Department of Vermont Health Access
Division of Health Care Reform
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Combined Meeting of
Blueprint Executive Committee Meeting and
Blueprint Expansion, Design and Evaluation Committee
Minutes of
May 21, 2014
8:30 – 10:00

Attendees: J. Andersson-Swayze, D. Andrews, P. Barry, Batra, P. Biron, P. Cobb, P. Dupre, N. Eldridge, E. Emard, J. Evans, P. Farnham, A. French, K. Fulton, A. Garland, B. Grause, C. O'Hara, K. Hein, C. Jones, J. Krulewitz, P. Launer, N. Lovejoy, C. MacLean, L. McLaren, E. Medved, T. Moore, S. Narkewicz, D. Noble, M. Olszewski, A. Ramsay, J. Samuelson, C. Shultz, K. Sutter, B. Tanzman, G. Peters, J. Peterson, T. Peterson, L. Ruggles, B. Warnock, S. Wehry, M. Young

The meeting opened at 8:35 a.m.

1. Program Impact on Expenditures and Utilization – Craig Jones, MD

    - There are approximately 120 medical homes around the state. Vermont is plagued with low volumes but we now have a large enough population to look at a state-wide set of trends.
    - Julie Krulewitz from the University of Vermont will share the NCQA scoring distributions with Committee members.
    - A PowerPoint presentation was reviewed. (Attachment A)

      Highlights include:

        - Commercial and Medicaid groups are comparable.
        - Medical homes tended to have higher rates of chronic care conditions
        - Medical home expenses were lower with a divergence occurring between 10/11 and 11/12.
        - One interesting note is that all expenditures are coming down.

- We are seeing similar trends from the RTI / Medicare evaluation results.
- Major differences are being seen in utilization and expenditures NOT quality.

2. Variation & Comparative Reporting

- We are now distributing practice profiles. The profiles show practices how they compare to statewide averages and how they compare to their peers. The current lag time for the report continues to be an issue. We believe we can reduce the lag time to 6 months in the future. Slide 11 "Annual Total Expenditures per Capita vs. Resource Use Index (RUI) may be the most important slide for learning purposes.
- Total utilization vs. actual expenditures: About 80% of variation of expenditures is due to pure utilization. There is opportunity to influence expenditures by influencing utilization.
- Understanding what is actually driving the variation is very powerful.
- The combination of the Health Service Area Profiles and the Practice Population profiles are giving communities real opportunities for improvement.

3. Composite Payment Model

- Our payment model has not kept up with the delivery system. We hear consistently across the state that payments are insufficient. Staffing payments have not been revisited since 2008.
- The small payments have still stimulated substantial transformation such as improved healthcare patterns, linkage to services and lower expenditures.
- Proposed payment modifications are needed to <u>maintain</u> participation and stimulate continued improvement.
- NCQA standards will be even more difficult/onerous in the future. There is a point going from pilot to production where payment will need to change. Our goal is to stimulate continued improvement. Good, solid primary care and supported social services are important to a valued base structure.
- Accepting more accountability than ever before, our primary care providers are at a breaking point. These are complex reform efforts and the primary care providers have excelled. Where does the Blueprint fit into the future health care reform picture? Approximately 70% of primary care providers have signed up for the Blueprint program.
- The Blueprint is a nonprescriptive program and does not have control over practices. There is a call for a coherent approach to blend the Blueprint / ACO's and FQHC's.

- Allan Ramsay (GMCB) has called for a change to the payment model now. Suggested that we should look to SIM to fund that bridge.
- Patterns need to be scrutinized and system wide reduction of duplication is necessary.

With no further business, the meeting adjourned at 10:05 a.m.

Executive Committee
Planning & Evaluation Committee

May 21, 2014

Agenda

1. Program Outcomes
2. Variation & Comparative Reporting
3. Composite Payment Model
   - Increasing PCMH payments (Transformation)
   - Increasing CHT payments (Capacity)
   - Adding a P4P payment (Outcomes)

Program Outcomes

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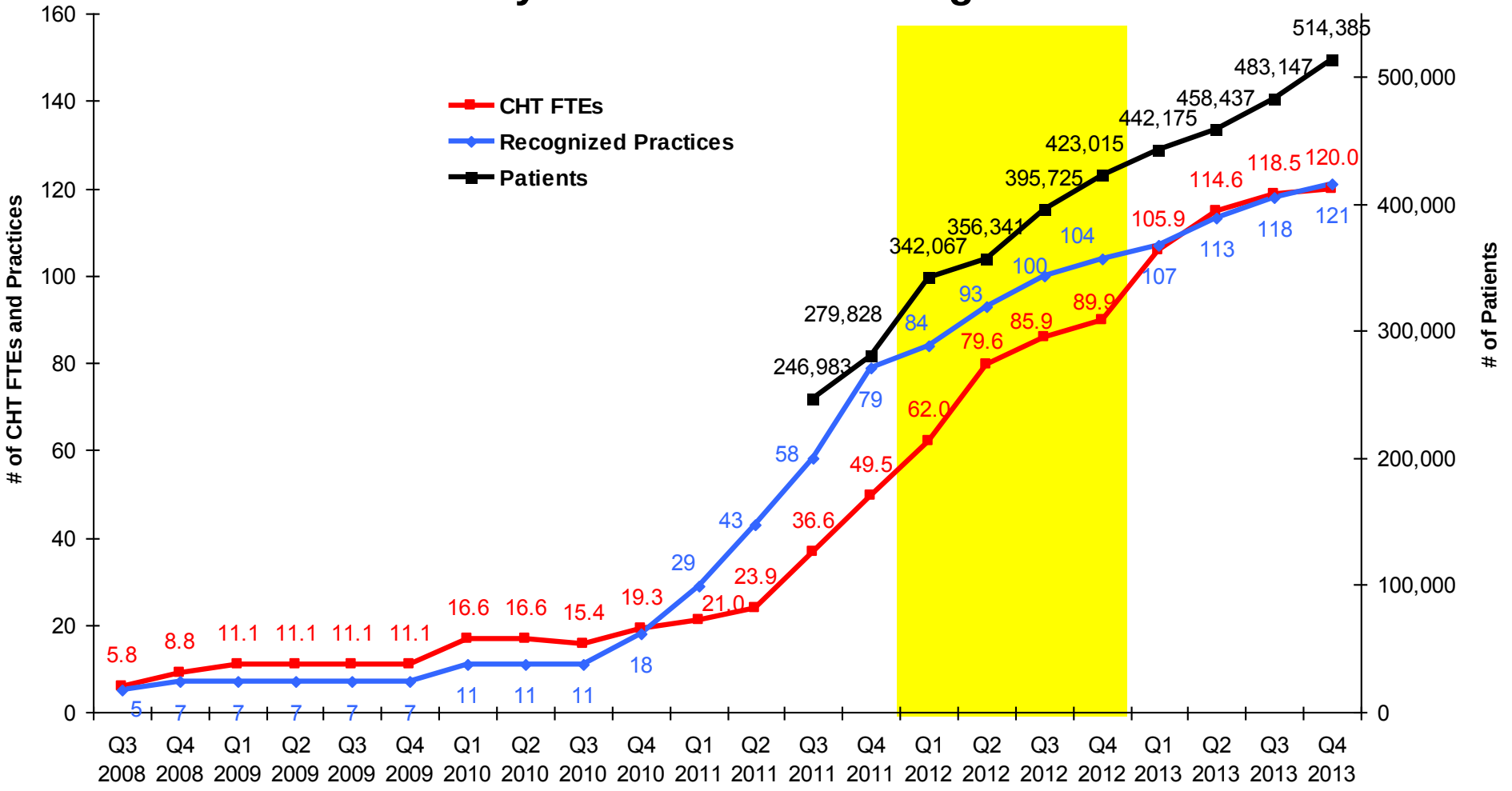
Patient Centered Medical Homes and Community Health Team Staffing in Vermont

