Blueprint for Health
combined
Executive Committee
Planning & Evaluation Committee

September 16, 2020

Agenda

- Welcome & Updates
- Integrated Community Care Management Learning Collaborative Study (became the foundation of the OCV Care Model)
- Discussion: Initial Proposals of the OCV Primary Care Work Group in Development
- Initial Articulation of Guiding Principles for BP-OCV Alignment
- Medicaid Expanded Population: Identification of Questions

Updates

- Self-Management Program Transition Delayed till 2021; plan for Oct – Dec 2020 HSA Grants
- Resume Planning for QI Facilitator Transition
- Hub & Spoke Virtual Conference: Opioid Use & Family Care (Oct 6 & 7 8:30-12:30 each day)
- Introduction of New Field Staff
  - Denise Smith, Program Manager St Albans
  - Kathy Boyd, Program Manager Rutland
  - Karen Garrand, Practice QI Facilitator St Albans
  - Julie Trottier, State Community Facilitator
- Congratulations Maurine Gilbert, Director Client Engagement VITL

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Integrated Community Care Management Learning Collaborative

- What: Rapid-cycle quality improvement learning collaborative in 11 HSAs to improve cross-organization coordination of care
- Who: Individuals with complex psychosocial and health needs
- How: Develop person- and family-centered multi-disciplinary care teams with lead care coordinator, shared care plans, and common care management tools

Evaluation Objective

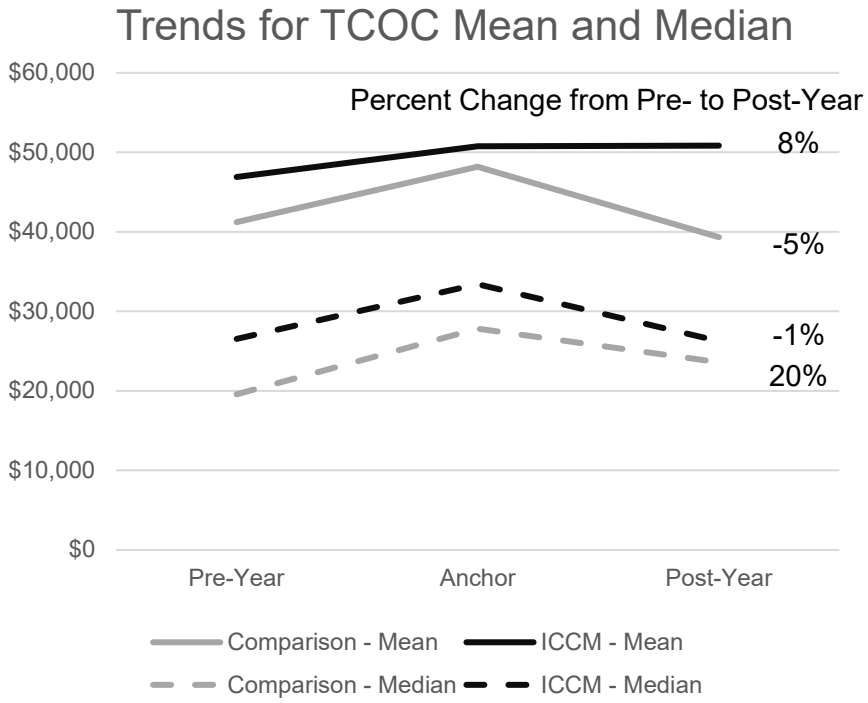
Asses Impacts on Health Care Expenditures & Utilization

Study Design

- Retrospective longitudinal analysis following intervention group (those in ICCM) from 12 months prior to beginning ICCM through the following 12 months.
- Compared outcomes to a matched comparison group over same timeframe using difference-in-difference approach.
- Identified 209 individuals for ICCM group, 209 individuals for comparison group matched by propensity score
- Follow 96% of individuals in each group over 3 years (previous year, intervention year, post year
- Excluded (99 individuals from ICCM group):
  Those who died during the study (population reviewed separately)
  Those with only one year of data, including those who joined the ICCM in 2017.
- Inclusion: Medicaid and Dually Eligible (numbers for commercial and Medicare only were very small)

Comparison of Expenditures

Figure 1. ICCM vs. Matched Comparison Group – Distribution of Total Expenditures



Expenditure Details (Selected)

