VERMONT

State of Vermont
Department of Vermont Health Access
Vermont Blueprint for Health
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

[Phone] 802-879-5988
[Fax] 802-879-5651

Agency of Human Services

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

June 3, 2015

Attendees: S. Aranoff; J. Batra; S. Bruce; S. Cartwright; P. Cobb; R. Dooley; P.Farnham; P. Flood; J. Franz; C. Fulton; A. Garland; M. Gilbert; D. Hawkins; M. Hazard; P. Jackson; C. Jones; K. Kelley; J. Krulewitz; J. Le; S. Maier; S. Mark; M. McAdoo; E. McKenna; L. McLaren; M. Mohlman; T. Moore; S. Narkewicz; H. Pallotta; D. Prail; A. Ramsay; P. Reiss; J. Riffon; L. Ruggles; J. Samuelson; R. Slusky; B. Tanzman; T. Tremblay; J. Wallace; S. Weppler; R. Wheeler; S. Winn; M. Young

By phone: P. Biron; W. Cornwell; G. Epstein; J. Fels; S. Fine; T. Hanbridge; P. Harrington; E. Lange; P. Launer; J. Lord; T. Reinertson; J. Swayze

The meeting opened at 8:30 a.m.

I. Opening Comments: Craig Jones, MD.

- The agenda and PowerPoint slide deck were distributed prior to this meeting.

II. The purpose of today's meeting is to finalize the payment plan based on the legislative allocations. We will review a couple of options to support the new model and the integration work with the ACO's. After committee discussion, ultimately we would like to make a set of recommendations today.

III. Review Options for Payment Changes for FY2016

- This was a challenging budget year and funding issues had to be entertained. Funding hasn't changed in eight (8) years and priorities had to be laid out for policy makers. The three (3) priorities are as followed:

    1. New medical home payments are critical to a) keep practices in the program and; b) undertake new work in the community collaboratives.

2. Shore up CHTs. The Insurer market share has changed dramatically in Vermont. Department of Vermont Health Access (DVHA) attorneys have agreed that CHT payments need to be based on market share and adjusted on a routine basis. If we do not move to a market share adjustment, we will be significantly underfunding the CHT's over the next 6 months. A market share adjustment is needed for the CHT's to remain stable.

3. In order to shore up CHTs, we needed to increase payments by $4-5 million. The Legislature has actually appropriated $2.4 million for FY16.

- Dr. Bob Wheeler stated that funding on the commercial side is dependent on Green Mountain Care Board (GMCB) approval. This leads to a timing issue. Dr. Wheeler also stated the commercial world is providing money without federal match. Taxpayers paying BCBS premiums are also contributing to Medicaid increases. Craig Jones responded that Medicare's market share is in alignment and Medicare will actually be paying close to current market share. Dr. Wheeler - Due to the size of the program, it is the Executive Committee that should be providing input. Response: The way statute is written, the Blueprint Planning and Evaluation Committee provides recommendations into the payment and planning process for the program. (all members of the Executive Committee are automatically members of the Blueprint Planning and Evaluation Committee) We are going to stick to that process.

- C. Jones presented to the group a <u>Balanced Option</u> (*slide #7*). The Balanced Option addresses both priorities one (1) and two (2) in the first fiscal year vs. PCMH payment model only.

  - Highlights include:

    1. PCMH payment increases will not start until January 1, 2016, are estimated to effectively double current PCMH payment levels in the first year, and the cost will be $1.2 million.
    2. We could use CHT market share adjustment as of July 1, 2015 (at least Medicaid's portion to shore up CHTs), and the cost will be $1.19 million.

  Details of the proposed Balanced Option have been specified in the latest draft revisions of the Blueprint Manual posted on the Blueprint website.

  - Lou McLaren expressed concerns that their results can't be calculated on a six (6) month period because the new PCMH model includes utilization and quality payments. C. Jones responded we can do rolling twelve (12) month results every six (6) months; adjusting the incentives twice per year. This is worthy of discussion and more planning needs to be done on the benchmarks.