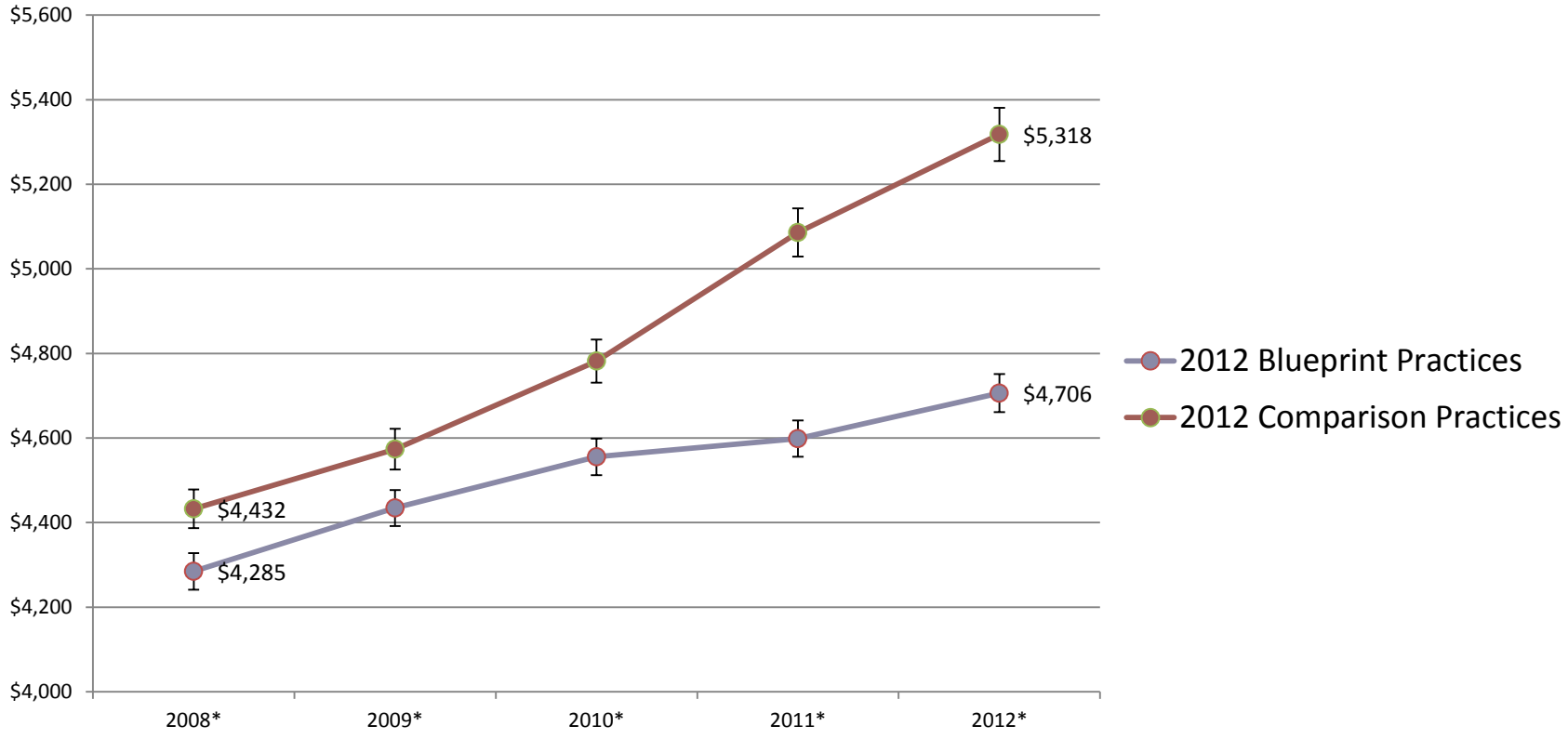


*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

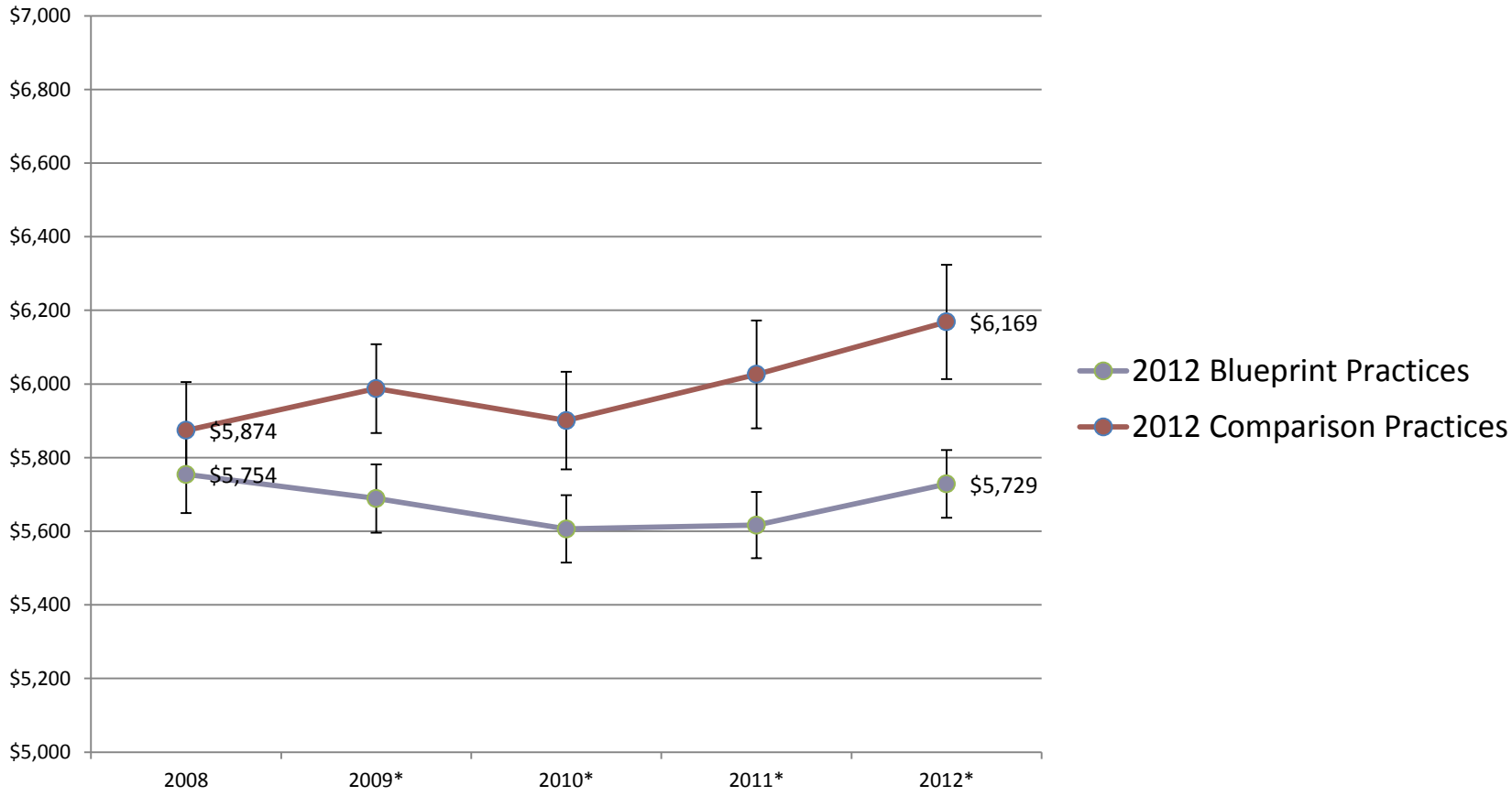
Study Groups by Age & Insurance Coverage

	Commercial (Ages 1-17 Years)		Commercial (Ages 18-64 Years)		Full Medicaid (Ages 1-17 Years)		Full Medicaid (Ages 18-64 Years)	
Demographic Measures	Blueprint 2012 Practices	Comparison 2012 Practices	Blueprint 2012 Practices	Comparison 2012 Practices	Blueprint 2012 Practices	