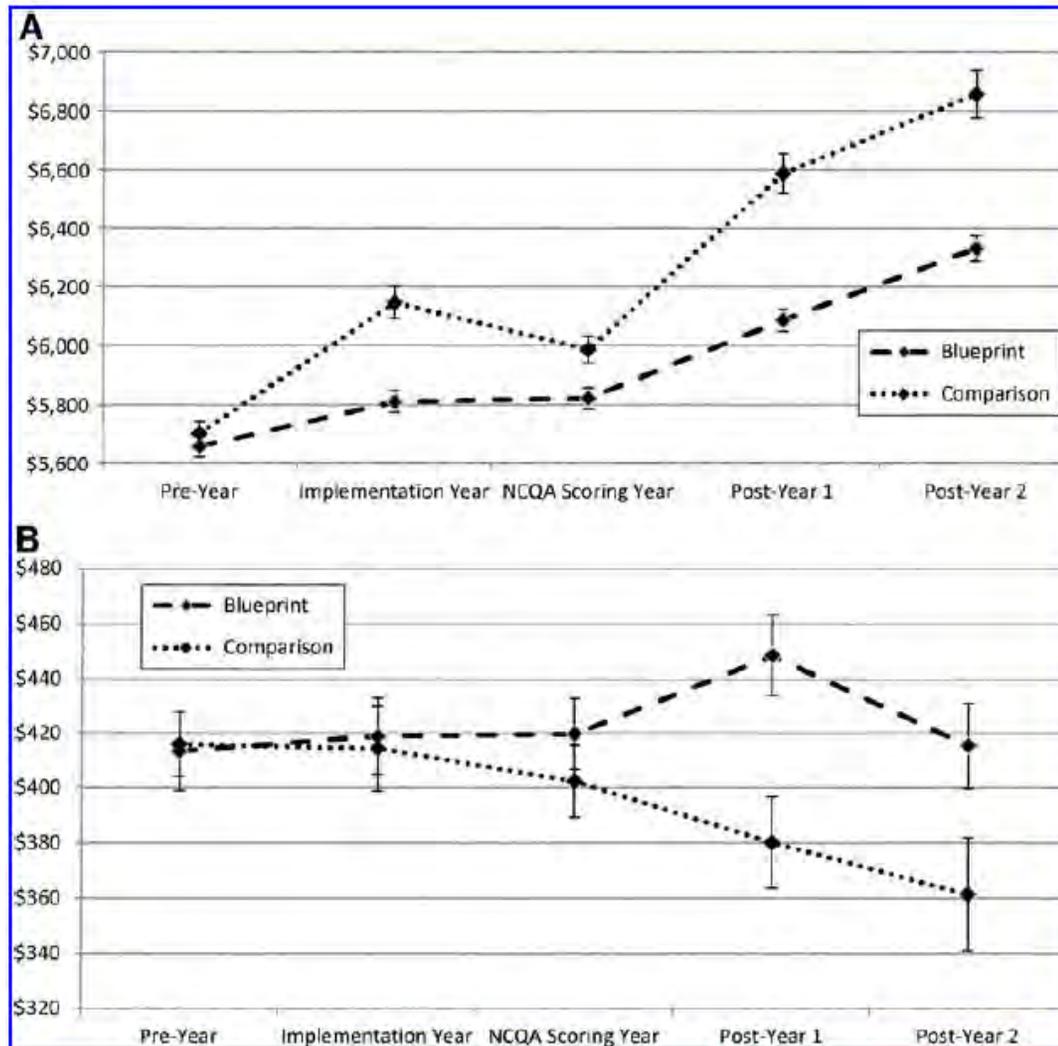
- Published Results
- Community Collaboratives
- Payment Modifications
- Data, Evaluation, & Reporting