  - P. Harrington feels the legislation is explicit and that the funding of the appropriated money to increase both PCMH and CHT payments begins on July 1, 2015. The Medical Society's position is to direct a portion of $2.4 million to PCMHs as of July 1st rather than waiting until January 1, 2016. P. Harrington requested the opinion of DVHA's legal counsel. C. Jones responded that in

discussion with Conference Committee policy leads, the use of the money was left to the discretion of Blueprint. P. Harrington plans to discuss this with Bill Lippert as well as chairs, and plans to contest it through Conference Committee if DVHA counsel disagrees with Medical Society's interpretation.

- C. Jones stated the implications of doing nothing for CHT market share in July are substantial. C. Jones recognized the importance of the rate setting process, but there are other implications and bigger discussion that needs to take place here. P. Harrington suggested that funding for both start in July; Allan Ramsay suggested looking at the appropriation itself. The best argument to legislature is that there have been savings achieved through this model of care. These savings are reflected in our own evaluation as well as CMS' evaluation of Medicare. C. Jones emphasized that A. Ramsay made a good point and savings are far outpacing investments by insurer.

- Dr. Wheeler stated if CHT community wide held at no increase, that money only partly funds the full proposal for PCMHs. Given the proposed shift to market share approach to CHTs, Medicaid will be unable to pick up its share of CHTs on a market share basis and simultaneously fund the PCMHs. 25% reduction in CHTs for first six (6) months and 12% reduction over twelve (12) months. This will reduce the payment overall to PCMHs; instead of $3.50 PPPM, move down to $2.90 PPPM. C. Jones responded he would like to see the numbers and allocations of money that Dr. Wheeler is proposing.

- Patrick Flood would like to see dollar amounts attached to the Medical Home Payment Modifications diagram. From the medical home perspective, it may be premature to allocate for half the year. To have a balanced proposal, both new payment streams should start at the same time. The remaining balance can be moved towards the payment of CHT.

- Richard Slusky proposed there may be an opportunity for SIM money to bridge the gap between July and January for these types of payments. R. Slusky is not sure if it's possible but would like to explore the options. C. Jones stated his understanding is that SIM funds could not be used to directly support providers, which Jenney Samuelson confirmed at the end of the meeting.

- P. Harrington stated he is not optimistic about the long-term horizon for Medicaid reimbursement. He does not see how delaying PMPM payments for six (6) months could increase funding. C. Jones responded if you lock in higher PCMH payment rate in FY16 those rates would continue into FY17. DVHA's challenge would be to find the funding for CHTs in FY17. Todd Moore suggested throwing in as much as incentive you can throw in now because in FY17, the incentives will be higher. This could also solve the CMMI hold up on the SIM funding because it shows all parties are in alignment (Blueprint/ACO, etc.).

• C. Jones presented the <u>Community Health Team Payment Based on Market Share</u> *(slide #9).* Without Medicaid and BCBS increases as of July 1st, there will be an additional $1.17 million

funding gap between July and December 2015. This will result in CHT job losses and will erode confidence in the PCMH model supported by multi-disciplinary teams.

  - R. Slusky asked if we are being literal about legislative language, which requires insurers to pay Blueprint under the Blueprint rules for CHT payments and PMPMs, why are Cigna and MVP allowed to make unilateral reductions in their payments, which seems to be counter to legislation? DVHA's legal counsel, Howard Pallotta, responded that Cigna filed an appeal on basis that statute requires market share for CHT payments. Legal counsel found CIGNA to be right. This structure is a legal structure. The contracts expire on June 30. Andrew Garland stated that MVP does not mind subsidizing Medicare and Medicaid, but asking one commercial carrier to subsidize another is not appropriate. MVP lost money in state in 2014 and rates were cut in 2015. Dr. Wheeler mentioned BCBS does believe the market share approach is correct. What GMCB approves may be different than what C. Jones is requesting. A solution to this is embedded in Blueprint document which requires collaboration between GMCB, DRF and legislature.

  - Penrose Jackson pointed out because there have been no new increases; there has been a 7% decrease over time in the Burlington CHTs. Moral of the employees will be weakened.

- C. Jones gave an overview of who the CHTs are serving (*slide 14*). The assumption that CHTs are only caring for Medicare and Medicaid is inaccurate. A significant commercial population is being served. State wide about 36% commercial, 42% Medicare, and the rest Medicaid.

