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**Department of Vermont Health Access**
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# Combined Meeting of The Blueprint Executive Committee and Blueprint Expansion, Design and Evaluation Committee March 25, 2015

***Attendees*** D. Andrews; S. Aranoff; J.Batra; S. Cartwright; P. Clark; C. Collins; W. Cornwell; R. Dooley; P. Dupre; N. Eldridge; E. Emard; J. Evans; P. Farnham; J. Fels; S. Fine; M. Halnon; T. Hanbridge; J. Hester; M. Hazard; P. Jackson; C. Jones, J. Krulewitz; K. Lange; J. Le; L. MacLaren; C. MacLean; M. McAdoo; M. Mohlman; T. Moore; S. Narkewicz; J. Peterson; D. Ransmeier; P. Reiss; L. Ruggles; J. Samuelson; R. Slusky; K. Suter; B. Tanzman; T. Tremblay; S. Weppler; R. Wheeler; S. Winn

The meeting opened at 8:30 a.m.

I. Opening Comments: Craig Jones, MD.

- The *Proposal for Delivery System Reforms: Phase II Payment Reforms* document was e-mailed to the committee in advance of this meeting. We want to be ready to implement the plan if payment increases recommended by the Governor are passed by the legislature and become available on January 1, 2016.
- Planning the new financing model for 2017 is ongoing.
- Our discussion today will be concentrated around payment and we look to our committee members for recommendations around payment modifications. The four components include:

  i. Increase PCMH amounts linked to new payment model
  ii. Shift to composite measures based payment for PCMHs
  iii. Increase CHT payments and capacity
  iv. Adjust insurer portion of CHT costs to reflect market share

II. Review Proposals for Transition to Community Health Systems, Unified Collaborative Structure, New Payment Models and Related Poll of Committee Members

- Discussed proposed changes to Blueprint payments and Blueprint for Health Manual, per Craig Jones' slide presentation: market-share basis for CHT payments effective July 2015; doubling of CHT payments effective January 2016; doubling of PCMH payments and new criteria for PCHM payments effective January 2016.

- Dr. Wheeler asked that there be coordination with the GMCB so that funding increases can be part of the premium planning process. BCBS intends for the increases to be included in this year's rate setting process.

- *Lou McLaren* – Lou voiced concern that measuring and issuing payment on quality measures has not previously been a part of the PCMH process before. Craig responded that the measures are being picked from the ACO measure set against which the practices have been benchmarking and monitoring performance over the past 2 years. The practices and systems have had at least 2 years of experience with payments linked to these measures. They have also received Practice Profiles and HSA profiles reporting on utilization (Claims).

- *Kara Suter* – Kara requested a list of measures before the end of the year. Medicaid will need Federal approval. Therefore, more detail on the measurement selection process is needed in order to build in an appropriate timeline for the Feds.

  *Response*: We will be selecting a subset of measures which have been included in the practice profiles. We are currently working on selecting the measures and coming together on agreement on the benchmarks. Initially payments would be based on agreed upon benchmarks with the ACO's. There are a series of core ACO measures that can be generated on claims data. We would reward achieving both benchmarks and improvement. Rewarding communities for past collaboration and benchmark achievement based on past performance will incentivize other communities for future level of collaboration. Dropping back to the practice level would be a loss since the intent is to stimulate the interdependence at the community level.

- *Todd Moore* – When is the right time to start rewarding value? If not 1/16, when is the right time? Everything cannot fall on 1/1/17, when as a collective state we may have a one-time collective pot of money. CMS contributions to the Blueprint sunset on 12/31/16. Medicare is not participating in the increases. Medicaid's participation is based on legislature approval. Having a pay-for-performance component may help sell concept to more self-insured employers to pitch in.

- *Craig Jones* – The proposed process is to move to a market share basis which each insurer will pay on their share of CHT costs. Once that adjustment is made, double the CHT payments.

- *Dr. Wheeler*, on behalf of BCBSVT, objected to having the Blueprint Expansion Design and Evaluation Committee polled on the question of whether BCBSVT's Community Health Team (CHT) payments share, for the first calendar quarter of 2015 and forward, should be increased by 4.56% of total CHT costs, to account for the shift of the Vermont State Employees Health Plan members from Cigna to BCBSVT. Requested that Question #6 be removed from the survey.