# Population Health Management

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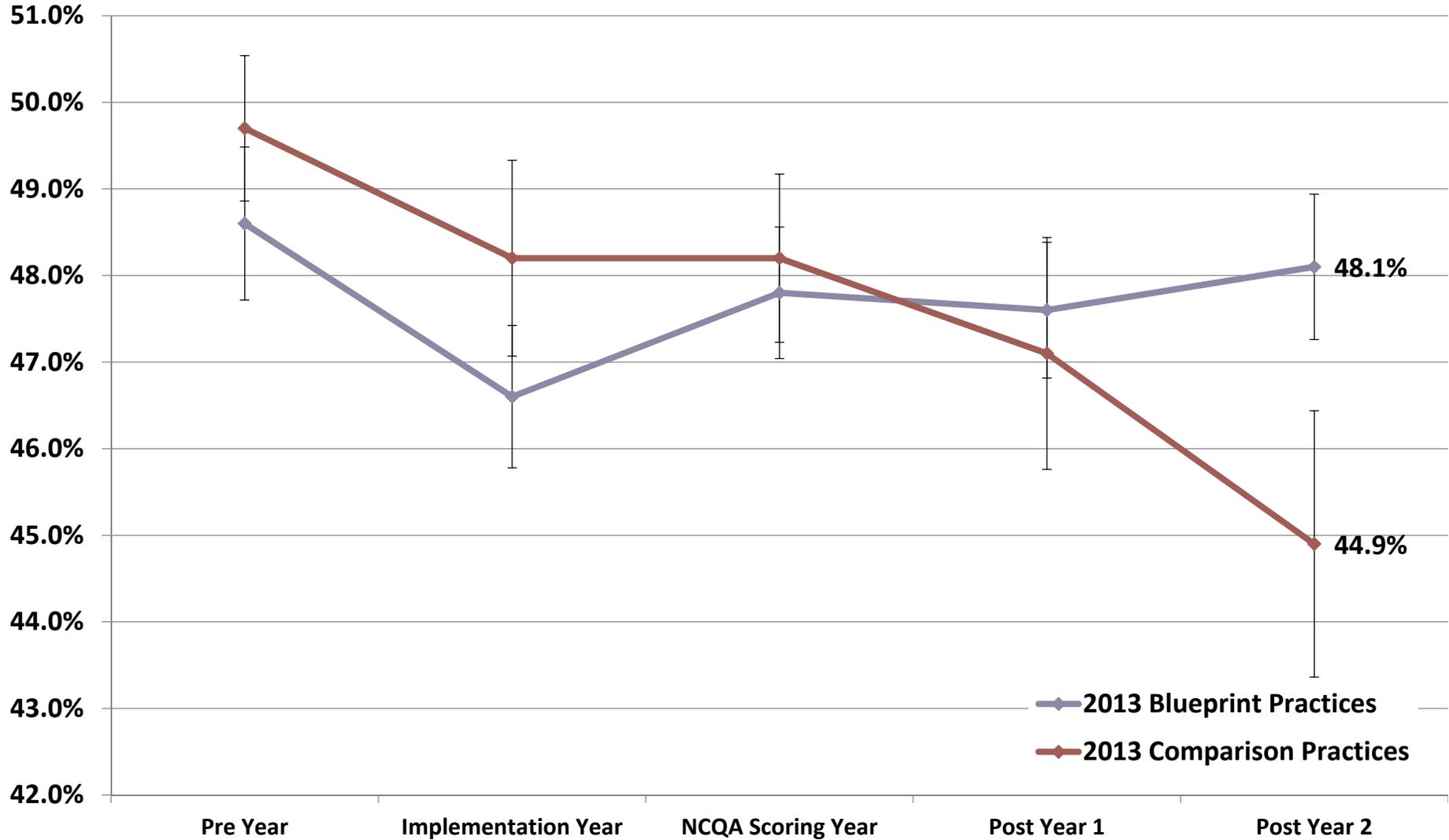
Original Article

Vermont's Community-Oriented All-Payer  
Medical Home Model Reduces Expenditures  
and Utilization While Delivering High-Quality Care