- 2016 could bring major developments. To be most effective, this needs to be a complete uplift in the community model and moving to a community health system structure. Any adverse impact could diminish progress that can be made this year. Negotiations on finance and trends won't directly translate into changes on the ground in delivery system strengthening; we don't want to lose the mission in 2016.

    1. T. Moore questioned what percentage of the money will go to hospital-employed PCMHs? He suggested that hospitals (who in most cases are the administrative entities for CHT's) might be able to use PCMH payments in part to shore up their CHT's in the short term.

    2. In summary, there was a clear commitment in the room not to undermine the progress of the CHT's, as well as a demand to further explore the option of starting PCMH payment increases in July. We will examine all options and reconvene this group again before July 1st.

With no further time, the meeting adjourned.

Executive Committee
Planning & Evaluation Committee

June 3, 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 thru Blueprint grants
- Comparative performance reporting to guide initiatives
- New NCQA scoring process

Funding Priorities to Support Reforms

1. Implement new medical home payment model
2. Implement CHT payment model based on insurer market share
3. Increase CHT payment amounts

Appropriation

Journal of the House, Saturday, May 16, 2015:

Sec. 56. BLUEPRINT FOR HEALTH INCREASES

(a) The sum of $2,446,075.00 in Global Commitment funds is appropriated to the Department of Vermont Health Access in fiscal year 2016 to increase payments to patient-centered medical homes and community health teams pursuant to 18 V.S.A. § 702 beginning on July 1, 2015.

Decision Points

- Need to determine best use of the new appropriation
- $2,446,075.00 is adequate to cover Medicaid's annual increase for the new PCMH payment model
- There is an important need to stabilize CHT operations with a market share based payment model even if there isn't money to increase overall CHT payments
- Discuss options: New PCMH & CHT payment model vs. new PCMH payment model only

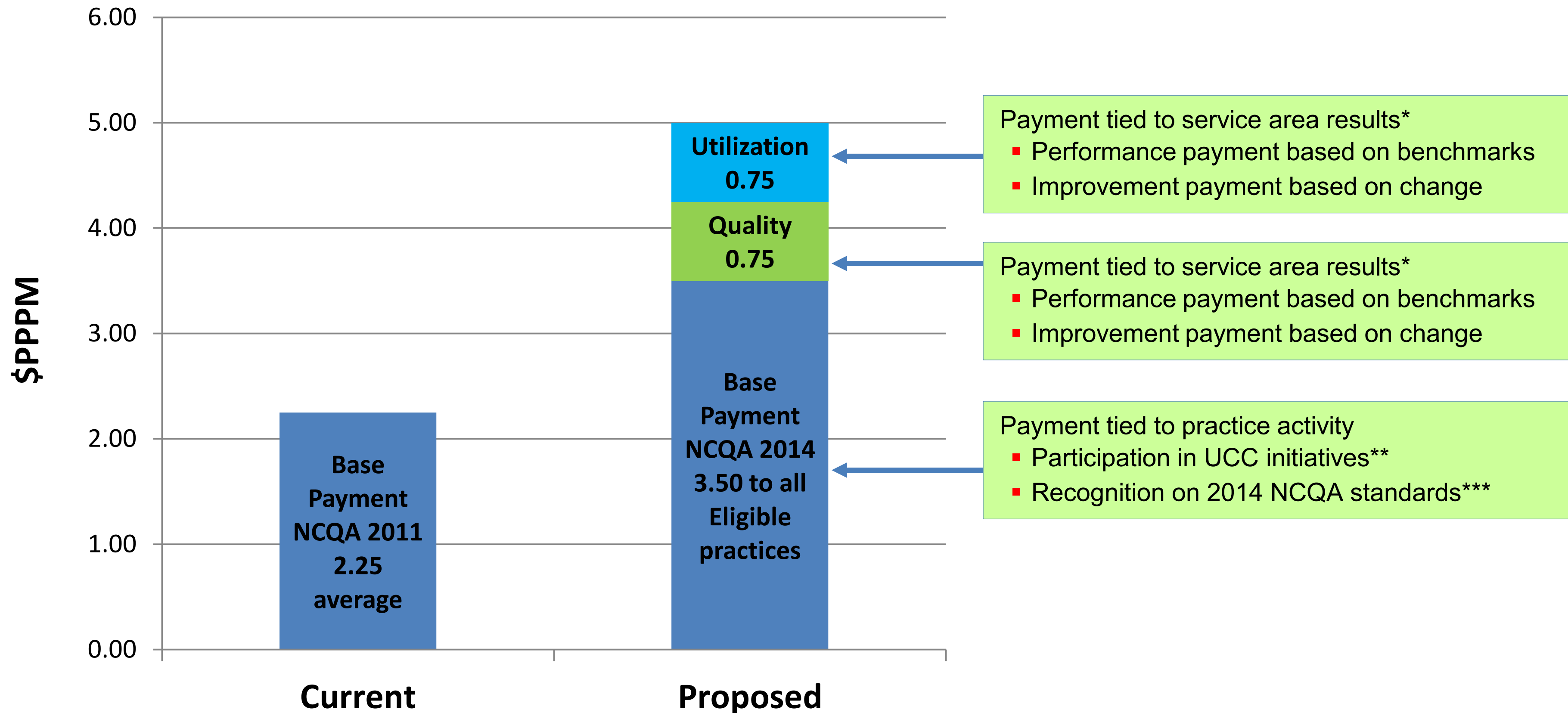
Options for FY16 Appropriation ($2,446,075)