  *Craig stated* that this will be taken under consideration. DVHA leadership and attorneys need to revisit and regroup with BCBSVT.

- 2010 Statute (Act 128) states that the Blueprint can make changes to payment methodologies (general recommendations) with the approval of this committee. We want to gather recommendations on the basic aspects and structure of the proposed model itself. Statute calls for the Expansion, Design and Evaluation Committee to make recommendation, which includes, but is not limited to, the Executive Committee. There may be issues around specific details, but globally do we have agreement with the proposed increase in the payments? People need to budget for these increases in payments. This committee needs to give a clear yes/no signal regarding the proposed increases. That is what the statute calls for.

With no further time, the meeting adjourned.

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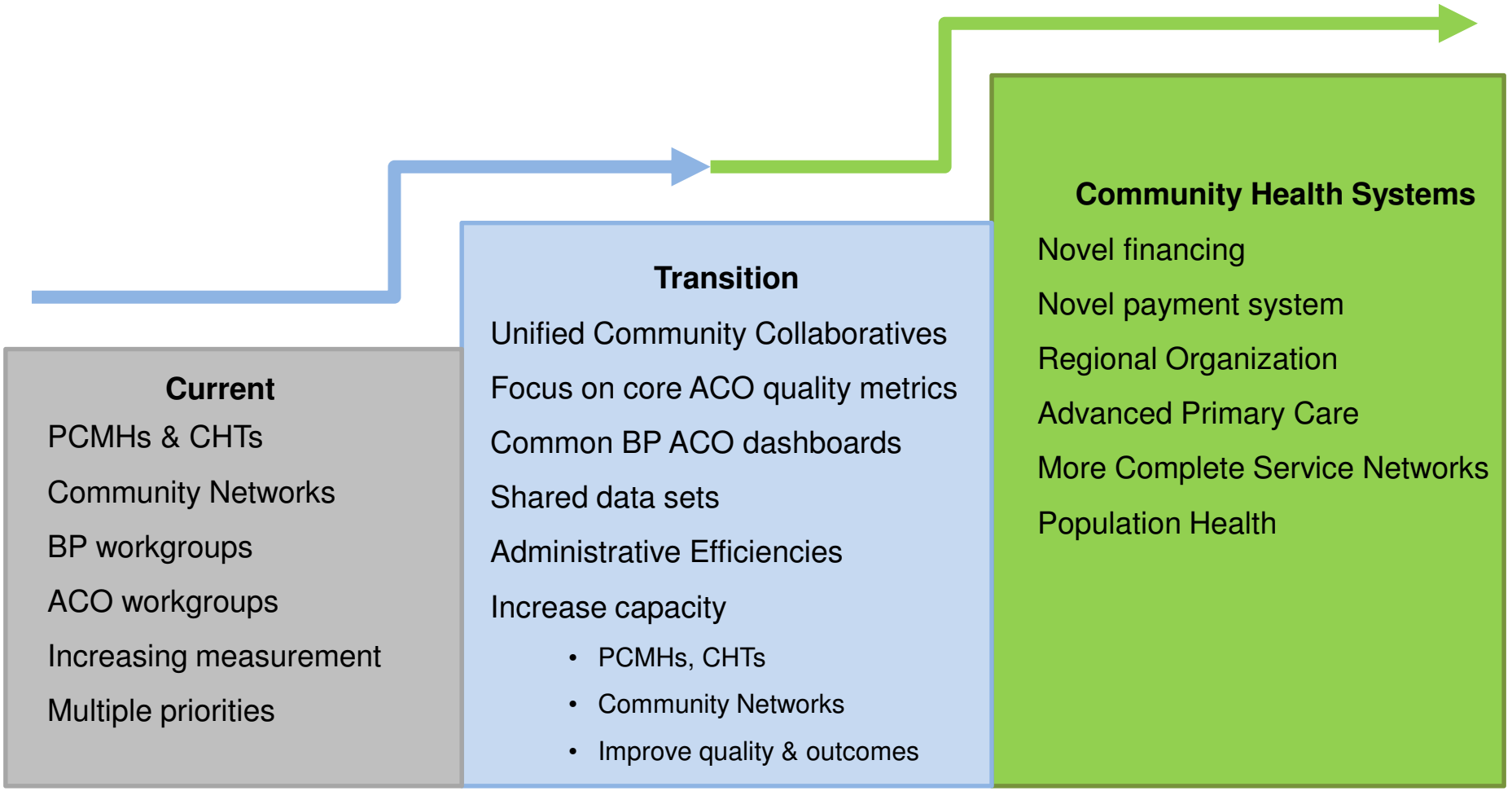
# Blueprint Plan