**FIG. 2.** Expenditures per capita, all insurers, members ages 1 year and older. **(A)** Total medical expenditures per patient receiving the plurality of care in either Blueprint for Health or comparison practices over programmatic stages and maturation (excludes social support service expenditures shown in Fig. 2B). **(B)** Total Special Medicaid Services expenditures per patient receiving the plurality of care in either Blueprint for Health or comparison practices over programmatic stages and maturation. <sup>4</sup>

**Diabetes: Eye Screening 2008 - 2013 All Insurers Ages 18 - 75 Years**



## Community Collaboratives

- Integration of ACO and Blueprint workgroups
- Blended ACO and Blueprint support network
- Focus on improving coordination, quality, core ACO measures
- Decision making includes medical and community providers
- Aligning with SIM care coordination collaborative

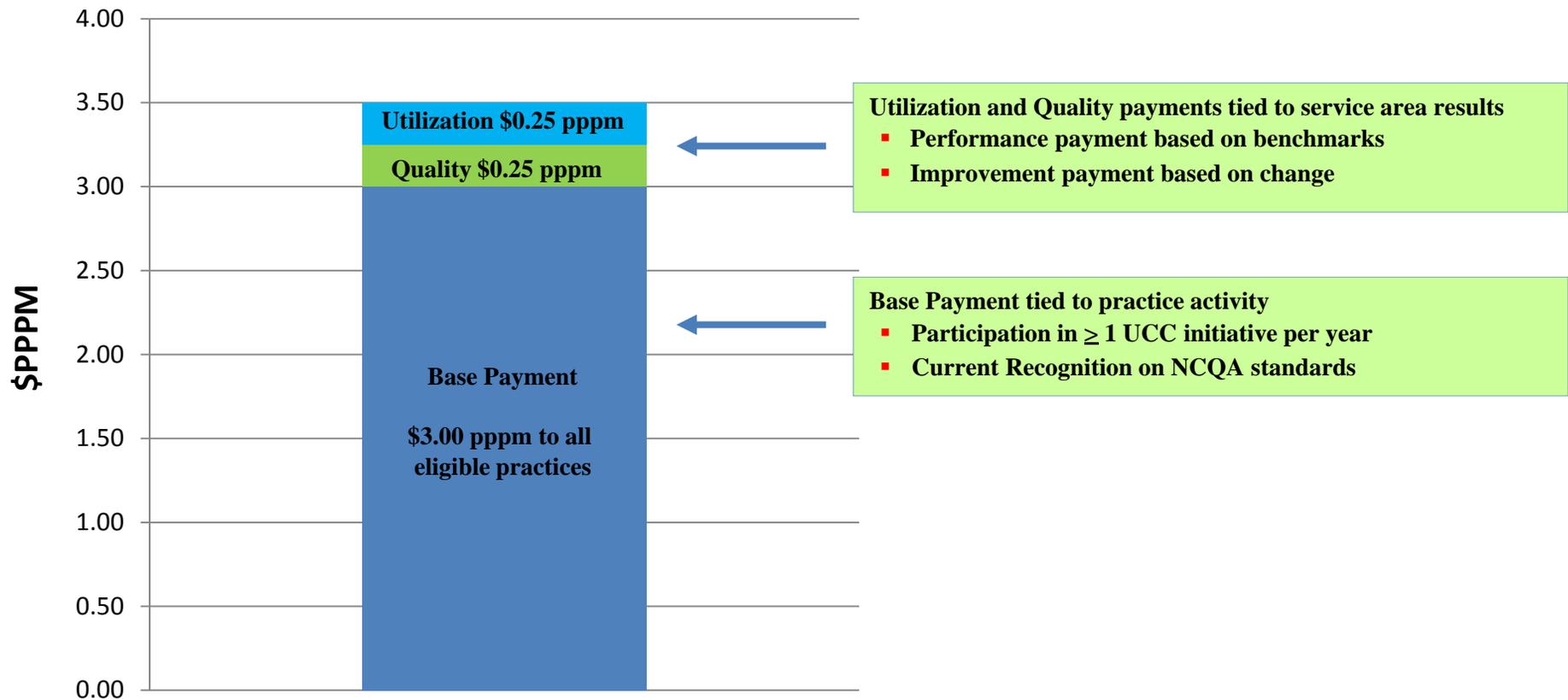
## Payment Modifications

- Increase medical home payments (range from \$3.00 to \$3.50 pppm)
- All eligible practices receive \$3.00 pppm base payment
- Practices earn up to \$0.50 pppm based on performance
- Performance payment tied to service area results of core measures
- Each insurers portion of CHT costs based on market share

