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VERMONT Blueprint for Health

Smart choices. Powerful tools.

Homes, Teams, and Networks: A Foundation for Vermont's Health Reforms

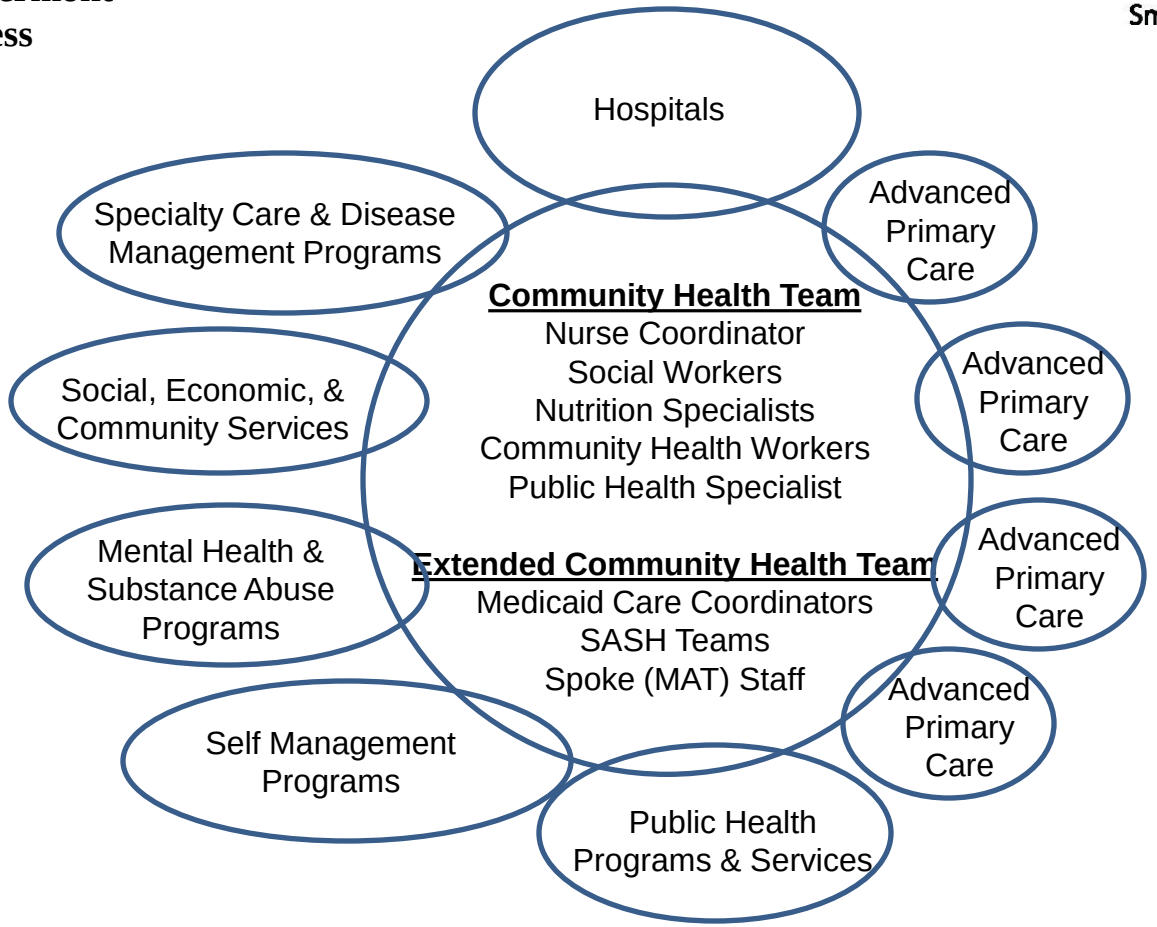
Blueprint Semi-Annual Meeting

October 20, 2014

Agenda

1. Program Update
2. Unified Community Health Systems
3. Payment Modifications
4. Solicit input for strategies & implementation