Comparison 2012 Practices	Blueprint 2012 Practices	Comparison 2012 Practices
N								
2008	26417	32029	101919	105339	21714	19955	21417	17862
2009	29162	30675	117933	105811	24976	19515	27168	18993
2010	29260	27161	126593	95579	27562	18294	32313	18385
2011	29866	25082	135317	88880	29832	17189	35714	17321
2012	30632	22488	138994	83171	32812	15333	38281	16159

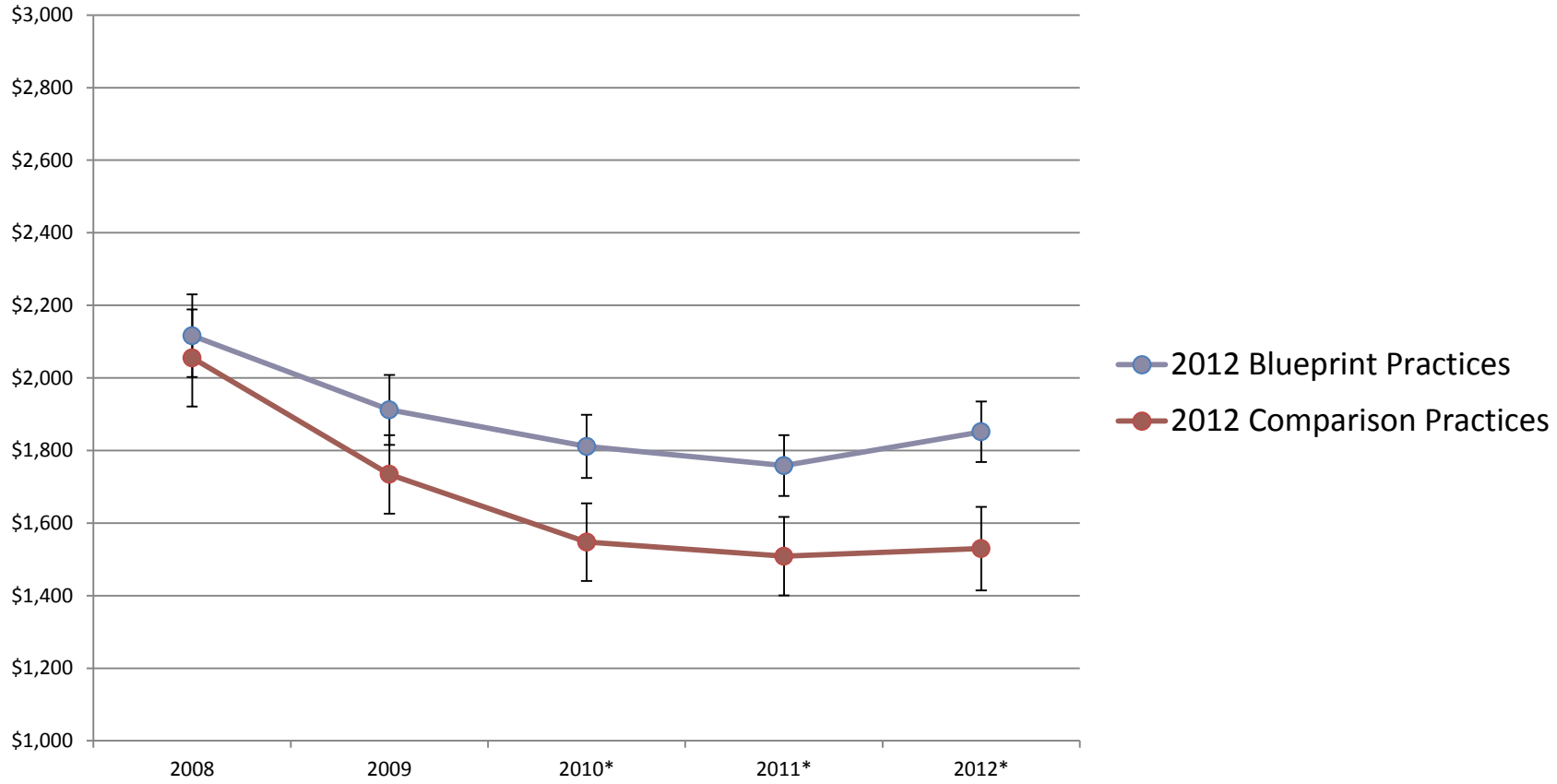
Total Expenditures Per Capita – Commercial Ages 18-64



