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
Blueprint Executive Committee Meeting and
Blueprint Expansion, Design and Evaluation Committee
Minutes of
September 17, 2014
8:30 – 10:00

Attendees: D. Andrews, P. Cobb, N. Eldridge, J. Evans, M. Hazard, P. Jackson, C. Jones, J. Krulewitz, C. MacLean, S. Maier, C. McLean, T. Moore, C. Oliver, A. Ramsay, P. Reiss, J. Samuelson, C. Schutz, K. Suter, B. Tanzman, C. Thomas, T. Tremblay, C. Thomas, K. Hentcy, M. Young

Attendees via Phone: J. Andersson-Swayze, P. Biron, J. Fels, S. Frey, A. Garland, B. Grause, P. Harrington, J. Hester, L. McLaren, E. Medved, S. Narkewicz, D. Noble, T. Peterson, K. Suter, T. Voci, R. Wheeler

The meeting opened at 8:32 a.m.

1. **General Update:**

   Dr. Jones provided a quick update for the group.

   - As of July, 2014 there are 123 practices in Vermont operating as Medical Homes
   - Onpoint attribution as of December, 2013 = 347,489 patients vs. Practice Report attribution of 514,035. 644 Unique primary providers.
   - In countries such as the UK and Netherlands, practices specifically ask patients to identify their PCP and their responses then get entered into a registry. This method appears to be more accurate as opposed to what claims show on attribution algorithms.
   - To the degree that any insurer has a product where members must choose a PCP, it is recorded in the system. Attribution algorithm then only applies to patients who do not have an insurer package where they must choose a PCP.
   - Eric Medved stated that at Gifford there are hundreds of patients who have not identified providers and he is not sure if these patients are getting attributed anywhere.

- Jean Anderson Swayze (HealthFirst) wanted to discuss the future of the Blueprint since the new Medicare G-codes for chronic care will force many practices to choose between Blueprint and Medicare G-codes to reimburse practices. The chronic care management fee will begin in January if a practice meets certain eligibility requirements. Dr. Jones responded that all 8 states in the MAPCP Demonstration have looked into this. If eligibility requirements are met for targeted subpopulations, then the numbers work out to $42.00 PPPM. When most of the sites ran the numbers, it was quite different than the medical home payments because the fee doesn't apply to all Medicare patients in the practice. If Blueprint payments are increased as we are requesting, practices will actually make more by being a Medical Home. Every practice should look very carefully at the math.

2. **Draft Recommendation to the Legislature**:

- A Draft Recommendations document was distributed prior to this meeting. (Attachment A) The Blueprint has been asked to provide the legislature with Blueprint payment increase recommendations in context of a greater plan to continue advancements and stimulate health. We believe the future is moving toward a population health approach. Therefore, the focus of the report will be a proposal to stimulate systems and recommendations to take steps to strengthen community health systems, ACO's, and to build a foundation for Green Mountain Care.

- What can be done to strengthen the foundation for community systems of health, ACO, and Green Mountain Care? During the transition period, we can take steps to strengthen the foundation. The intent is to set a common game plan and create a platform for all. Opportunities include:

    - Unify operations in each community
    - Shared governance – one in each community
    - Unified performance reporting and dashboards
    - Sharing resources such as evaluation and data sets
    - Administrative simplification
    - Engaging specialists and strengthening the medical neighborhood
    - Strong foundation for primary care, preventative services and community oriented services.
    - Increases in payments that result in a more unified transition period.

- Craig Jones – There will be a strong emphasis on local ownership and leadership, we don't want to come up with a scripted structure but instead take input from all

communities to put together a thoughtful plan that recognizes the interests of all players involved.

- It is important to increase the capacity of PCMHs and CHTs during the transition phase as well as to maintain participation and to strengthen the foundation. We are not talking about pulling money away but instead we are talking about strengthening the investment.
- None of the insurers have voluntarily agreed to any increases.
- This is going to be a journey by coalition of the willing partners who believe in this approach. The transition period will define the role of the Blueprint, OneCare and ACOs moving forward. Now is the time to explore how to build a permanent infrastructure with shared resources in addition to funding full-capacity practices that are doing more with less every year in primary care practices. Payments remain the same today as they did six years ago which is not financially sustainable.
- The finished report is due on October 1st. Alan Ramsey stated that the Green Mountain Care Board wants to hear from stakeholders. Do you feel the proposed changes and recommendations are indeed the right kind of changes to implement moving forward? Will the changes lead to better outcomes?