Program Update



All-Insurer Payment Reforms

Local leadership, Practice Facilitators, Workgroups

Local, Regional, Statewide Learning Forums

Health IT Infrastructure

Evaluation & Comparative Reporting

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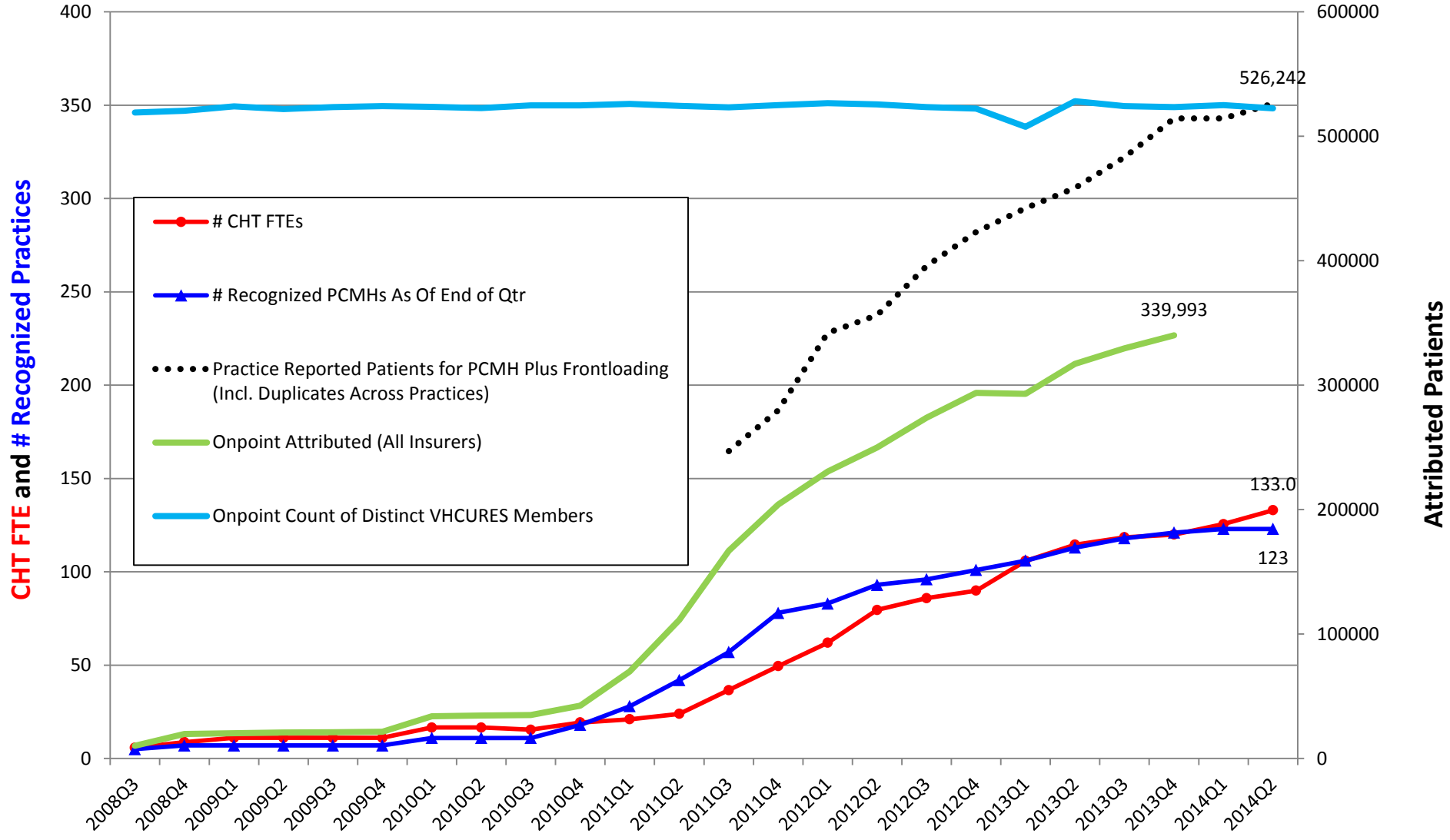
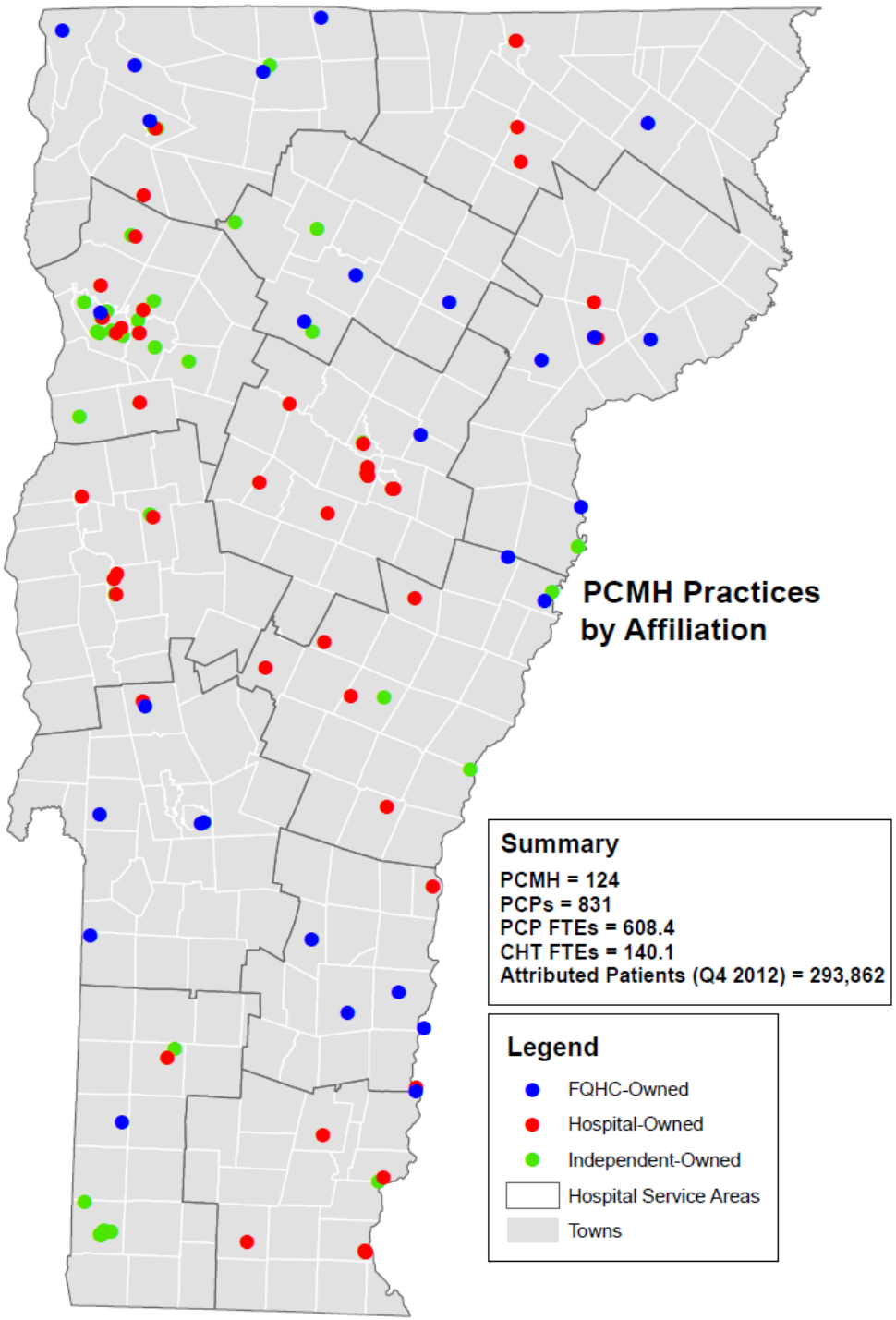