# Executive Committee
# Expansion, Design & Evaluation Committee

# March 25, 2015

# Transition to Community Health Systems



# Strategy for Building Community Health Systems

## Action Steps

- Unified Community Collaboratives (quality & coordination initiatives)
- UCC Leadership Team (3 ACOs, DA, VNA, AAA, DRHO, Peds, ad hoc)
- Collaborative Performance Reporting & Data Utility
- Increase PCMH and CHT payments
- PCMH: Base Payment + Service Area Performance
- CHT: Each insurers share tied to PCMH market share (attribution)

# Unified Community Collaborative (UCC)

## Overview

- Leadership Team (up to 11member team)
  - 1 local clinical lead from each ACO (2 to 3)
  - 1 local representative from VNA, DA, SASH, AAA, Peds
  - Additional ad hoc members chosen locally
- Use measure results and comparative data to guide planning
- Planning & coordination for quality initiatives & service models
- Project managers provide support (convening, coordination)
- PCMHs & CHTs participate in quality initiatives

# Performance Reporting & Data Utility

## Reporting & Comparative Performance

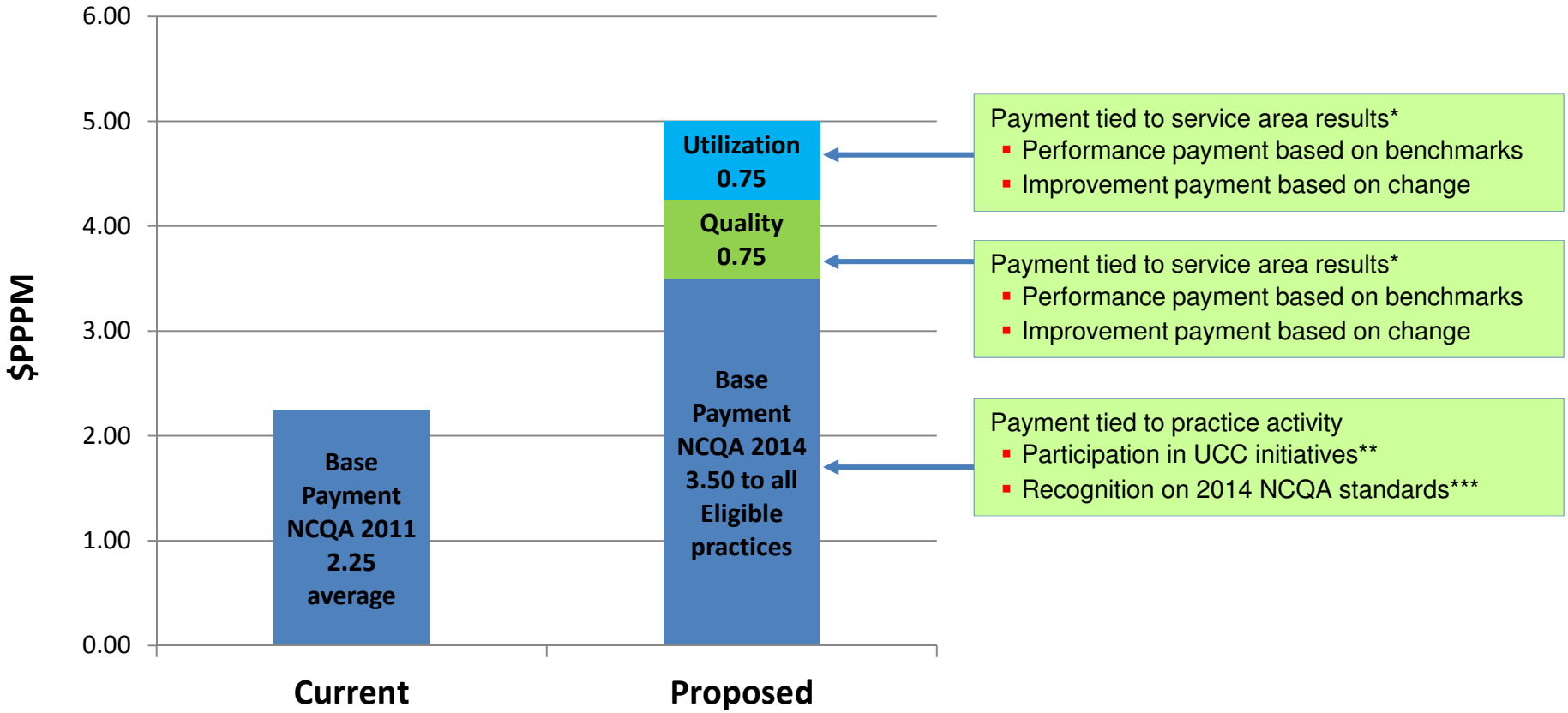
- Profiles for each medical home practice
- Profiles for each Health Service Area
- Whole population results (MCAID, MCARE, Commercial)
- Measures - Expenditures, utilization, quality (core ACO for HSAs)
- Can help guide collaborative work & performance payments
- Produced every 6 months (rolling 12 month look back)

