# Blueprint for Health
## Executive Committee
## Planning & Evaluation Committee

September 20, 2017

# Agenda September 20, 2017

- Welcome & Blueprint Program Status
- Medicare PCMH, CHT and SASH Payments CY 2018 - Discussion
- Women's Health Initiative – Program Implementation
- Payment Manual Updates

# Current State of Play in Vermont

- Statewide foundation of primary care medical homes
- Community Health Teams providing supportive services
- Statewide transformation and learning network
- Maturing community collaboratives, accountable communities for health
- Community initiated prevention framework (RISE-VT)
- HIE Assessment & opportunity to re-set business case for data aggregation, data exchange, whole population measurement
- All payer model agreement
- Expanding network of providers and payers in ACO risk-bearing arrangements

# Health Services Network

| Key Programs | # Practices | # Providers | # Patients | CHT Staff FTEs |
|---|---|---|---|---|
| PCMH | 134 | 782 | 351,198 | 158.6 |
| MAT - Spokes | 77 | 212 | 2,605 | 63.2 |
| SASH - DRHOs | 6 | n/a | 4,741 | 54.37 |
| WHI - WH Practices | 19 | 117 | 11,937 | 7.75 |
| WHI - PCMHs | 13 | 109 | 4,704 | n/a |

Note: Practices and providers may participate in multiple Blueprint Programs and as a result they and their patients may be attributed and counted multiple times in the above table. CHT staff represent actual FTEs the total which statewide is 283.92 FTEs.

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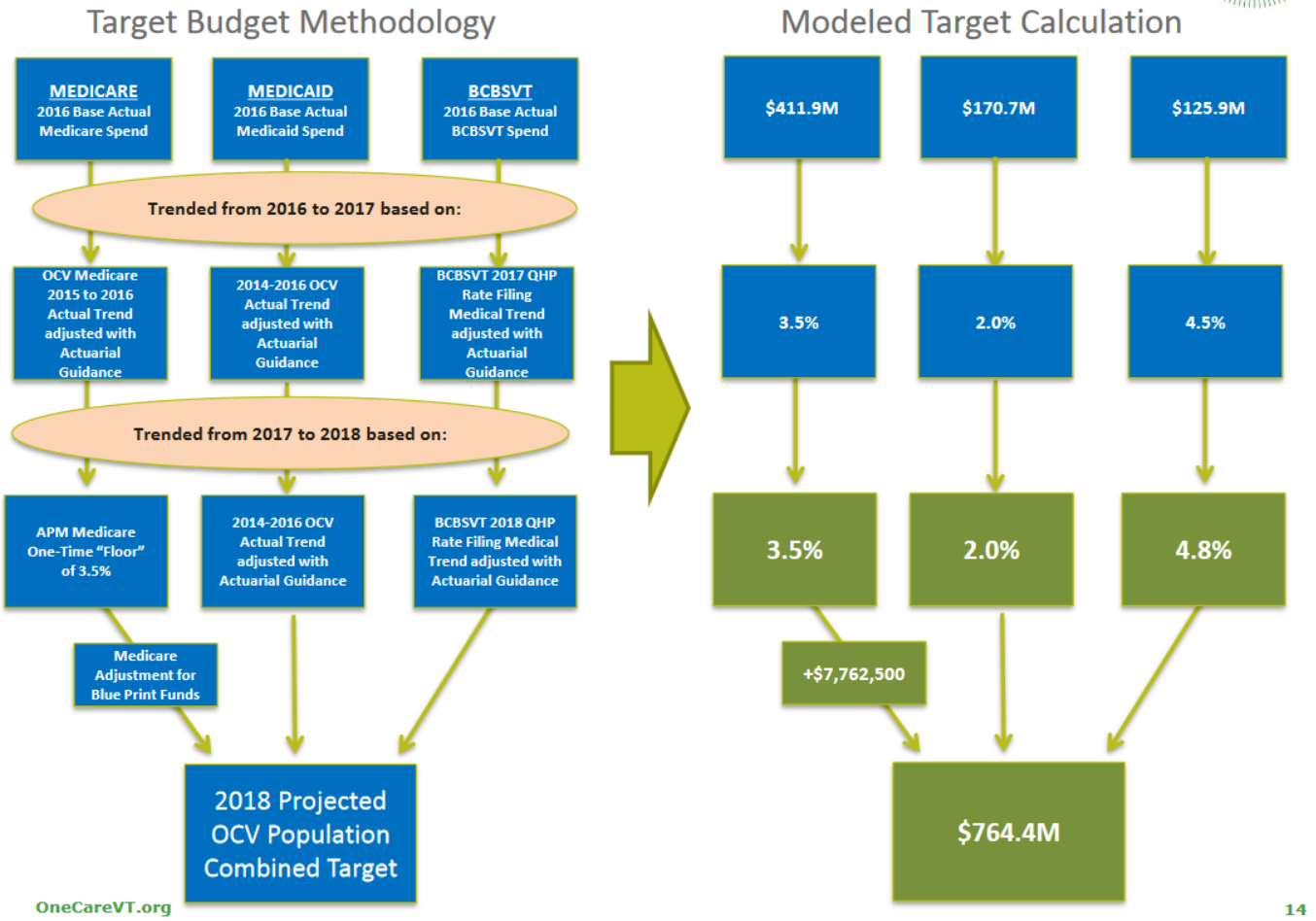
# Budgeting 2018 Program Targets



