Department of Vermont Health Access
Division of Health Care Reform
312 Hurricane Lane, Suite 201
Williston, VT 05495
hcr.vermont.gov
[phone] 802-879-5988

Combined Meeting of The Blueprint Executive Committee and Blueprint Expansion, Design and Evaluation Committee January 21, 2015

Present: D. Anderson, S. Aranoff, J. Batra, J. Biron, P. Cobb, W. Cornwell, N. Eldridge, E. Emard, P. Farnham, J. Fels, J. Franz, A. French, K. Fulton, M. Hazard, J. Hester, P. Jackson, C. Jones, J. Krulewitz, M. Landon, M. Larson, C. MacLean, S. Maier, M. McAdoo, L. McLaren, T. Moore, S. Narkowitz, A.Ramsay, P. Reiss, J. Samuelson, C. Schutz, J. Shaw, R. Slusky, B. Tanzman, R. Terriciano, T. Tremblay, S. Weppler, R. Wheeler, S. Winn, M. Young

The meeting opened promptly at 8:30 a.m.

I. Opening Comments – Craig Jones, MD.

- The Blueprint Annual Report is now available online. http://blueprintforhealth.vermont.gov/
- Program Evaluation: We now have a substantial comparison group and Medicare data is also included. We are now able to report outcomes of the whole population, ages 1 and above.

II. Review Proposal for Unified Collaborative Structure & New Payment Model

- A "Community Oriented Health Systems Plan" is being assembled. We will review some of the elements of the Plan today and would like Committee Members input regarding the details and framework.
- Putting primary care in a central coordinating role is happening outside of the United States as well as here in the U.S.
- We are looking to establish shared interests among medical and non-medical providers and more cohesive working groups in all communities to drive quality. We want to advance our payment model to drive the work of coordination and quality. We are currently in the transition phase of the plan. Incredible advancements have been made statewide.
- Dr. Wheeler – There is a lot of real energy and interest worldwide asking the question, "how do we make care better?" Many foreign countries and certain states throughout the U.S. are achieving important improvement outcomes in healthcare systems. They are doing that by focusing on the actual outcomes they're trying to achieve. Dr. Wheeler recommended checking out the International Consortium for Health Outcomes Measurement web site.

- Strategy and Action steps for building Community Health Systems were discussed. There are real opportunities for data measurement and administrative efficiencies.
- *UCC Structure/Leadership Teams Discussion*: The current recommendation is to form a decision-making leadership team consisting of up to 11 members. (*Slide #5*) Final recommendations will rest with this leadership team, driven by consensus of the team and/or vote process as needed. The leadership team would meet on a regular basis (e.g. quarterly). Work groups would convene more often to drive planning and implementation. This is the starting point for quality collaboration, tied to a common framework.
- There is a natural evolution around the state that has already occurred in terms of forming collaboratives at the community level and combining ACO measures. This is an excellent opportunity to discuss how to select performance measures tied to a common framework –an important step which can be flexed and changed as time goes on. Craig is working with VITL and the ACO's to bring in clinical data from EMRs and to try and broaden clinical measures. The quality and linkage capability of the data in DocSite is good however, not all practices feed into DocSite. What needs to happen next is to move to a production level aggregation of the data to produce clinical measures statewide.
- Dr. Reiss expressed concern regarding ACO measure selection. Measures need to be selected by those who have a background in measure selection and production. Richard Slusky responded there was a very thoughtful, deliberative process in place for the selection of ACO measures. The measures have to be things with capturable data.
- *Payment Structure Proposal:* Our intent is to increase PCMH and CHT payments. Modifications are needed for further advancement. The proposed modifications will support UCCs as well as quality improvement efforts. (*Slides 9 -14*)
- Dr. Wheeler expressed opinion that CHT funding should no longer come from insurance premiums but instead come from statewide funding similar to other public utilities.
- Craig Jones: What we are doing here is organizing to be in a better place in the future – initial steps toward a more complete waiver structure. Moving toward more flexible opportunities to pay for different types of services.