## Changes to Payment & Eligibility Requirements

	ACO Support
Currently recognized practices can defer requirement for NCQA recognition until December 31 2016, and remain eligible for payment.	3 ACOs
Eligibility for payment is based on recognition and not on NCQA score emphasizing ‘must pass’ elements, while reducing documentation burden.	3 ACOs
Base payment is the predominance of payment, not performance.	3 ACOs
Medicaid starts increase of base payment on July 1, 2015.	CHAC, HealthFirst
Performance component of payment tied to service area results on core measures, not on practice results.	CHAC, OneCare
Transition community health team payments to a market share basis.	CHAC, OneCare
Continued support for community collaboratives and practices including project managers, facilitators, CHT leaders, analytics, and reporting.	3 ACOs

# Medical Home Payment Model



## Core ACO Measures Selected

- Core- 2: Adolescent Well-Care Visit
- Core- 8: Developmental Screening in the First Three Years of Life
- Core- 12: Rate of Hospitalization for ACS Conditions (PQI Chronic Composite)
- Core- 17: Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)

## Annualized Impact of New Medical Home Payment Model

Payer	Current Annualized PCMH Costs	Payer-Reported Attributed PCMH Patients*	Market Share of PCMH Patients	Increased Annualized PCMH Costs (\$3.25 Avg)	Increased Annualized Cost Difference	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%

## Annualized Impact of Market Based CHT Payments

Payer	Current Share of CHT Costs	Current Annualized CHT Costs	Payer-Reported Attributed Patients*	Market Share of Attributed Patients	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%

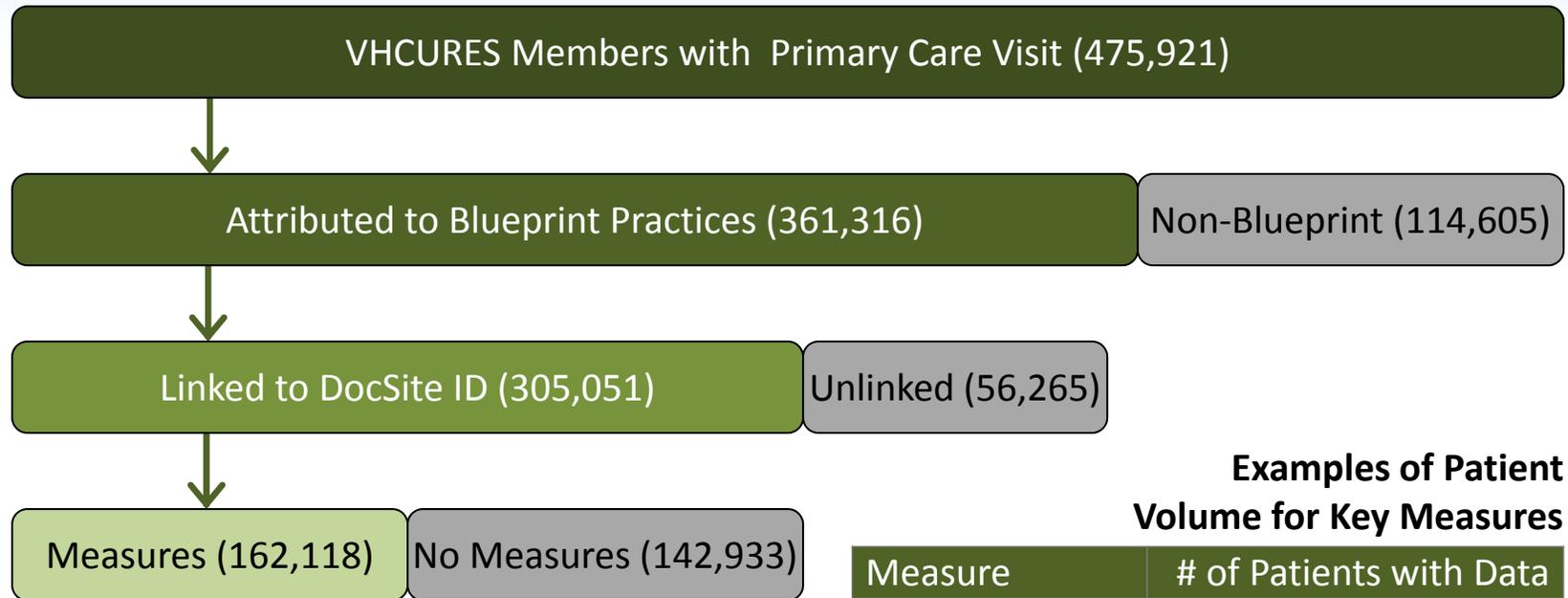
\*Medicare share of CHT patient allocation remains unchanged at 22.22% and payment level remains unchanged at \$1.50 PPPM.