Category	Group	Pre-Year (C: N=199; I: N=202)	Anchor Year (C: N=206; I: N=206)	Post-Year (C: N=199; I: N=200)	Overall (Pre to Post)
Emergency department	Comparison	$1,970	$2,611	$1,707	-13.3%
	ICCM	$3,061	$3,258	$2,207	-27.9%
Services specific to Medicaid (SSM)	Comparison	$9,477	$9,674	$9,533	0.6%
	ICCM	$8,496	$9,370	$11,666	37.3%
Total cost	Comparison	$41,111	$46,510	$39,319	-4.4%
	ICCM	$44,834	$49,439	$48,211	7.5%
Total cost, excluding SSM	Comparison	$31,634	$36,837	$29,786	-5.8%
	ICCM	$36,338	$40,070	$36,545	0.6%
Inpatient	Comparison	$7,145	$9,452	$5,679	-20.5%
	ICCM	$10,317	$11,894	$8,590	-16.7%
Outpatient	Comparison	$5,694	$6,653	$5,001	-12.2%
	ICCM	$7,444	$8,142	$7,187	-3.5%
Pharmacy	Comparison	$9,531	$9,299	$9,737	2.2%
	ICCM	$8,208	$7,814	$8,506	3.6%
Professional mental health	Comparison	$741	$788	$671	-9.3%
	ICCM	$1,001	$1,296	$1,006	0.5%
Professional non-mental health	Comparison	$3,829	$4,377	$3,772	-1.5%
	ICCM	$3,564	$3,843	$3,268	-8.3%
Home-based care	Comparison	$618	$847	$797	29.1%
	ICCM	$986	$1,462	$1,015	2.9%

Conclusions

- While ICCM intervention was not associated with an overall decrease in expenditures, it was associated with changes in care patterns. The ICCM group had greater:
  - Decrease in ED visits and expenditures (statistically significant);
  - Increase in Home- and Community-Based Services (not statistically significant).
- Future analysis should look at following study populations over longer periods of time.
- Persistently higher expenditures of the ICCM group could indicate that claims data alone is insufficient to find the best matched comparison group and future analyses should consider including additional dataset with SDoH.

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OCV Primary Care Work Group

(August 25 – September 21)

Complex Care Coordination Program

- Major element of OneCare Vermont health services delivery reform effort and financial subsidies
- Care Navigator software essential element of communication between diverse agencies interacting with complex patients
- New compensation model launched July 1, 2020 – "tasks" instead of "capacity payments"
- New auditing function for meeting program requirements for payment
- Program requirements for payment
  - Triggers for payments – lead CC, care team member, care conferences
  - Baseline expectations – frequency of contacts by risk level, licensed team members, patient ratios

OCV Primary Care Work Group

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Blueprint for Health Requirements

- Ongoing discussions between OneCare Vermont and Blueprint
- Consideration of transitioning self-management programs (diabetes, hypertension) in January 2021
- Discussions of transitions of Blueprint Quality Improvement Facilitators to OneCare, spring 2021
- Future exploration of role of NCQA certification/recertification or alternatives for Patient Centered Medical Home designation
  - FQHCs currently obligated to obtain NCQA status for certification
  - Assess recent changes to NCQA recertification format
  - Assess current legislative mandate requirements/alternatives to medical home status

Quality Metric Selection

- Largely payer driven
  - Medicare ACO national programs – 616 patients per clinical measure
  - Vermont Medicaid – 372 patients per clinical measure
  - Blue Cross Blue Shield of Vermont & MVP – 411 patients per clinical measure
- Vermont All Payer Model quality metrics
  - Preventive Care, Care Coordination and Patient Safety for at Risk Population(s)
  - Reduce Deaths Mental Health and Substance User Disorder
  - Reduce Prevalence in Chronic conditions (HTN, Diabetes, COPD)
- OneCare Vermont has historically negotiated for fewer measures that align across payers (VT All Payer Model)
- Measures that relate to all demographic categories
- ? Opportunities for additional network input

OCV Primary Care Work Group

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Other Program Elements

- Value Based Incentive Fund – return of withhold of total cost linked to quality performance
- Population Health Management – PMPM to attributing practices
- Prior Authorization Waivers – Vermont Medicaid currently
- Medicare Program
  - Benefit waivers
  - MIPS forgiveness
  - Part B bonus payments to Advanced Alternative Payment Model ACOs
- Comprehensive Payment Reform (CPR) – independent practices blended capitation
- Maximizing attribution – Medicaid Expanded Attribution primary care incentives

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Draft Guiding Principles for Alignment & Integration

All Payer	Promote Seamless, Integrated Care
Whole Population	Primary Care Services are Grounded in Patient Centered Medical Home (PCMH) Principals
Local Health Systems Organize Care	Population Health and Prevention Expenditures Increase within Overall Growth in Spending Limits

Population Health Goals of APM Drive Priorities

- Increase Access to Primary Care
- Reduce Deaths from Suicide and Drug Overdose
- Decrease the Incidence and Morbidity of Chronic Disease

Limit Growth in the Cost of Health Care (no more than 3.5% annually)	Learning Health System