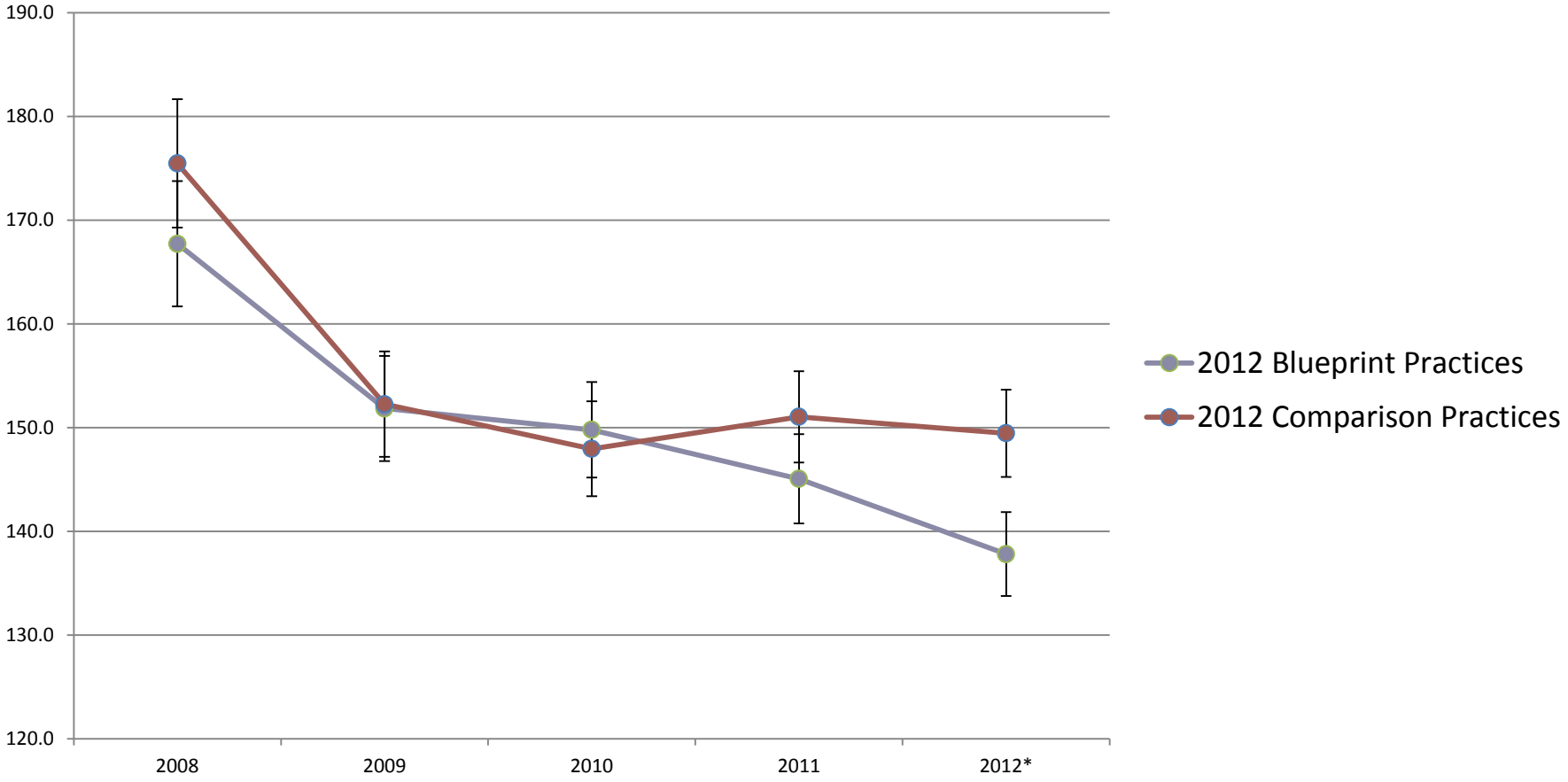
Total Expenditures Per Capita – Medicaid (minus SMS) Ages 18-64