With no further business, the meeting adjourned at 10:15 a.m.

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Department of Vermont
Health Access

VERMONT Blueprint for Health

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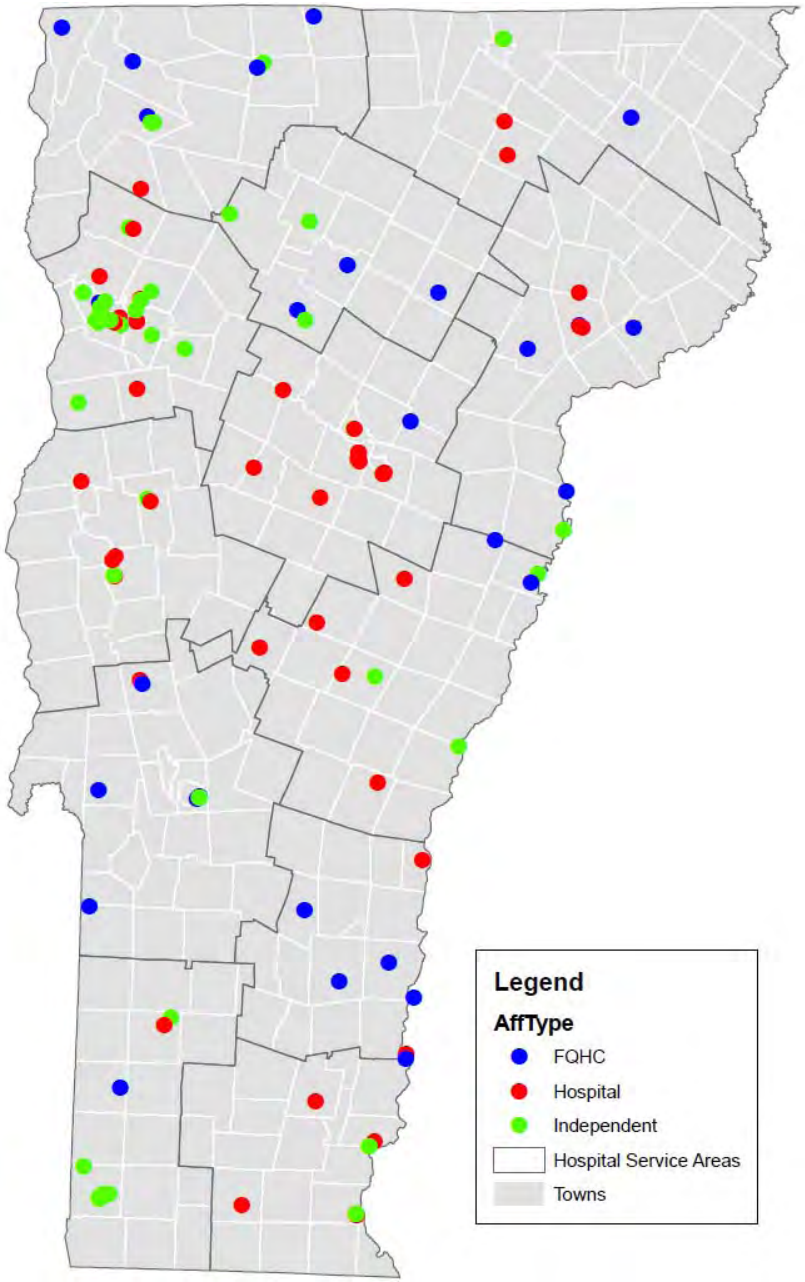
Executive Committee
Expansion Design & Evaluation Committee