# Agenda July 19, 2017

- Welcome
- Medicare PCMH, CHT and SASH Payments CY 2018 - Update
- **NCQA 2017 PCMH Recognition Process**
- RTI Final Evaluation of the Medicare Advanced Primary Care Practice Demonstration (MAPCP)
- Program Updates

# Medicare Blueprint Funding 2018

- Medicare funds for Blueprint support:
  - Patient Centered Medical Homes Per Patient per Month (PMPM)
  - Community Health Teams
  - Supports and Services at Home (SASH)

- Available funding from Medicare is less than the estimated annual cost of the program by -$120,165.36 if no part of the program is increased by 3.5%

# Medicare Funding For Blueprint Current

| Blueprint Programs | Calendar Year 2018 |
|---|---|
| PCMH PMPMs | $1,932,413 |
| CHTs | $2,245,853 |
| SASH | $3,704,400 |
| **Total** | $7,882,665 |
| **Available 2018 Medicare Funding** | $7,762,500 |
| **Shortfall** | (-$120,165) |

# Proposed Payment Change

Change Patient Centered Medical Home Per Member per Month Payment (PCMH PMPM) to a common base payment of $2.00

- Under the 2017 Standards which went into effect on April 1, 2017, NCQA eliminated assigning a score from 0 to 100 for PCMH recognition
- Changing to a common PCMH PMPM base payment aligns Medicare with other insurers
  - In 2016 with the exception of Medicare, the Blueprint under the advice of providers shifted away from basing PCMH PMPMs on the NCQA score
  - Providers felt strongly that Incenting higher NCQA scores increases the administrative burden of scoring without enhancing clinical value

# Adjust PCMH Payments with a Common Base $2.00

| Blueprint Programs | Calendar Year 2018 |
|---|---|
| PCMHs PMPM $2.00 | $1,830,264 |
| CHTs | $2,245,853 |
| SASH | $3,704,400 |
| **Total** | $7,780,517 |
| **Available 2018 Medicare Funding** | $7,762,500 |
| **Shortfall** | (-$18,017) |

# Market Share and Impact of Common Base $2.00

| Practices Receiving Medicare $ | 112 | 100% |
|---|---|---|
| Independent Practices | 28 | 25% |
| FQHC-Owned Practices | 39 | 35% |
| Hospital-Owned Practices | 45 | 40% |

| Impact of a Common $2.00 | % Change Overall | $ Change Overall | Average Change By Site |
|---|---|---|---|
| **Statewide** | **-4.03%** | **-$102,149** | **-$912** |
| % Change Overall for Independent Practices | -2.63% | -$7,541 | -$269 |
| % Change Overall for FQHC-Owned Practices | -4.52% | -$34,699 | -$890 |
| % Change Overall for Hospital-Owned Practices | -4.47% | -$59,909 | -$1,331 |

Predict 2018 funding based upon annualized 2017 funding

# Comparison Of Payment Options

| Blueprint Programs | CY 2018 3.5% Increase All | Divide shortfall equally | CY 2018 $2.00 PCMH PMPM |
|---|---|---|---|
| PCMHs PMPM | $2,000,047 | $1,892,358 | $1,830,264 |
| CHTs | $2,324,457 | $2,205,797 | $2,245,853 |
| SASH | $3,834,054 | $3,664,345 | $3,704,400 |
| **Total** | $8,158,559 | $7,762,500 | $7,780,517 |
| **Available 2018 Medicare Funding** | $7,762,500 | $7,762,500 | $7,762,500 |
| **Shortfall** | (-$396,059) | (-$0) | (-$18,017) |