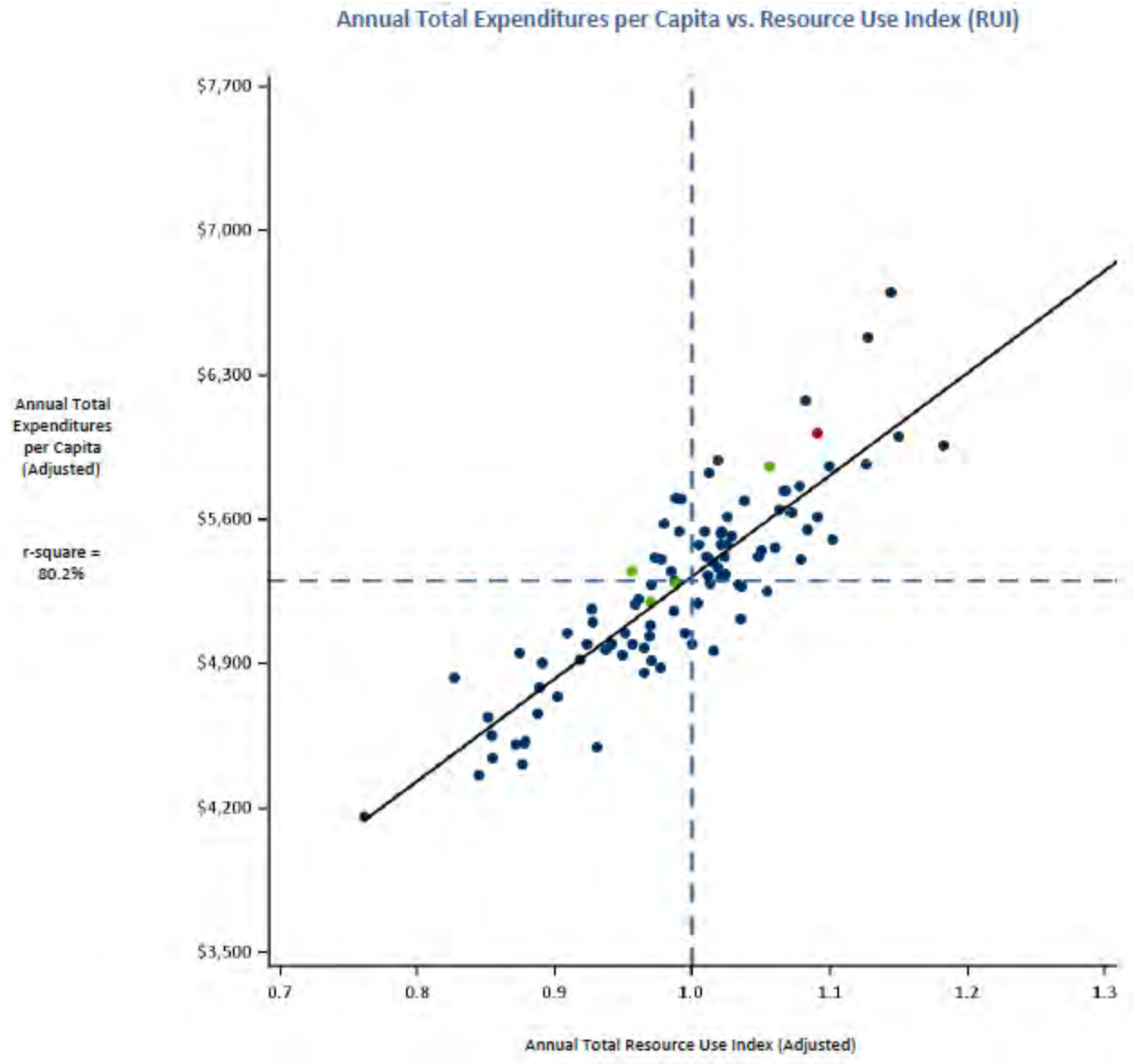
Expenditures Per Capita on Special Medicaid Services Ages 18-64



Inpatient Discharges Per 1000 Medicaid Ages 18-64



Variation & Comparative Reporting


Annual Total Expenditures per Capita vs. Resource Use Index (RUI)
$7,700
$7,000
$6,300
$5,600
$4,900
$4,200
$3,500
Annual Total Expenditures per Capita (Adjusted)
r-square = 80.2%
0.7
0.8
0.9
1.0
1.1
1.2
1.3
Annual Total Resource Use Index (Adjusted)

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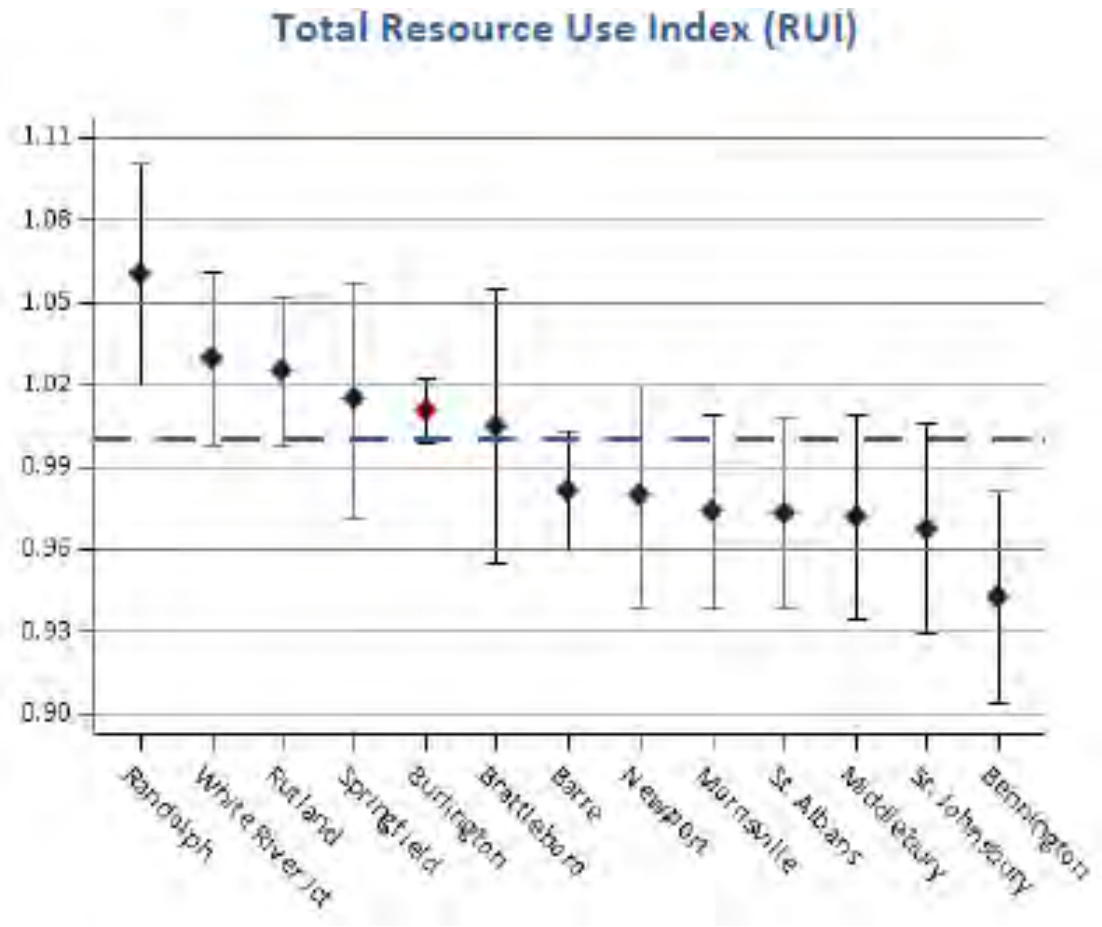
Practice Profile: Practice A

Period: 01/2012 - 12/2012 Practice HSA: ABC Profile Type: Adults (18-64 Years)