# Payment Modifications

## Recommendations

- Increase PCMH payment amounts
- Shift to a composite measures based payment for PCMHs
- Increase CHT payments and capacity
- Adjust insurer portion of CHT costs to reflect market share

# Proposed 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.

# Proposed Modifications to CHT Payments (example only)

| | Current Share of CHT Costs | Current Annual CHT Cost | Proposed Share of CHT Costs | Proposed Annual CHT Cost | Differential (annual) |
|---|---|---|---|---|---|
| | | Based on $1.50 PPPM and current cost allocations | Based on percentages of attributed beneficiaries | Based on $3.00 PPPM for non-Medicare, and new cost allocations | |
| Medicare* | 22.22% | $2,150,229 | 22.22% | $2,150,229 | $0 |
| Medicaid | 24.22% | $2,343,768 | 35.66% | $6,901,634 | $4,557,865 |
| BCBS | 24.22% | $2,343,768 | 36.92% | $7,145,494 | $4,801,725 |
| MVP | 11.12% | $1,076,082 | 4.71% | $911,573 | -$164,509 |
| Cigna | 18.22% | $1,763,149 | 0.49% | $94,835 | -$1,668,314 |
| Total | 100.00% | $9,676,996 | 100.00% | $17,203,763 | $7,526,767 |

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

# Community Oriented Health Systems


- Core measures set priorities and provide a statewide framework
- Portion of medical home payment model tied to community outcomes
- Community collaboratives guide quality & coordination initiatives
- Shared interests stimulate goal oriented health services & networks
- Health System (Accessible, Equitable, Patient Centered, Preventive, Affordable)