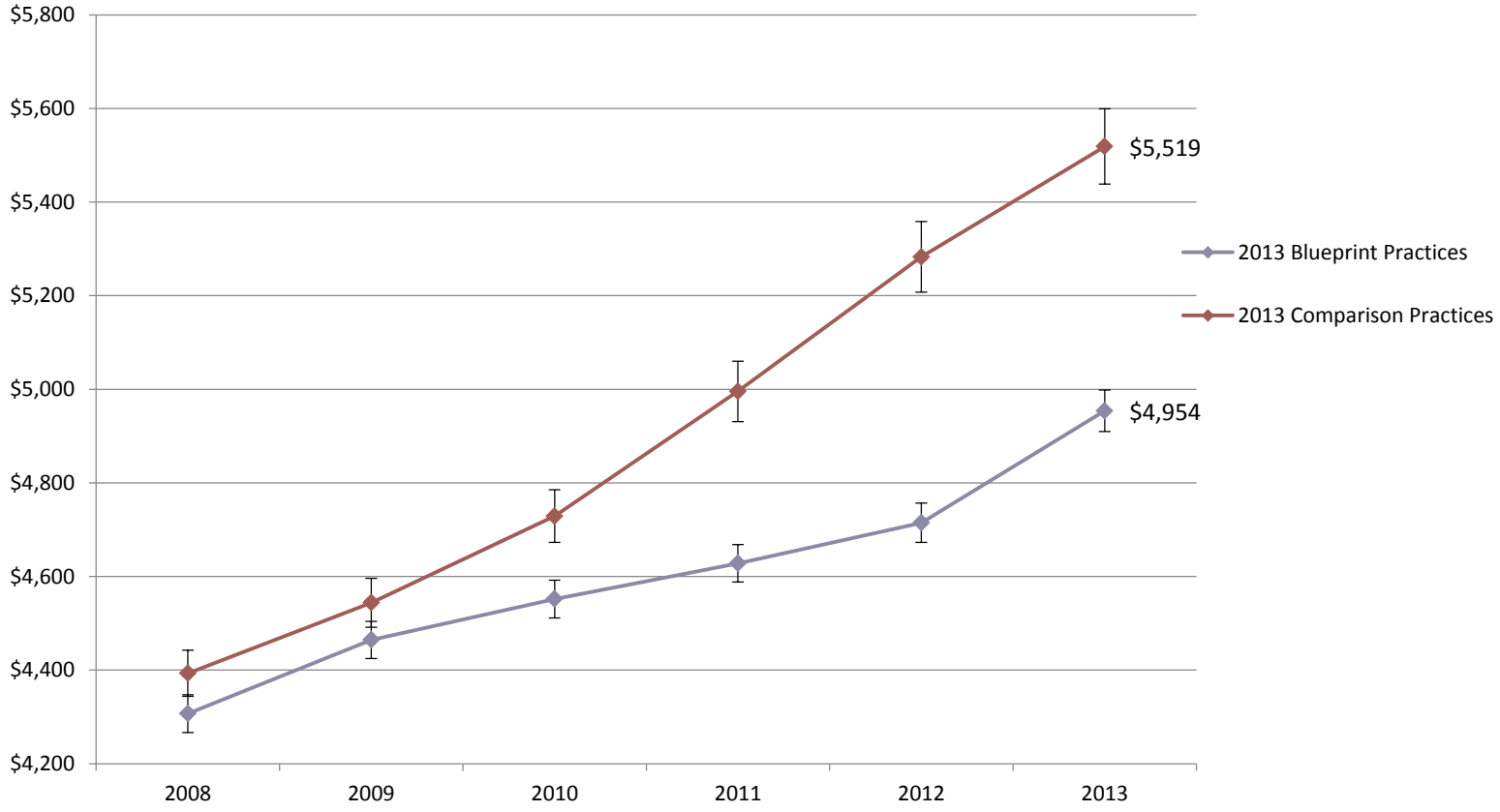
Health Services Network

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

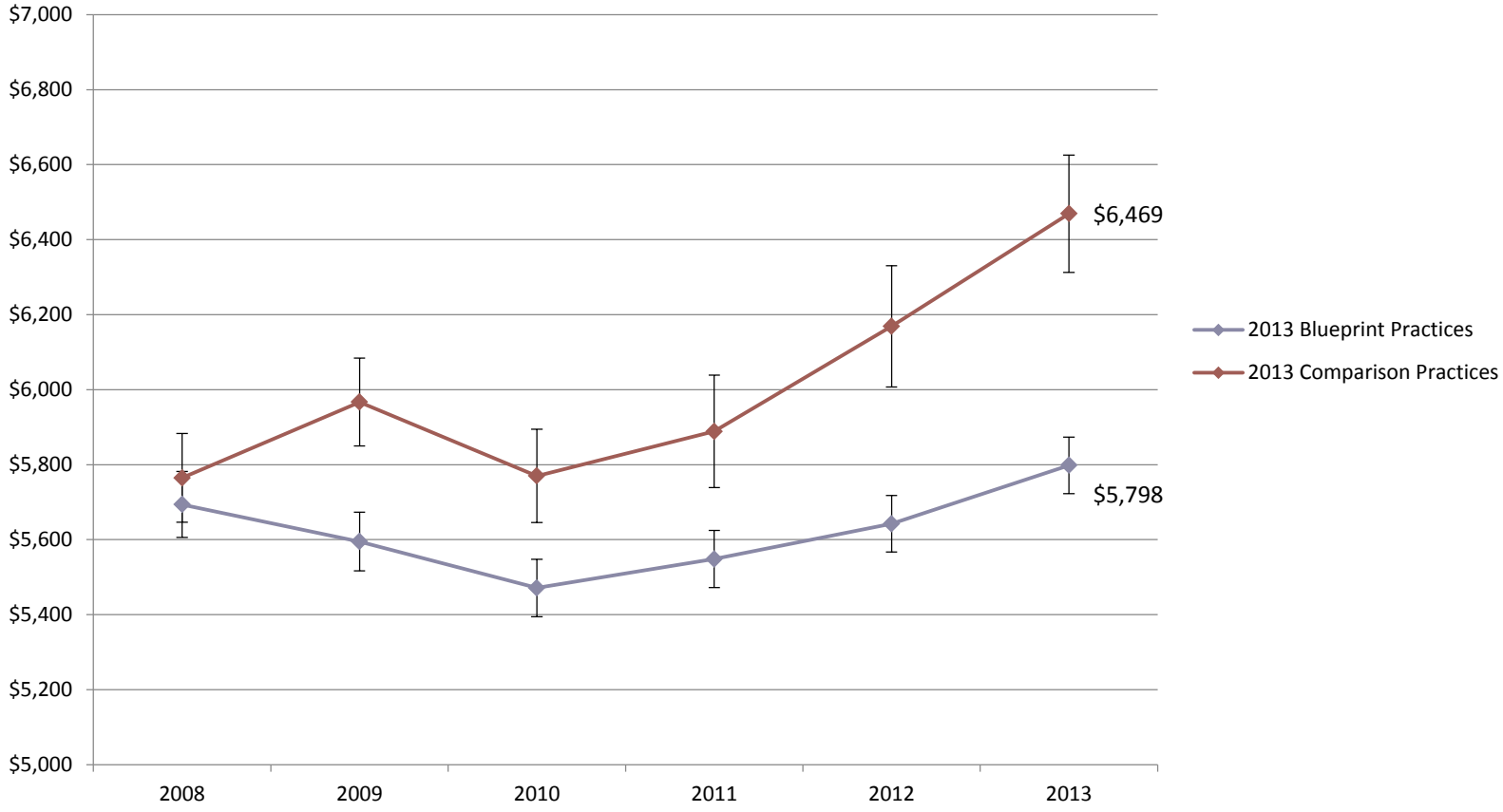

PCMH Practices by Affiliation
Summary
PCMH = 124
PCPs = 831
PCP FTEs = 608.4
CHT FTEs = 140.1
Attributed Patients (Q4 2012) = 293,862
Legend
FQHC-Owned
Hospital-Owned
Independent-Owned
Hospital Service Areas
Towns

	Participant Practices Included in Evaluation		Commercial (Ages 18-64 Years)		Medicaid (Ages 18-64 Years)	
Year of entry into the program			Participant	Comparison	Participant	Comparison
2008	6	For each year of the evaluation, the participant population includes all people who received care in practices that would become medical homes by 2013*	118,132	91,106	23,965	15,344
2009	6		136,445	89,452	30,362	15,851
2010	17		145,207	77,980	36,014	14,792
2011	76		156,695	68,281	40,245	12,980
2012	100		162,211	60,045	45,036	11,771
2013	123		160,350	59,402	44,385	12,247

