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Combined Meeting of The Blueprint Executive Committee and Blueprint Expansion, Design and Evaluation Committee December 11, 2014

Attendance: D. Anderson; S. Cartwright; P. Cobb; A. Cooper; E. Emard; P. Farnham,; E. Girling; M. Hazard; P. Jackson; C. Jones, J. Krulewitz,; M. McAdoo; L. McLaren; E. Medved; S. Maier; T. Moore; S. Narkowitz; G. Peters; A. Ramsay; P. Reiss; C. Schutz; J. Shaw; R. Slusky; B. Tanzman; R. Terricciano; T. Tremblay; S. Wehry; B. Wheeler; S. Winn; L. Winterbaur; M. Young

The meeting opened promptly at 8:00 a.m.

I. *Opening Remarks and Context – Dr. Craig Jones*
   a. Today's agenda and PowerPoint slide deck, "Community Oriented Health Systems" were distributed prior to this meeting. (Attachment #1)
   b. The Blueprint Program is currently entering an evolution phase. This phase represents a shift on how to work together. We need guidance from this committee regarding statewide governance and a more structured design. Proposals are steadily emerging as we work with the three relatively new provider ACO networks.
   c. Opportunities exist to unify work, strengthen community health system structure, and line up medical home payments with unified collaborative goals.

II. *Unified Community Collaboratives – Structure & Governance*
   a. How can we blend together ACO activities and local communities to work toward a real unified community health structure?
   b. Initial Proposal - Structure & Activity:
      i. We are proposing a leadership team made up of:
         1. One local clinical lead from each ACO (2-3)
         2. 1 local representative from each of the following provider types that serves the HSA –
            - VNA/Home Health;
            - Designated Agency;
            - Designated Regional Housing Authority;
            - Area Agency on Aging; Pediatric Provider.
            - Additional representatives selected by local leadership teams. (Up to a total of 11 members)

3. The premise is that this governance team should be small enough to lead effectively. Our focus is to balance the leadership of the executive/governance team.
4. Appointments would be driven by consensus of leadership team and/or vote process as needed. We would convene workgroups to drive planning and implementation. Formed workgroups will meet as needed. (e.g. bi-weekly, monthly).

ii. We propose that a charter be developed and that local priorities and agendas be set. Some communities have already begun blending structures/meetings.

iii. Funding: This is a pilot concept and we are not proposing to fund the Leadership team. The Blueprint is willing to shift its emphasis of our community grant structure to help support these changes. The SIMM Grant will also be used to help organize these groups. Blueprint project managers would have a new role to coordinate and move things to a different level. We will be shifting our organization from one set of standards to outcome measures.

c. Action Steps:
   i. Unified Community Health System Collaboratives
   ii. Unified Performance Reporting & Data Utility
   iii. Administrative simplification and efficiencies
   iv. Implement new service models (e.g. ACE, ECHO)
   v. Payment Modifications

Amy Cooper stated that the "Blueprint is viewed as a neutral party". Regarding communication and clarity about what is going on in all of the different HSAs, it seems that the Blueprint could serve that communication role best right now.

Bob Wheeler would like to see the separation between Blueprint reforms from other healthcare reform initiatives reduced.

III. Payment Modifications

a. Payments have been stagnant since 2008.
b. We need to transition to a new payment structure for primary care.
c. Lou McLaren, MVP – MVP is willing to double current PCMH payments as well as discuss increasing CHT payments by 15% - 20% effective 1/1/15 with the caveat that insurer share adjusted to portion of CHT costs reflecting market share. (Adjust insurer portion of CHT costs to reflect market share - % of money each insurer will pay)
d. Lou is willing to share New York reward levels with this committee if requested.
e. Payment modification options were discussed. Committee was asked to forward any ideas around payment models directly to Craig Jones.