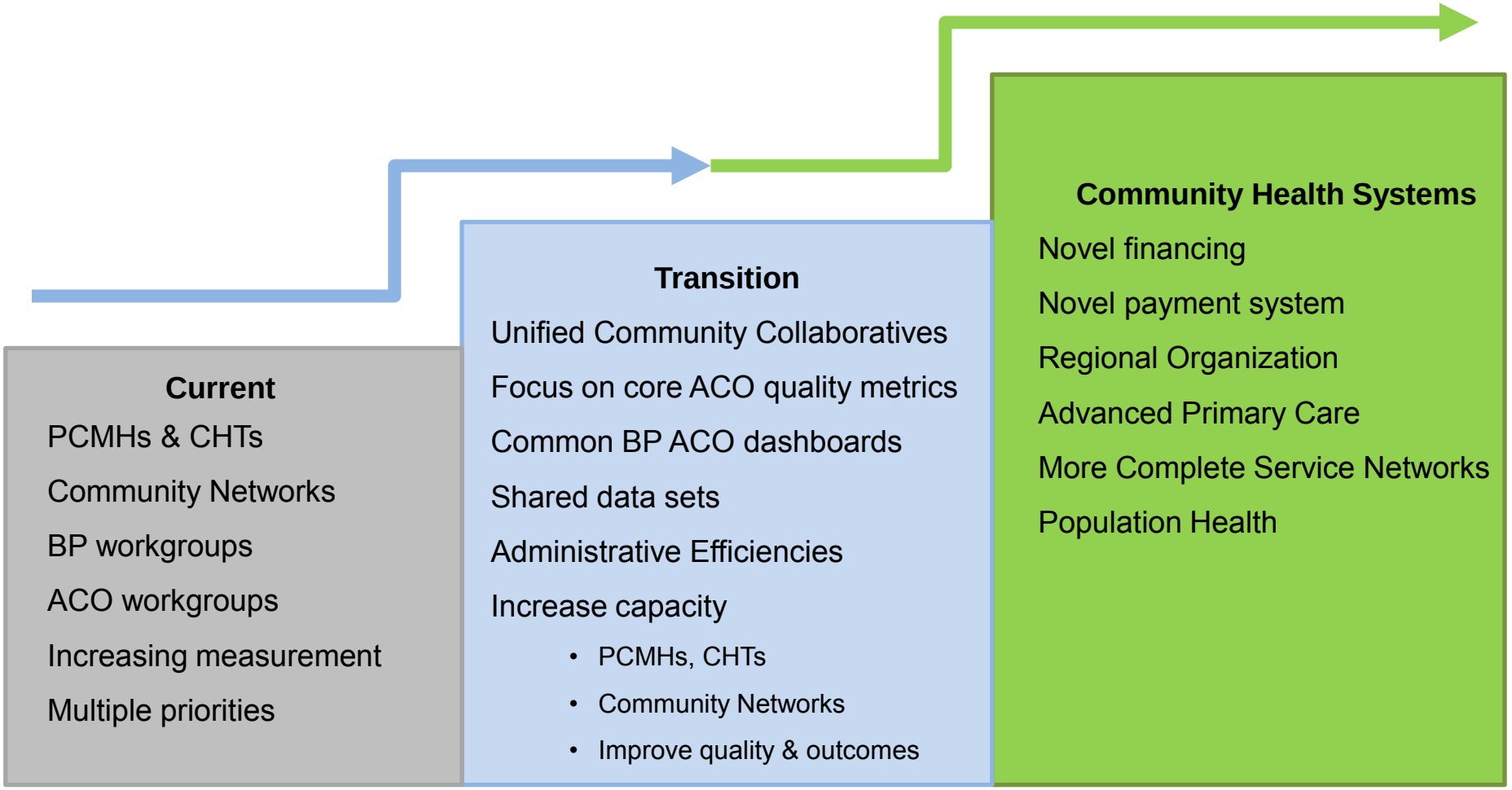
With no further time, the meeting adjourned at 10:10 a.m.