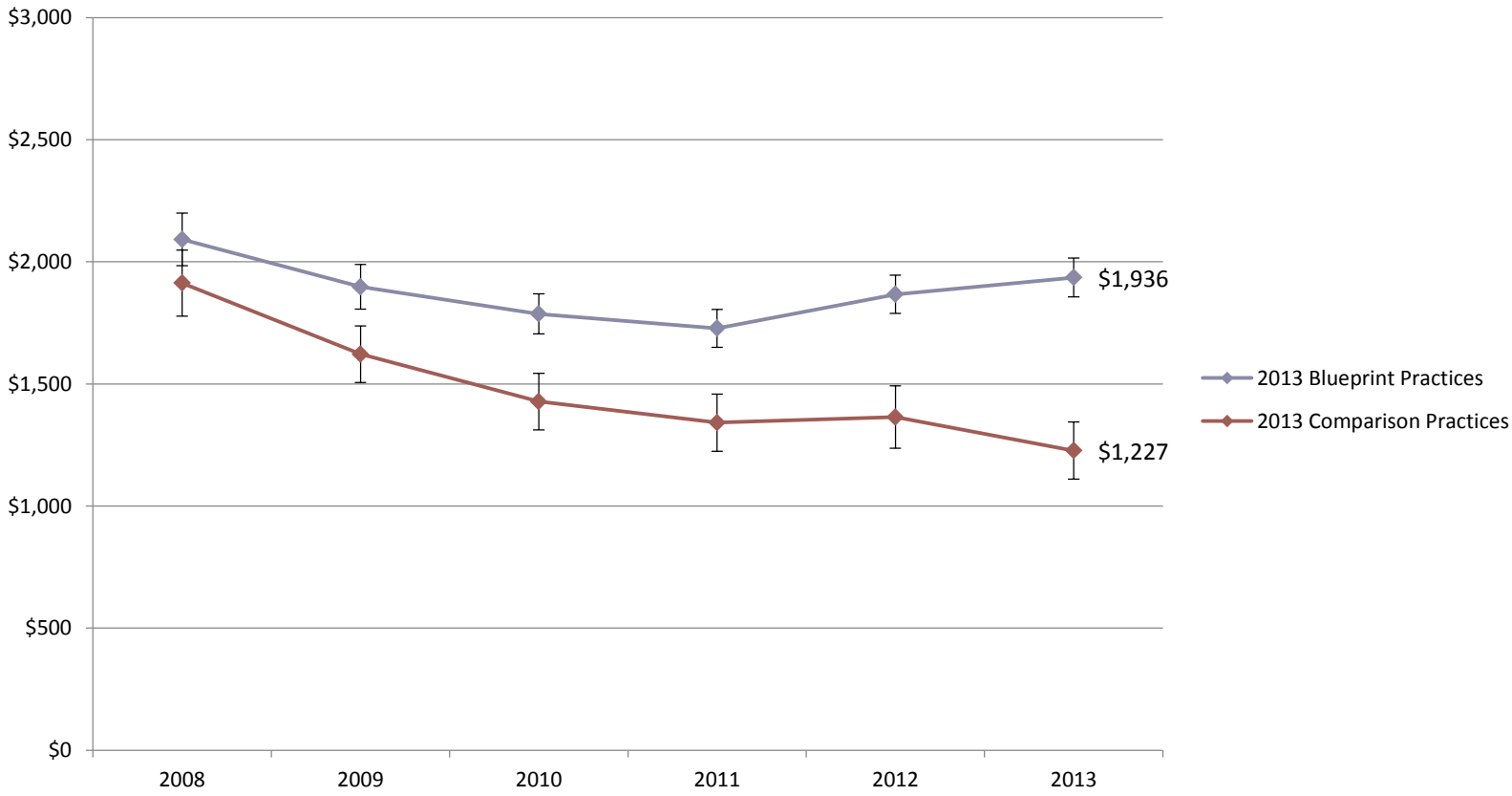
Total Expenditures per Capita 2008 - 2013 Commercial Ages 18-64 Years