Balanced Option

- New PCMH Payment Model Starts January 1, 2016
- CHT Market Share Adjustment Starts July 1, 2015

Action	Year	Start	End	Additional Cost
PCMH Payment	.50 FY16	01/01/2016	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

Medical Home Payment Modifications



*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. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

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)

Balanced Option

- Medicaid PCMH increase requires $1,216,933 for FY16 (01/01/2016 start)
- A 01/01/2016 PCMH start would leave $1,216,933 available in FY16
- This would cover Medicaid portion of CHT market share adjustment (FY16)
- The full $2,433,867 will be needed for PCMH payment in FY17
- Monies to cover costs above $2,433,867 need to be identified for FY17

Options for FY16 Appropriation ($2,446,075)

PCMH Only Option

- New PCMH Payment Model Starts July 1, 2015

Action	Year	Start	End	Additional Cost
PCMH Payment	1.0 FY16	07/01/2015	06/30/2016	$2,433,867
CHT Market Share				
Total				$2,433,867

PCMH Only Option

- Medicaid increase for PCMH payment requires $2,433,867 (07/01/15 start)
- Other insurers would start new payments 01/01/15
- The full $2,433,867 would be needed for PCMH payment in FY17
- Medicaid would not have funds for CHT market share in FY16
- CHTs are not stabilized and risk losing staffing