Community Oriented Health Systems

Executive Committee
Planning & Evaluation Committee

January 20, 2015

Transition to Community Health Focus



Strategies for Community Health Systems

Design Principles

- Services that improve population health thru prevention
- Services organized at a community level
- Integration of medical and social services
- Enhanced primary care with a central coordinating role
- Coordination and shared interests across providers in each area
- Capitated payment that drives desired outcomes

Strategy for Building Community Health Systems

Action Steps

- Unified Community Collaboratives
- Unified Performance Reporting & Data Utility
- Community driven quality & coordination initiatives
- Enhanced primary care and community health team capacity
- Modified medical home and community health team payment model
- Administrative simplification and efficiencies

Unified Community Collaborative (UCC)

Structure & Activity

- 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
- Convening and support from local BP project manager/admin entity
- Develop charter, invite participants, set local priorities & agenda

Unified Community Collaborative (UCC)

Structure & Activity

- Final recommendations rest with leadership team
- Driven by consensus of leadership team and/or vote process as needed
- Solicit structured input of larger group (stakeholders, consumers)
- Larger group meets regularly (e.g. quarterly)
- Convene workgroups to drive planning & implementation
- Workgroups form and meet as needed (e.g. bi-weekly, monthly)

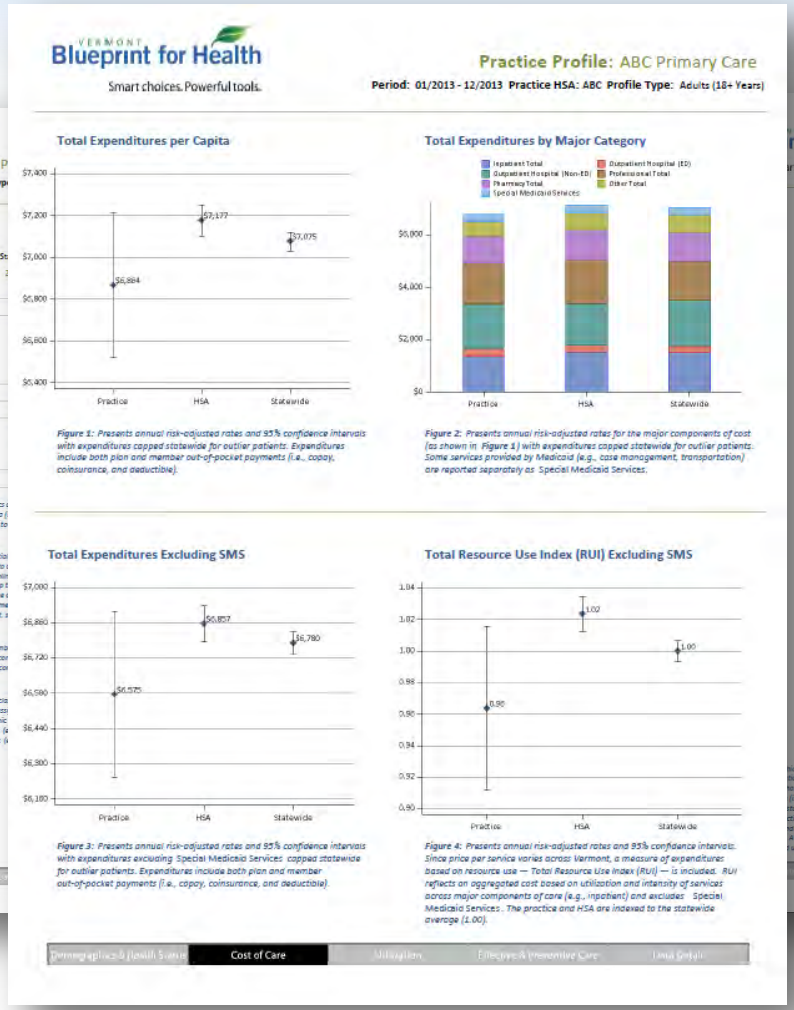
Unified Community Collaborative (UCC)