Measure	Practice			HSA			Statewide		
	Rate	95% LCL	95% UCL	Rate	95% LCL	95% UCL	Rate	95% LCL	95% UCL
Total	$6,019	$5,512	$6,526	$5,773	$5,576	$5,969	$5,307	$5,267	$5,347
Inpatient Total	$958	$649	$1,266	$977	$844	$1,109	$883	$854	$911
Inpatient Mental Health	$80	$14	$151	$90	$58	$122	$72	$66	$79
Inpatient Maternity	$128	$61	$195	$113	$92	$133	$108	$104	$111
Inpatient Surgical	$385	$193	$577	$453	$360	$546	$443	$420	$465
Inpatient Medical	$364	$152	$576	$321	$252	$391	$264	$251	$278
Outpatient Total	$2,171	$1,959	$2,382	$2,108	$2,023	$2,192	$1,741	$1,725	$1,756
Outpatient Hospital Mental Health	$36	$25	$48	$33	$27	$38	$21	$20	$22
Outpatient Hospital ED	$236	$194	$278	$242	$224	$260	$237	$233	$241
Outpatient Hospital Surgery	$692	$564	$820	$619	$567	$672	$421	$413	$430
Outpatient Hospital Radiology	$474	$351	$596	$507	$455	$558	$402	$392	$413
Outpatient Hospital Laboratory	$265	$244	$287	$300	$288	$313	$275	$273	$278
Outpatient Hospital Pharmacy	$48	$27	$70	$47	$36	$59	$103	$99	$108
Outpatient Hospital Other	$1,140	$988	$1,292	$1,047	$985	$1,109	$748	$737	$758
Professional Non-Mental Health Total	$1,187	$1,106	$1,268	$1,128	$1,096	$1,160	$1,191	$1,184	$1,199
Professional Physician Total	$924	$851	$998	$872	$843	$901	$899	$893	$906
Professional Physician Inpatient	$146	$95	$197	$134	$130	$177	$141	$136	$146
Professional Physician Outpatient Facility	$321	$278	$364	$285	$268	$302	$286	$282	$289
Professional Physician Office Visit	$427	$403	$452	$415	$405	$426	$444	$442	$447
Professional Non-Physician	$261	$239	$282	$252	$243	$261	$290	$288	$293
Professional Mental Health Provider	$105	$82	$128	$149	$138	$161	$167	$165	$170
Pharmacy Total	$973	$863	$1,084	$864	$823	$905	$835	$827	$844
Pharmacy Psych Medication	$192	$142	$241	$160	$145	$176	$167	$163	$170
Other Total	$173	$129	$217	$159	$140	$179	$140	$137	$144
Special Medicaid Services	$390	$187	$592	$384	$310	$459	$347	$331	$362
Mental Health Substance Combined*	$449	$349	$548	$425	$391	$460	$409	$402	$416


Total Resource Use Index (RUI)
1.11
1.08
1.05
1.02
0.99
0.96
0.93
0.90
Randolph
White River Jct
Rutland
Springfield
Burlington
Brattleboro
Barre
Newport
Morrisville
St. Albans
Middlebury
St. Johnsbury
Bennington

Composite Payment Model

Basis for Proposed Payment Model

- Current payments have stimulated substantial transformation
- Improved healthcare patterns, linkage to services, lower expenditures
- Reduced expenditures offset investments in PCMHs and CHTs
- Proposed payment modifications are needed to maintain participation
- Proposed payment modifications stimulate continued improvement
- PCMHs, CHTs, Networks - ingredients for a value based health system

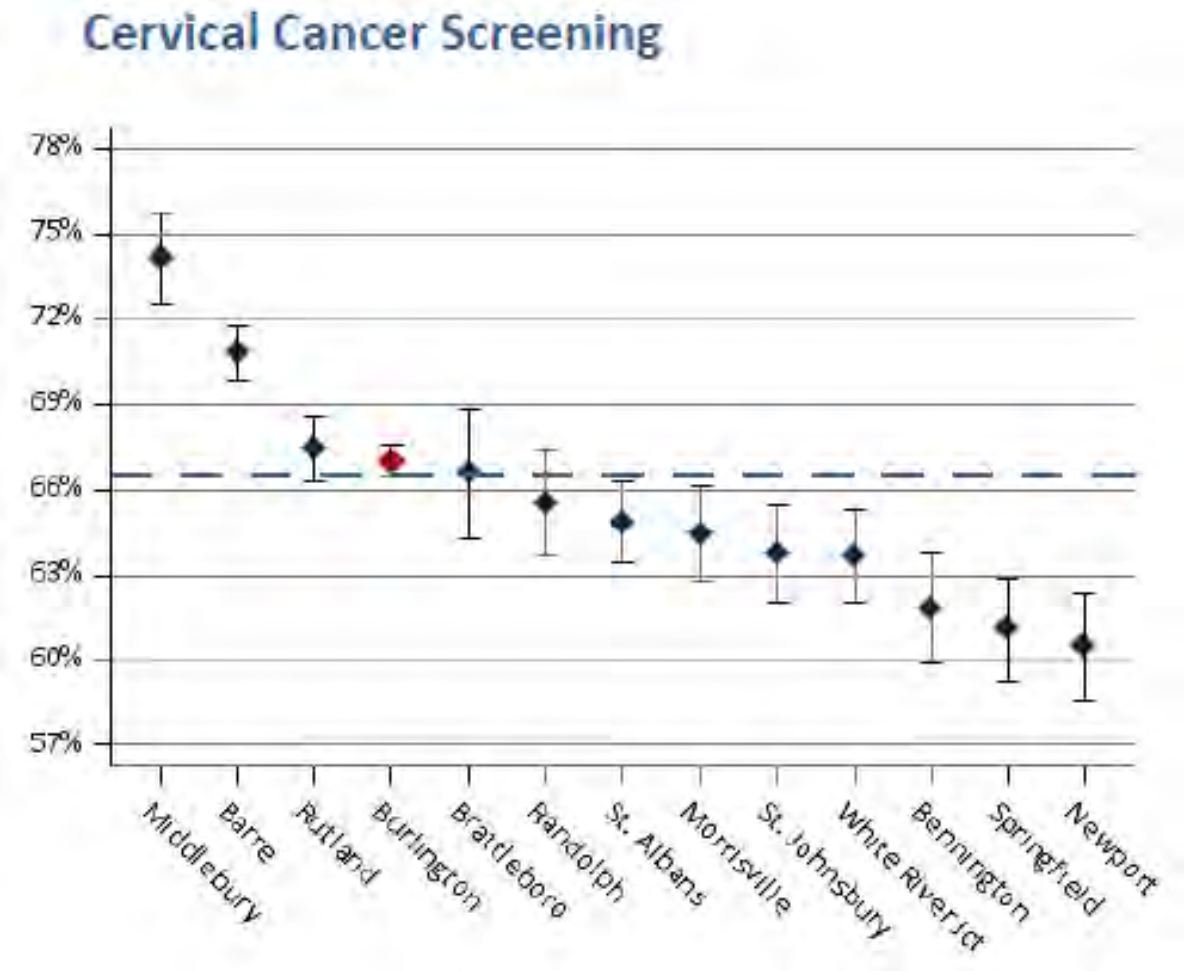
Composite Payment Model

- Pay for *transformation* – based on NCQA PCMH score
- Pay for *capacity* – investment in CHT Staff
- Pay for *outcomes* - incentive to achieve goals (new component)
- *Composite = Transformation + Capacity + Outcomes*