# Blueprint Committee Recommendations

**2010 ACT 128**

**§ 706. HEALTH INSURER PARTICIPATION**

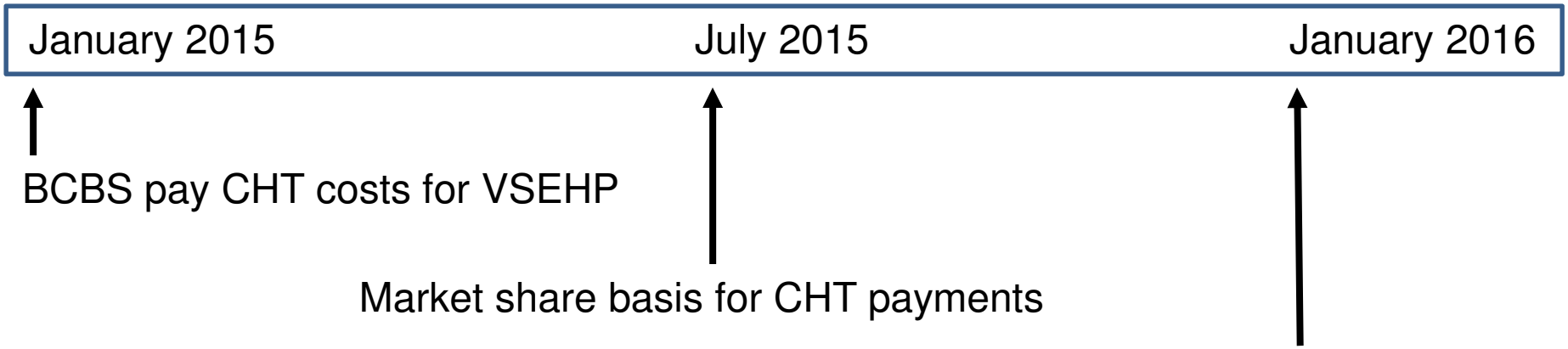
***

(c)(1) The Blueprint payment reform methodologies shall include per-person per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating the community health teams. Per-person per-month payments to practices shall be based on the official National Committee for Quality Assurance's Physician Practice Connections – Patient Centered Medical Home (NCQA PPC-PCMH) score and shall be in addition to their normal fee-for-service or other payments.

(2) Consistent with the recommendation of the Blueprint expansion design and evaluation committee, the director of the Blueprint may implement changes to the payment amounts or to the payment reform methodologies described in subdivision (1) of this subsection, including by providing for enhanced payment to health care professional practices which operate as a medical home, payment toward the shared costs for community health teams, or other payment methodologies required by the Centers for Medicare and Medicaid Services (CMS) for participation by Medicaid or Medicare.

# Blueprint Committee Recommendations

## Timeline



# Blueprint Committee Recommendations

## Adjust for State Employee Health Plan Shortfall

Should Community Health Team (CHT) payments paid by Blue Cross Blue Shield and Cigna be adjusted to account for a change in their overall market share due to the shift of the State Employees Health Plan:

The State Employees Health Plan, a self-insured plan that has opted into the Blueprint, changed carriers from Cigna to Blue Cross Blue Shield. Blue Cross Blue Shield's share would increase by 4.56% of total CHT costs and Cigna's share would decrease by 4.56% of total CHT costs effective immediately and applicable to quarter 1 of 2015 (January 1, 2015 to March 31, 2015) and forward (Yes, No, No Response).

# Blueprint Committee Recommendations

## Adjust CHT Payment to a Market Share Basis

Should the formula for payer contributions to Blueprint Community Health Teams (CHTs) be changed, effective July 1, 2015, as follows:

Payments will be based on payer-reported, claims-attributed patient-counts, and thus be based on market share of medical home patients. An adjustment to the CHT per-patient-per month amount would be made so that the total CHT payments would be maintained at the current levels (Yes, No, No Response). (Details are described in the Draft Blueprint Manual effective July 1, 2015.)

# Blueprint Committee Recommendations

## Double CHT Payment Amounts

Should the Blueprint Community Health Team (CHT) Per Patient Per Month (PPPM) payment rate be doubled from the adjusted July 1, 2015 level, effective January 1, 2016 (Yes, No, No Response)?

# Blueprint Committee Recommendations

## Double PCMH Payment Amounts

Should the average effective Blueprint Patient-Centered Medical Home (PCMH) Per Patient Per Month (PPPM) payment rate be doubled from 2015 levels, effective January 1, 2016 (Yes, No, No Response)?

# Blueprint Committee Recommendations

## New PCMH Payment Model

Should changes be implemented to the payment method for Blueprint PCMH PPPM payments, consistent with the Blueprint Phase II Payments and ACO Integration Plan, effective January 1, 2016 (Yes, No, No Response). (Details of the model are described in the Draft Blueprint Manual effective January 1, 2016.)

# Blueprint Committee Recommendations

## Survey Process

- Send out materials (Integration Plan, Updated Blueprint Manuals)
- Send out survey to committee members (one vote per organization)
- Tally survey results
- Finalize payment model & implementation details
- Execute on plan