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

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Department of Vermont Health Access

VERMONT Blueprint for Health

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Community Oriented Health Systems

Transition to Green Mountain Care

Executive Commttee
Planning, Design, Evaluation Committee

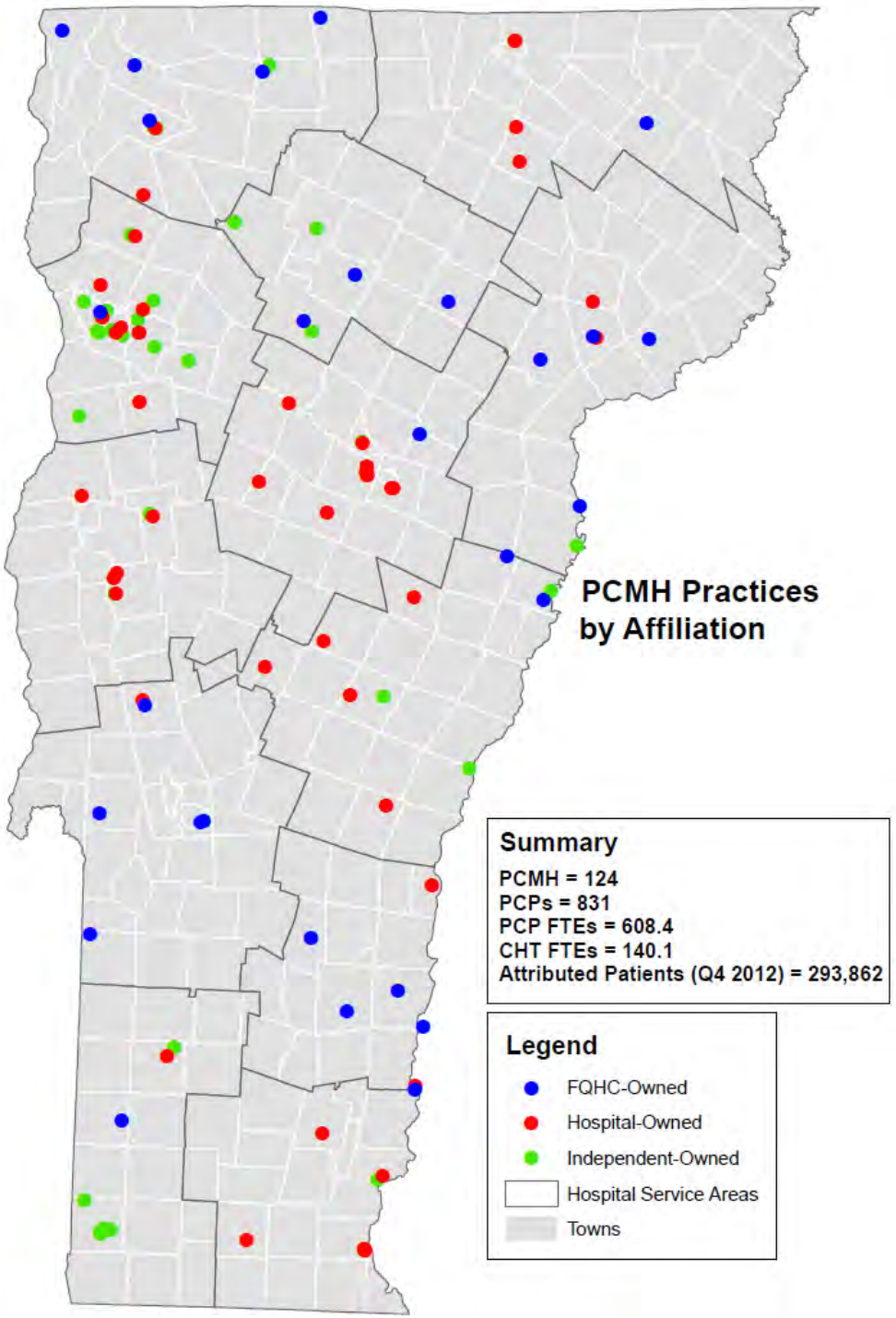
December 11, 2014

Agenda Items

1. Opening remarks and context
2. Unified Community Collaboratives
3. HSA Profiles & Comparative Reporting
4. Proposed Payment Modifications
5. Medicare Chronic Care Management Fee