Continue Current Investments in PCMH and Community Health Teams

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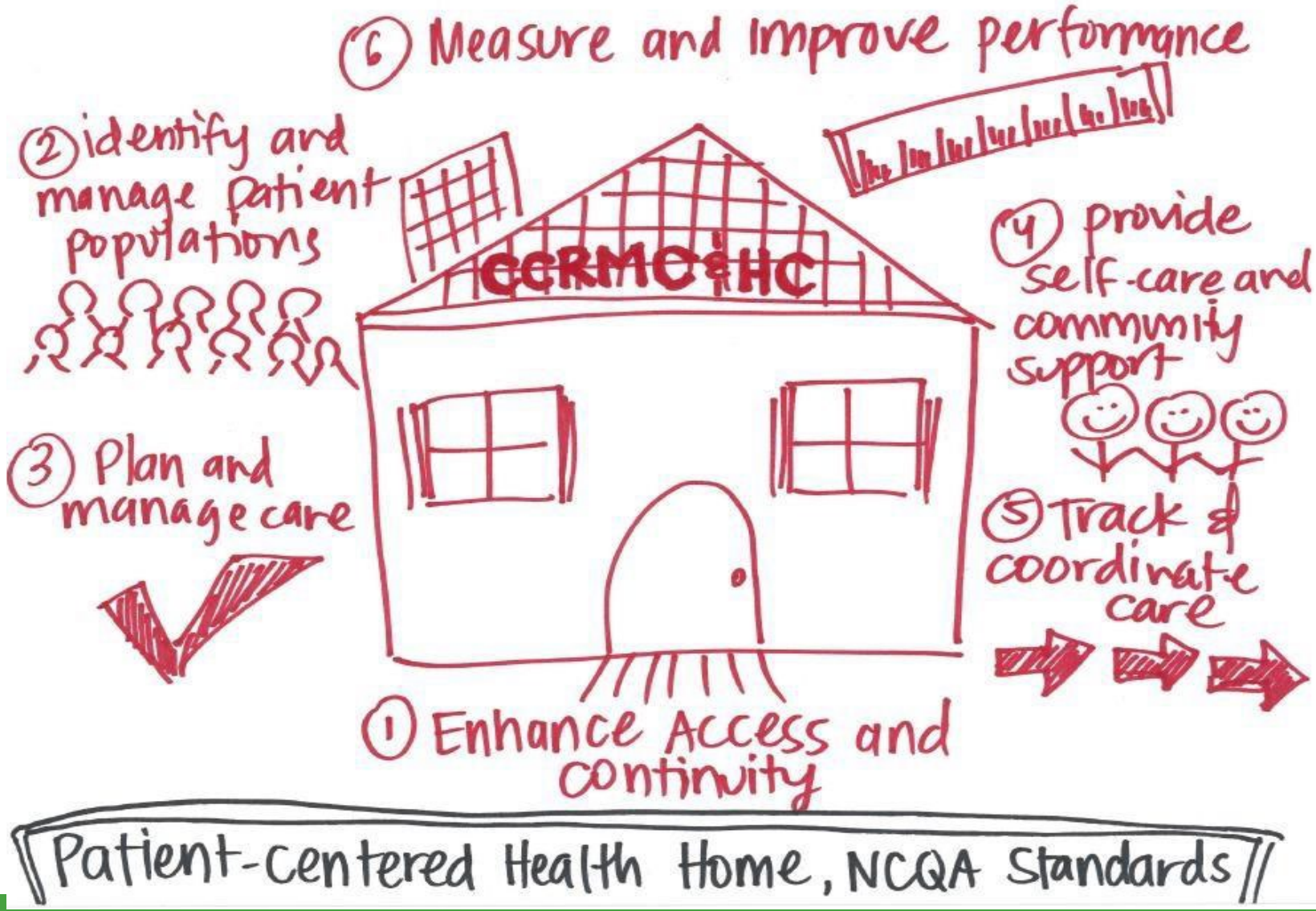
Medicaid Expanded Population



Medicaid Expanded (ME) Project Goals and Activities

Goal 1: Increase access to primary care for the ME population (N = 28, 500)

Goal 2: Assess need for care coordination and care manage as appropriate

KPI: Initial QE&M Visit

HSA Community Steps:

1) Identify ME patient panel, including sub-groups, in Care Coordination Process Metrics (CCPM), Care Navigator, and/or COVID-19 Patient Prioritization app
2) Review patient records in Care Navigator and EHR
3) Collaborate with your community health team and VCCI Regional Case Managers to determine processes for each sub-group and identify a formal workflow including responsibilities
4) Identify entry points and outreach protocols
5) Ensure PCMH access to schedule new patients in a timely manner
6) Monitor performance related to KPIs of access and care management status