## Data, Evaluation, & Reporting

- Linkage of claims, clinical, and other data sets
- Production of standard measure results including core ACO measures
- Capacity to relate clinical outcomes with healthcare patterns
- Migration of clinical registry
- Work with VITL to optimize data capture and availability

# Linking Claims & Clinical Data – 2014\*

## Enhancing Blueprint Reporting: Clinical Outcomes



**Examples of Patient Volume for Key Measures**

Measure	# of Patients with Data
Weight	142,600
Blood pressure	140,286
BMI	122,428
Triglycerides	44,639
LDL-C	43,652
Tobacco use	28,779
HbA1c	21,418

\*CY 2014 represents dates of services on and between 01/01/2014 and 12/30/2014.

### Linked Clinical Data: Obesity & Hypertension

Measure (N = Count of distinct members)	Practice N=4,556	HSA N=34,022	Statewide N=283,153
	Rate %	Rate %	Rate %
% linked to clinical data	86%	84%	48%
% with BMI data	79%	76%	40%
% meeting obesity criteria	42%	38%	38%
% with blood pressure data	85%	81%	43%
% meeting hypertension criteria	23%	17%	20%
Measure (N = Count of distinct members with diabetes)	Practice N=383	HSA N=2,423	Statewide N=19,098
	Rate %	Rate %	Rate %
% linked to clinical data	97%	96%	63%
% with BMI data	94%	93%	50%
% meeting obesity criteria	73%	72%	71%
% with blood pressure data	97%	94%	53%
% meeting hypertension criteria	25%	23%	27%
% with BMI and blood pressure data	94%	92%	50%
% meeting obesity and hypertension criteria	20%	18%	20%

*Table 3: Presents the proportion of distinct members and distinct members with diabetes linked to clinical data with valid body mass index (BMI) and blood pressure data meeting the criteria for obesity (BMI  $\geq$  30.0) and hypertension (mmHg  $\geq$  140/90).*

## Current State of Play

- Foundation of primary care based on NCQA standards
- Infrastructure of team services & evolving community networks
- Network supporting transformation, self-management, quality
- Maturing health information & data systems
- Comparative evaluation & reporting (profiles, trends, variation)
- Progress towards community organized population health system

## Questions & Discussion

# Current Direction

- Integration of ACO and Blueprint workgroups
- Blended ACO and Blueprint support network
- Focus on improving coordination, quality, core ACO measures
- Decision making includes medical and community providers
- Aligning with SIM care coordination collaborative
- Progress in all 14 service areas

# Community Collaboratives

- Community Collaboratives are forming in communities across Vermont
- These in many cases are they are a mergers of stakeholder meetings formed under different initiatives (ACOs and BP), with the formation of a leadership team and governance
- To date investments have been made independently by the ACOs and BP to ensure these collaboratives are successful

# Merging Efforts

Work collaboratively across the ACOs and Blueprint to support the Community Collaboratives and member organizations to improve care across the accountable health system.