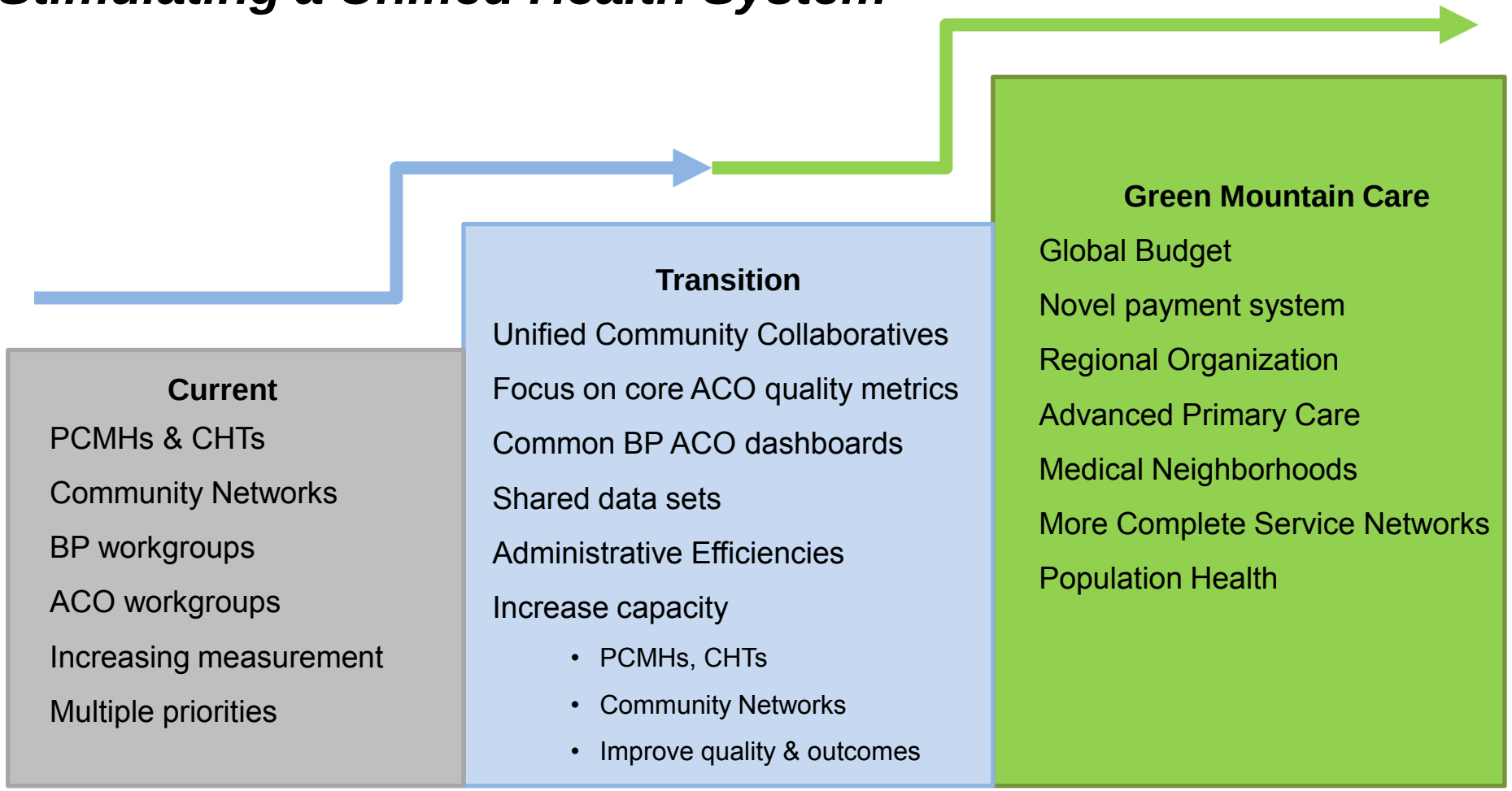
Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & evolving community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Three relatively new provider networks (OneCare, CHAC, HealthFirst)
- Opportunity to unify work, strengthen community health system structure