*All models predict 2018 funding based upon annualized 2017 funding

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July 2016

*"Building a Healthy Bennington"*

# Women's Health Initiative (WHI)

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**Key Partners**: Bennington Blueprint Community Health Team and Spoke Program, Department of Health - Bennington Office, Ladies First, Nurse Family Partnership, Planned Parenthood, Sunrise Family Services, SVMC OB/GYN, United Counseling Services, PAVE **Vermont Blueprint for Health State Leadership**: Beth Tanzman, Jenney Samuelson, Nissa Walke **Physician Champion**: Themarge Small, MD **Local lead**: Jennifer Fels

## Program Goals

1. Increase the Vermont intended pregnancy rate from 50% to 65%
2. Identify women/families at risk and refer to services
3. Coordinate services across the community
4. Early identification of substance use disorders and other risk factors, refer and engage in treatment

## Program Components

- Social Worker Staffing in the WHI Practice
- Screening of High risk women and families
- Per member per month payment to eligible practices participating in the WHI program
- Capacity Payments to stock a supply of long acting reversible contraception (LARC) in the practice
- Coordination of services for at risk women and families

## Target Population

Vermont Medicaid beneficiaries, Women ages 14 – 44

## High Level Workflow

Women are screened the one key question: Do you want to become pregnant within the next year? And, evaluated for other risk factors such substance use disorder, safety, heavy alcohol use, housing, partner violence and food insecurity.

- Women who do not want to become pregnant in the next year are referred to SVMC OB/GYN.
- Women who screen positive for risk factors are referred for services.

With patient consent: Patient/client follow-up and engagement in services or treatment are communicated to the referring provider and coordinating agencies/services.

## Collaboration and Care Coordination

Team risk screening results, referrals and follow-up are communicated with the OB or Pediatric Practice. The Blueprint case manager in the Pediatric and Spoke Practices follows the population across Pediatric and Spoke setting in collaboration with the WHI Team. Communication, coordination and engagement is not limited to the WHI Team.

### WHI Team

Blueprint CHT
Blueprint Spoke Program
Children's Integrated Services
Department of Health
Ladies First
Nurse Family Partnership
PAVE
Sunrise Family Services
SVMC OB/GYN
United Counseling Services

**SVMC Safe Arms Program SVMC Women's and Children's Service**

**Bennington HSA Pediatric Practices**

**SVMC OB GYN**

# Social Worker Referral Data

| Type of Referral | May 17 | June 17 | July 17 | Aug 17 | Sept 17 |
|---|---|---|---|---|---|
| Primary Care | | | | | |
| Housing Stability | | 3 | 1 | | |
| Food Insecurity | | 2 | 2 | | |
| Intimate Partner Violence | | | | | |
| Adverse Childhood Experiences | | | | | |
| Mental Health | 1 | 4 | 7 | | |
| Substance Use | | | 1 | | |
| Education | | | | | |
| Other | 4 | 12 | 6 | | |
| Total Referrals | 5 | 21 | 17 | | |
| Total patients | 4 | 21 | 17 | | |

**Services/organizations receiving referrals**

Dental Services
Designated Agency
Nurse Family Partnership
Food Stamps
Neighbor Works
Family Court
VT Health Connect
Shires Housing
Dietitian
BROC
Lund Center
Sunrise Family Services
VCCI
WIC
Bennington Free Clinic

# *Key* team actions

- Use of standard screening tool
- Capacity for next day appointments
- Communications among community partners and the practice
- Monthly meeting of partners to address high risk patients
- Extended reach to pediatric, inpatient and Spoke services

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# What is different for patients?

- Timely access to services
- A wrap around team to address social determinates of health
- Medical model is integrated with social services

”The addition of the social worker to our practice is a game changer”

T. Small, MD

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# Proposed Blueprint Manual Updates

For Final Review:

- Section 4.3.2 – NCQA Scoring and Section 5.3 - NCQA Recognition and PCMH PPPM and CHT Payments
  - Definition of a Blueprint practice has been expanded to include those practices that start the engaging process with NCQA. All associated references to "Blueprint-frontloaded practices" have been removed.
- Section 6.3.3 – WHI Practice PMPM Payment
  - WHI performance payment methodology has been added to this section.
- Section 6.5 – Participation in the WHI for Patient Centered Medical Homes
  - The WHI PMPM payment has been extended to Patient Centered Medical Homes effective October 1, 2017.

For Initial Review:

- Section 5.1 Patient-Centered Medical Home (PCMH) Payments
  - Calendar Year 2018 Medicare PCMH Payments will be calculated using a standardized $2.00 PMPM.