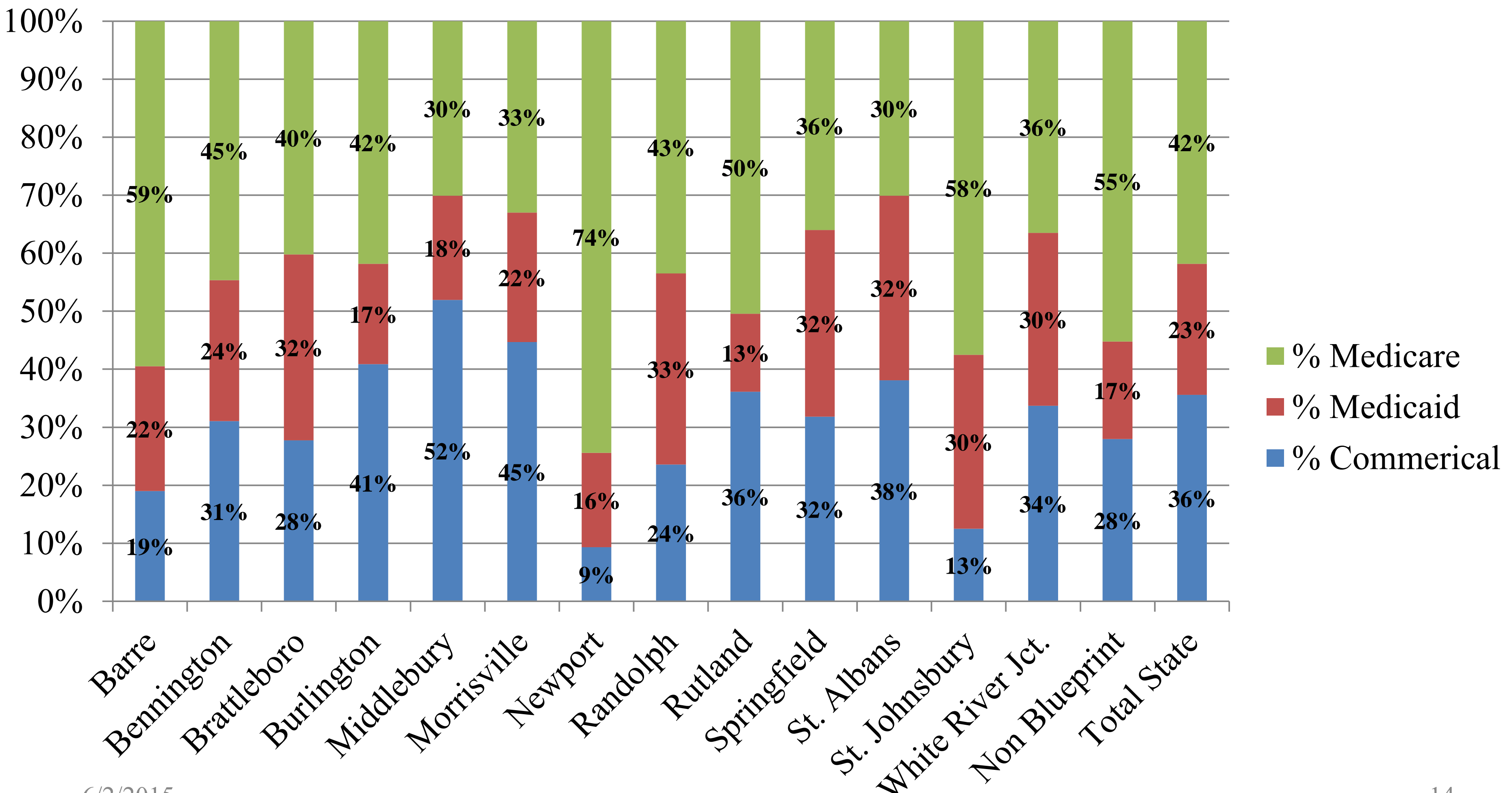
Medicare's MAPCP Demonstration: Findings for Vermont

- "Payments are insufficient to support practices and CHTs. Broadly, stakeholders agreed that the Blueprint payments were no longer sufficient to support practices' and CHTs' operational costs and cost of living wage increases for staff."

- "During the 2014 site visit, practices reported an increase in the use of CHTs to better coordinate care for patients."

- "By and large, we heard that the CHTs were the most visible PCMH feature to patients over the past year. The CHTs refer patients to Healthier Living Workshops, and tobacco cessation programs, follow up and encourage patients to schedule preventive care appointments, coordinate patient care between primary care practices and other providers or facilities, and follow up with patients after discharge from the ER. Practices love that these resources are available for their patients and agree that the education the CHTs provide is helping with patient self-management."

Community Health Team Contacts by Payer



PCMH Payment Changes

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	Doubled Annualized PCMH Costs	Doubled Annualized Cost Difference	Percent Change From Current Costs
BCBSVT	$2,509,918.60	100,099	35.51%	$5,019,837.20	$2,509,918.60	100.00%
Cigna	$30,965.36	1,285	0.46%	$61,930.72	$30,965.36	100.00%
Medicaid	$2,433,867.00	101,084	35.86%	$4,867,734.00	$2,433,867.00	100.00%
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%	$642,644.64	$321,322.32	100.00%
Total	$6,915,363.16	281,880	100.00%	$12,211,436.44	$5,296,073.28	76.58%

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