# What Does that Mean

Blend resources of ACOs and BP to achieve common goals and outcomes:

- Merged Project Manager, QI Facilitator, and CHT meetings, and include the ACO QI teams
- Meetings co-lead by the Blueprint and ACOs
- Act as a team, embodying the principals of the IOM Team Based Care
- Work on projects across ACOs and BP

# Community Progress

Health Service Area	Charter	Priority areas of focus	Consumer
Bennington	1	1	1
Central Vermont	1	1	1
Brattleboro	1	1	
Burlington	1	1	Discussing
Middlebury	1	1	
Morrisville	1	1	
Newport	1	1	1
Randolph	Working on it	Under discussion	
Rutland	1	1	
Springfield	1	1	
St. Albans	1	1	
St. Johnsbury	1	1	1
Townshend	1	1	
Windsor	Working on it	1	
Upper Valley	Data Missing		

# Types of Organizations in Collaboratives

Types of Agencies Involved	Number of HSAs (of 13 formed collab)
Mental Health	12
Home Health	10
AAA	2
Housing Organizations	2
Hospital	13
FQHC	9
SNF	6

# Organizations In Collaboratives by HSA

Health Service Area	Mental Health	Home Health	AAA	Hospital	FQHC	SNF	Housing
Bennington	1	1		1	1	1	
Central Vermont	1	1		1		1	
Brattleboro	1	1		1		1	
Burlington	1	1	1	1	1		1
Middlebury	1	1	1	1	1	1	
Morrisville	1			1	1	1	
Newport	1	1		1	1		
Rutland	1	1		1	1		
Springfield	1			1	1		
St. Albans	1	1		1	1	1	
St. Johnsbury	1	1		1	1		1
Townshend				1			
Windsor	1	1		1			
Upper Valley	Data	Missing					
Randolph	Forming						

# Priorities Chosen By Communities

Category of Priority	Number of Health Service Area
Adverse Childhood Experience	1
Addiction	1
Care Coordination	12
CHF	4
COPD	4
ED	5
High Risk	3
Hospice	7
Mental Health	1
Obesity	1
Readmission	4
Transitions in Care	1
Undecided	1
<b>Total Number of Priorities Across 15 HSAs</b>	<b>45</b>

# Thresholds and Scores

Measure	State Averages*	High Achiever (90 <sup>th</sup> Percentile)*
Adolescent Well Visit	49%	50%
Developmental Screening, Age Three and Under	43%	46%
Diabetes, Poor Control, HbA1c > 9%	12%	10%
PQI #92, Chronic Composite	6.4	4.6

**\*Data from measure period July 2013 – June 2014; January 1 payments will be based on data from January 2014 to December 2014 measure period**

Scoring	Points
Being at or above the state average	1 point
Being at or above High Achiever	3 points

# Improvement and Scores

If not High Achiever , the following change scores apply	Points
Worsening of percent or index score	0 points
Maintaining (or not achieving minimum improvement)	1 point
Improving at or above the minimum improvement	2 points

3 options for change

- 1) Relative percent change – bias towards underperformers
- 2) Absolute percentage change – bias towards small populations
- 3) Sliding relative percent change to address bias of #1; those below threshold have to achieve higher percent change than those above threshold

Example of minimum improvements:

- Absolute percentage change – Minimum difference 5%
- Relative percent change – Minimum change 10%
- Sliding relative percent change
  - HSAs below state average – Minimum change 10%
  - HSAs above state average – Minimum change 5%
- Exception – PQI #92: minimum change=median change in rates

# Scoring and Payment Eligibility

- Total potential score for each measure: 3
  - Sum of state average threshold point (1 point) and improvement points (1 or 2 points)
  - OR
  - 3 point for High Achiever
- Total possible points: 12
- Payment eligibility based on total score (3 payment levels):
  - $\geq 3$  points: \$0.06
  - $\geq 6$  points: \$0.12
  - $\geq 9$  points: \$0.25