September 17, 2014

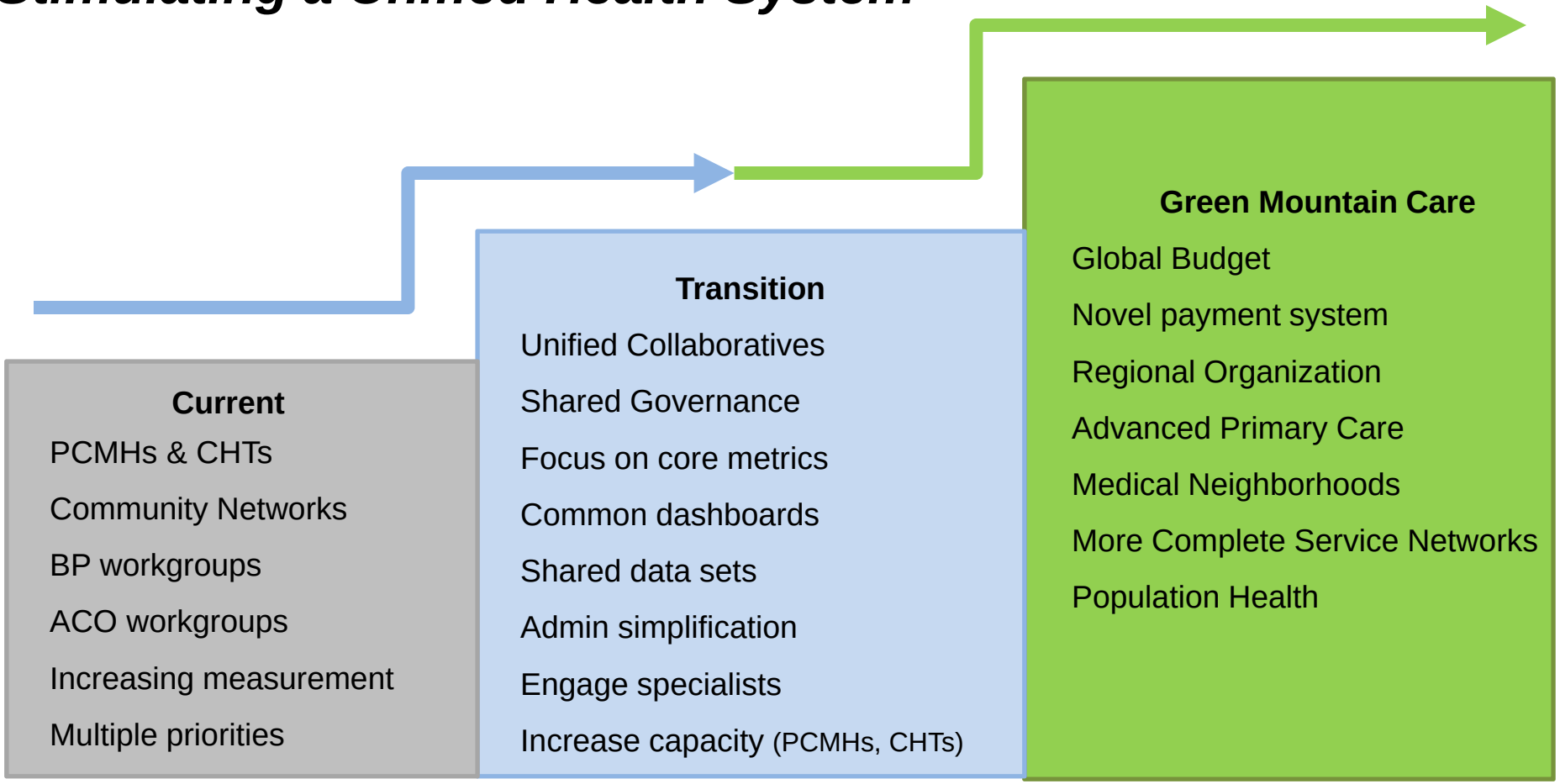
Health Services Network

Key Components	July, 2014
PCMHs (active PCMHs)	123
PCPs (unique providers)	644
Patients (Onpoint attribution) (12/2013)	347,489
Patients (practice report)	514,035
CHT Staff (core)	218 staff (133 FTEs)
SASH Staff (extenders)	60 FTEs (48 panels)
Spoke Staff (extenders)	47 staff (30 FTEs)

Medical Home Practice Sites by Affiliation



Transition to Green Mountain Care
Stimulating a Unified Health System



Unified Community Health Systems – In each Health Service Area, Blueprint and ACO leadership should merge their workgroups, and work with stakeholders to form a single unified health system collaborative. The collaborative should include medical and non-medical providers, a shared governance structure with local leadership, focus on improving the results of core ACO quality measures, support the introduction and extension of new service models, and provide guidance for medical home and community health team operations. This approach will establish a data guided community health system collaborative, result in more effective health and human services, and reduce the number of overlapping initiatives that currently exist. Resources that can be purposed to support these collaboratives including local project management, practice facilitators, and, shared learning forums.