Proposed Changes

- Increase $PPPM based on NCQA score (Transformation)
- Increase $PPPM for CHTs (Capacity)
- Introduce P4P $PPPM (Outcomes)
  - Eligibility – based on quality (Composite HEDIS)
  - Payment – based on Total Resource Utilization Index (TRUI)

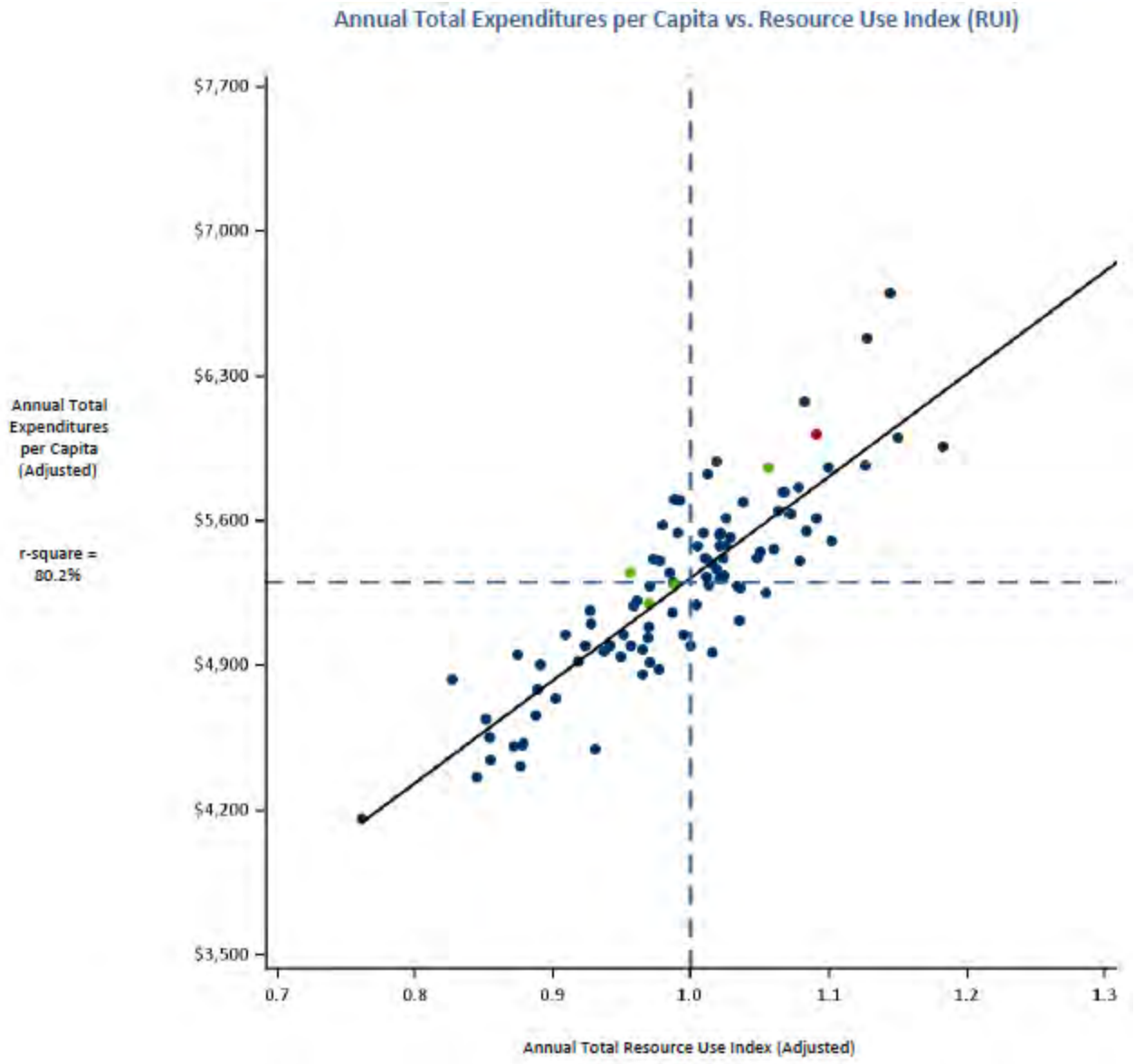
HEDIS Claims Based Quality Measures



Total Resource Use Index

- **TCRRV - Total Care Relative Resource Value.** Quantifies resource use for all procedures and services in a healthcare system. TCRRV reflects total utilization based on CMS weights applied to DRGs, APCs, RBRVS RVUs, & proprietary data source for Rxs. Designed to facilitate comparison across procedures, peer groups and healthcare settings (e.g. IP, OP, Professional, Pharm).