PCMH Practices by Affiliation
Summary
PCMH = 124
PCPs = 831
PCP FTEs = 608.4
CHT FTEs = 140.1
Attributed Patients (Q4 2012) = 293,862
Legend
FQHC-Owned
Hospital-Owned
Independent-Owned
Hospital Service Areas
Towns

Barre HSA
Full Network
Node color indicates sub-network membership
Node size indicates Betweenness Centrality

Transition to Green Mountain Care
Stimulating a Unified Health System



Strategy for the Transition to Green Mountain Care

Guiding Principles

- Whole population health & prevention
- Community oriented health system
- Primary care has a central coordinating role
- Integration of medical and social services
- Alignment across Provider Networks while supporting interests of each
- Capitated payment that drives desired outcomes

Unified Community Collaborative (UCC)

Overall Goals

- Improve results of priority quality measures
- Improve patient experience
- Improve patient access
- Improve coordination between medical and social services
- Improve patterns of utilization & expenditures
- Improve control over healthcare costs

Strategy for the Transition to Green Mountain Care

Action Steps

- Unified Community Health System Collaboratives
- Unified Performance Reporting & Data Utility
- Administrative simplification and efficiencies
- Implement new service models (e.g. ACE, ECHO)
- Payment Modifications

Unified Community Collaborative (UCC)

Structure & Activity

- Leadership Team (~ 7 member team)
  - 1 local clinical lead from each ACO (2 to 3)
  - 1 local representative from VNA, DA, SASH, AAA, Peds
- 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

Performance Reporting & Data Utility

Reporting & Comparative Performance

- Profiles for each medical home practice
- Profiles for each Health Service Area
- Whole population results & breakouts (MCAID, MCARE, Commercial)
- Measures - Expenditures, utilization, quality (core ACO for HSAs)
- Improving with input from provider networks

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 to stimulate continued improvement
- Proposed modifications will support UCCs & quality improvement

Payment Modifications

Options

- Increase current PCMH payments
- Or, change current PCMH payment to a composite measures based (interim step as new primary care payment model is planned)
- Increase CHT payments and capacity
- Adjust insurer portion of CHT costs to reflect market share

Payment Modifications

Example 1 - Composite Measures Based Payment

- Base Payment (all eligible practices)

  NCQA Recognition on 2011 standards (*rescore discretionary*)
  Participation in Unified Community Collaborative
  $2.00 PPPM

- Augmented Payment (performance based)

  $ .25 PPPM for rescore (level 2, current standards)
  $ .50 PPPM for rescore (level 3, current standards)
  $ .50 PPPM top 50% of Quality Composite (measures TBD)
  $ .50 PPPM top 50% of Total Utilization Index

Payment Modifications

Design Elements

- NCQA scoring is discretionary, reduces burden for practices that choose to opt out while rewarding those that choose to keep current on increasingly demanding standards.
- Should the Quality Composite and TRUI payments be linked to practice or HSA level results? HSA level results establishes interdependencies, a common interest across the 3 provider networks, and directly stimulates the work of Unified Community Collaboratives.
- Minimal budget impact in a tight fiscal environment while shifting to a focus on priority measure results that depend on the effectiveness of a community oriented health services structure.

Medicare Chronic Care Management Fee

Side-by-Side Comparison

Blueprint	Medicare CCM
Whole population	Sub population
Multi-payer	Single payer
Movement to capitated and measures based payment	Backwards step to fee for service payment
Supports medical home services for general population	Supports coordination services for targeted sub population
Supports community & team based services (CHT, MAT, SASH)	No community team support

Medicare Chronic Care Management Fee

Decision Points

- Providers can participate in MAPCP and receive the CCM fee for beneficiaries that are not attributed to the practice thru MAPCP
- Challenges of knowing who is attributed thru MAPCP and who is eligible for CCM fee (avoiding double payment) as well as administrative complexities (consent, documentation)
- Cleanest method is for a practice to pull out of MAPCP participation and use CCM fee for eligible Medicare beneficiaries. Pulling out of MAPCP reduces support Medicare for CHT and SASH.
- *Whether to permit a practice to participate in Blueprint if they pull out of the MAPCP (PCMH payments & CHT support from other insurers).*

Questions & Discussion