Unified Performance Reporting & Data Utility – Blueprint and ACO leadership should co-produce performance dashboards focusing on core ACO measure results. This activity aligns Blueprint's statewide measurement capacity with ACO measurement needs. These dashboards should present population level results and directly support the work of unified community collaboratives. The dashboards will augment the suite of comparative profiles that are currently produced for practices, HSAs, and organizations, providing a focused set of measure results that are important to all entities participating in ACO activity. Where possible, this approach should be generalized to include sharing data sets, collaborating on analytic activity, and planning for an advanced data infrastructure that can fuel the range of needs for Vermont's health system.

Building the Medical Neighborhood – Blueprint and ACO leadership should collaborate to engage specialty practices thru preparation and scoring on the NCQA Specialty Practice Standards. This activity builds on Vermont's well established NCQA scoring capacity, the statewide base of recognized PCMHs, assures consistent and proven statewide quality standards, and will result in more effective care across specialty practice and medical home settings. A statewide base of NCQA recognized PCMHs and Specialty practices establishes a high probability that ACOs are organizing high quality care in alignment with NCQA ACO standards, which provide a consistent, rigorous, objective, and nationally recognized quality framework across the care continuum.

Administrative Simplification & Cost Offsets – State leadership should work to deem insurers as meeting Vermont's rule 9-03 quality requirements for those requirements that are met or exceeded thru participation in the Blueprint program. State and insurer leadership should work with NCQA to have insurers deemed as meeting quality and care management standards for those requirements that are met or exceeded thru participation in the Blueprint program. Ideally, state leadership should work with NCQA toward a single credentialing process for all insurers and providers' participating in Vermont's unified Green Mountain Care system. Ideally measure results for credentialing can be generated in one consistent unified process for all participants from Vermont's all payer claims database and other data sources. Insurers should reduce their care management programs where possible, shifting resources to offset CHT costs in the community organized health service model. These shifts should occur as supported by evidence suggesting that populations of interest are achieving better outcomes in the locally organized community model than they are with insurer supplied care management services. These steps will help to reduce redundant quality activity, reduce redundant care management activity and shift organization to a community level, reduce insurers administrative burden, and bring a systems like approach to quality and care management in Vermont.

Support for the Green Mountain Care Board – The Blueprint team should use its expertise and experience to support the work of the GMCB in capacities such as: use and measurement of healthcare quality standards; understanding, extension, and evaluation of health service models; implementation and organization at a community level; utility of the data infrastructure including architecture, data quality, measurement, and evaluation; and strategies to support a continuously improving learning health system. The GMCB has wide ranging authority and responsibility for transforming Vermont's healthcare system. In addition to rate setting and budget approval, the GMCB is responsible for oversight of payment models and cost control, which is dependent to a substantial degree on the effectiveness of the delivery system. The Blueprint team can support the Boards work during the transition to Green Mountain Care with experience and expertise related to the effectiveness of the delivery system.

Payment Modifications and the Transition to Green Mountain Care – modifications to the existing Blueprint payment model are necessary to optimize the effectiveness of the community oriented health system (e.g. PCMHs, CHTs, Medical Neighborhoods, and the proposed Unified Community Collaboratives). In order to build on six years of work by providers, and demonstrated outcomes, modifications should be made with the following priorities: increase CHT payments to provide Vermonters with greater access to multi-disciplinary preventive services, and teams with adequate administrative support; increase PCMH payments to maintain practice participation and incent level 3 PCMH status; add an outcomes based payment that directly incents the goals of the unified community collaboratives with payment linked to achievement on core ACO quality measures and changes in avoidable utilization: and, extension of incentives to medical specialty practices to stimulate a more effective medical neighborhood. While budget considerations may limit payment opportunities, Vermont's experience suggests that this package will strengthen the capacity and effectiveness of unified community health systems, help ACOs meet their goals, and result in a high value learning health system as a foundation for Green Mountain Care. Failure to enhance CHT and PCMH payments is likely to result in reduced CHT staffing due to cost of living and administrative cost shifts, and practices choosing not to rescore as PCMHs.

Questions & Discussion