- **TRUI - Total Resource Use Index.** TRUI = Practice TCRRV / Statewide TCRRV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0.9
1.0
1.1
1.2
1.3
Annual Total Resource Use Index (Adjusted)

Key Components of Payment Model

- Baselines are derived from existing data
- Impact estimates are conservative relative to existing trends
- Doubles $PPPM based on NCQA score (range $2.50 - $5.00 PPPM)
- Doubles $PPPM for CHTs (increase from $1.50 to $3.00 PPPM)
- Introduces P4P $PPPM based on TRUI (eligibility based on HEDIS)
  - Pay for current performance (Quartiles 1,2,3)
  - Pay for improvement (% change in TRUI since last measurement)

Estimates for Models

LOOKUP TABLE
P4P COST- UTILIZATION

TUI QUARTILE	PMPM
1.00	$7.50
2.00	$5.00
3.00	$2.50
4.00	$0.00

LOOKUP TABLE
P4P GAIN- CHANGE IN TUI

CHANGE IN TUI INDEX	ANNUAL GAIN PER PATIENT
0.00	$0
0.01	$49
0.02	$98
0.03	$147
0.04	$196
0.05	$245
0.06	$294
0.07	$343
0.08	$392
0.09	$441
0.10	$490

LOOKUP TABLE
P4P COST- CHANGE IN TUI

CHANGE IN TUI INDEX	BONUS IN ADDITION TO PAYMENT/PATIENT	
	PMPM	PMPY
0.00	$0.00	$0.00
0.01	$1.00	$12.00
0.02	$1.50	$18.00
0.03	$2.00	$24.00
0.04	$2.50	$30.00
0.05	$3.00	$36.00
0.06	$3.50	$42.00
0.07	$4.00	$48.00
0.08	$4.50	$54.00
0.09	$5.00	$60.00
0.10	$5.50	$66.00

Increase PCMH & CHT Payments – Add TRUI Payment

	ACTUAL		PROJECTED		
	2012	2013	2014	2015	2016
TOTAL COMMERCIAL AND MEDICAID PRACTICES	105	123	128	130	131
AVERAGE PATIENTS PER PRACTICE	1847	1853	1854	1857	1858
TOTAL COST- PRACTICE TRANSFORM (NCQA PAYMENTS) W OR W/O SMS:	$4,816,377	$5,661,037	$9,124,039	$12,567,214	$12,665,531
TOTAL COST- CAPACITY EXPANSION (CHT PAYMENTS) W OR W/O SMS:	$3,490,128	$4,102,200	$6,408,331	$8,693,023	$8,761,031
TOTAL COST- TUI P4P PROGRAMS	$0	$0	$0	$14,488,372	$13,871,633
TOTAL GAIN- ADULTS AND PEDIATRICS- WITH SMS	$74,126,608	$86,894,214	$90,440,771	$91,869,516	$92,578,828
TOTAL GAIN- ADULTS AND PEDIATRICS- WITHOUT SMS	$91,413,165	$107,256,739	$111,657,731	$113,487,941	$114,368,140
TOTAL PROGRAM COSTS (INVEST'S NCQA & CHT) W OR W/O SMS	$8,306,505	$9,763,237	$15,532,370	$35,748,610	$35,298,196
PAYBACK- GAIN AS A MULTIPLE OF COST- WITH SMS:	8.92	8.90	5.82	3.07	3.05
PAYBACK- GAIN AS A MULTIPLE OF COST- WITHOUT SMS:	11.01	10.99	7.19	3.67	3.66

Consistency & Administrative Simplification

Blueprint Program Database

- Practice detail
- Provider detail
- NCQA Scores

→

All Payer Claims Database Analysts

- Person level record
- Provider-site linkage
- Attribution
- Patient counts
- Measure results
  - HEDIS Composite
  - Expenditures
  - Utilization
  - TRUI
- Comparative profiles
- Calculate payments
- Payment rosters

→

Insurers

- Verify patient counts
- Make payments

Consistency & Administrative Simplification

- Data (claims) aggregated as part of routine business
- No additional data collection or reporting by practices
- Minimize administrative burden on providers & insurers
- Supported by detailed comparative reporting to practices
- Consistency across all settings & insurers
- Transparency

Composite Payment Structure

Payment Type	Basis for Payment	Proposed Change
Transformation*		
PCMH	NCQA PCMH Score	Double $PPPM
Capacity		
CHT core	# PCMH Patients	Double $PPPM
Outcomes*		
Eligibility	HEDIS Quality Score	Introduce
P4P	Total Utilization Index Score	Introduce

*Extension of Transformation & Outcomes payments to specialty practices establishes aligned model & shared interests

Summary

- PCMHs, CHTs, Community Networks have demonstrated improvements in healthcare utilization & expenditures
- Supported by a transformation infrastructure and Learning Health System activities (leadership, facilitation, comparative reporting, shared learning)
- Proposed payment modifications continue to invest in and strengthen a foundation of preventive health services and a Learning Health System
- Coordination with emerging reforms (e.g. ACOs, Single Payer)
  - ACO partners can focus services on areas of need, add capacity as needed
  - Add new service layers based on population needs
  - Proposed P4P payment model aligns directly with goals
  - Testing targeted payment streams that can work under new financing model
  - Composite payment structure can be basis for reducing FFS

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AIMS	Operations	Payment	Payment Type
Access to Health Services Quality of Health Services Health Outcomes Control of Costs	<u>Improved Preventive Health Services</u> • Access & Continuity • Manage Populations • Plan & Manage Care • Self Care & Community Support • Track & Coordinate Care • Measure & Improve	<u>Current</u> • NCQA PCMH Stds - (PPPM, All Insurers) <u>Proposed</u> Step 1 - Agree to participate, preparation (PPPM, DVHA) Step 2 – NCQA Recognition (PPPM, DVHA) • NCQA PCMH Stds – (PPPM, All Insurers) • NCQA Specialty Stds - (PPPM, proposed)	Transformation
	<u>Care Support & Community Networks</u> • Multi-disciplinary team based preventive services for attributed populations (PCMH, Specialty) • Community workgroups tasked with improved coordination across an array of community providers (medical & non-medical) • Targeted support for Medicare & Medicaid beneficiaries • Targeted support for addiction & mental health	<u>Current</u> • CHT core – (All Insurers, shared cost) • SASH Teams – Medicare • MAT Staff - Medicaid • VCCI Staff – Medicaid <u>Proposed</u> • Increase CHT base payment • Determine needs for additional targeted CM (ACO)	Capacity

	<u>Improved Quality & Utilization</u>
	• Composite measure with broad impact
	• Shared interests between primary & specialty care
	• Coordination of services to improve quality & utilization
	  ○ increase recommended assessments
	  ○ increase access to practices & teams
	  ○ reduce unnecessary acute care
	  ○ attention to variation
	  ○ reduce unnecessary procedures, tests, & treatments
	• Change in TRUI associated with predictable change in healthcare expenditures per capita
	• Direct alignment with financial interests of ACOs
		<u>Current</u>
		• None
		
		<u>Proposed</u>
		• Eligibility - based on Quality (HEDIS)
		• Payment - based on TRUI
		• $PPPM for attributed patients
		  ○ top 3 quartiles on TRUI
		  ○ Improvement in TRUI
		• HEDIS & TRUI can be consistently measured at a practice level from the APCD
		• Reports routinely & automatically generated, sent to insurers
			Outcomes