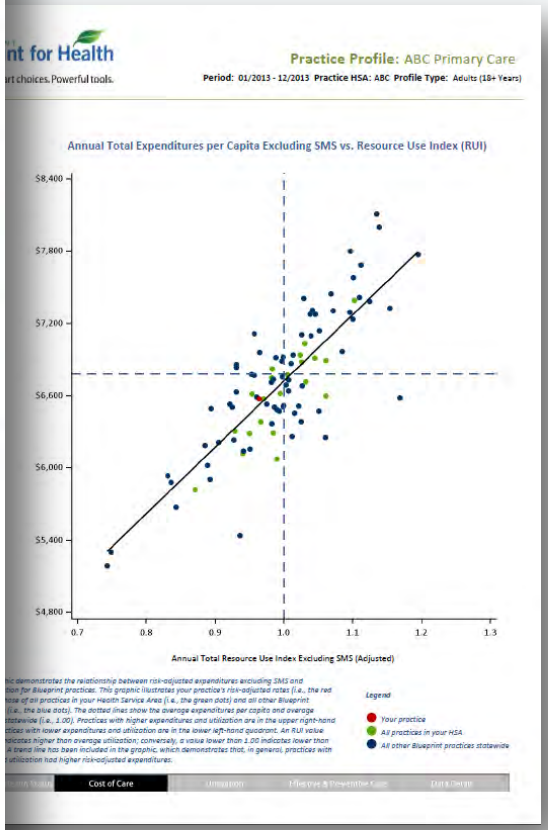
Structure & Activity

- Use measure results and comparative data to guide planning
- Adopt strategies and plans to meet overall goals & local priorities
- Planning & coordination for service models and quality initiatives
  - guide activities for CHT staff and PCMHs
  - guide coordination of services across settings
  - guide strategies to improve priority measures

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare





Payment Modifications

Need for Modifications

- Current payments have stimulated substantial transformation
- Improved healthcare patterns, linkage to services, local networks
- Reduced expenditures offset investments in PCMHs and CHTs
- Modifications are needed for further advancement
- Proposed modifications will support UCCs & quality improvement

Payment Modifications

Recommendations

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

Proposed Payment Modifications

Medical Home Payment

- Composite capitated payment ($PPPM)
- Total = Base + NCQA Rescore + Quality Composite + TUI
- Base payment for participation in UCCs – *practice control*
- NCQA rescore discretionary but rewarded – *practice control*
- Quality component based on HSA results –*interdependencies*
- TUI component based on HSA results – *interdependencies*

Proposed Payment Modifications

Current	Proposed
Targeted Payment	Composite Payment
▪ *Single Component* – based on NCQA PCMH score. Practice Control	▪ *Base Component* – participation in UCCs, and NCQA recognition on 2011 standards. Practice Control ▪ *NCQA Component* – rescore is discretionary but rewarded. Practice Control ▪ *Quality Component* – HSA results on a set of core measures. Interdependencies ▪ *Utilization Component* – HSA results on total utilization index. Interdependencies
Incentives for NCQA recognition, a high score on standards, and access to CHT staff.	Incentives for sustained practice quality, access to CHT staff; and coordination with others to improve service area outcomes

Proposed Payment Modifications

Payment Component	Eligibility	Intended Result
Base Payment	Participation in UCC Recognized on NCQA 2011	Organize practice and CHT activity to support UCC initiatives
NCQA Rescore Payment	Rescore on current NCQA standards (discretionary)	Maintain medical home quality & operations
Quality Composite Payment	HSA measure results • Top 50th percentile • Beat benchmarks • Incremental improvement	Coordinate with others to improve quality and coordination as reflected by core measures
Total Utilization Index	HSA measure results • Top 50th percentile • Incremental improvement	Coordinate with others to reduce unnecessary utilization and variation

Proposed Payment Modifications

Decision Points

- Payment amounts for each component (weighting)
- Selection of quality & performance measures for composite
- Payment tied to top performance vs. improvement vs. benchmarks
- Payment tied to service area results and/or practice results
- Use of consistent and/or centralized attribution for payment

Questions & Discussion