Total Expenditures Excluding SMS per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years



SMS Total Expenditures per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years

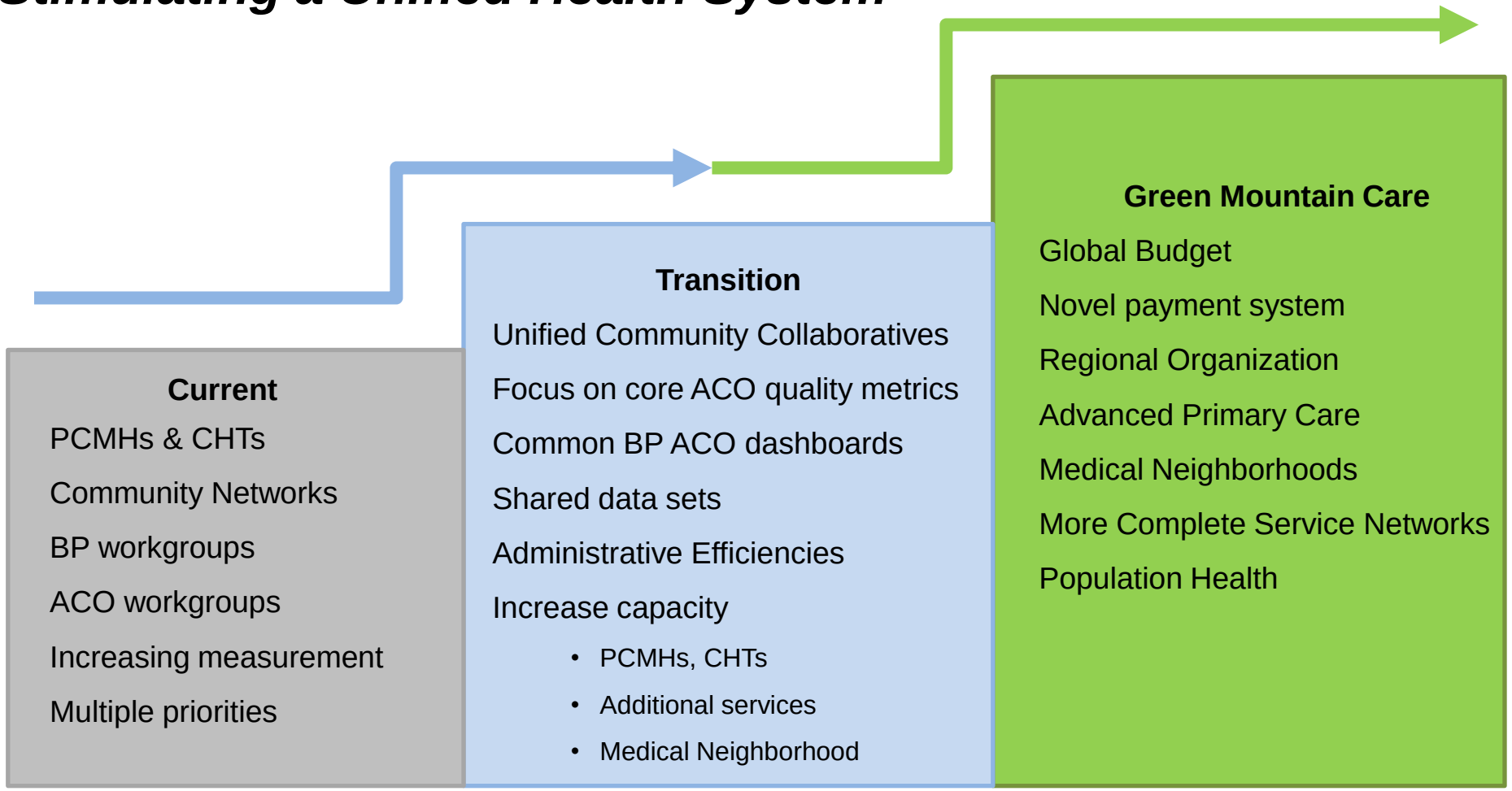


Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Essential delivery system foundation for Green Mountain Care
- Favorable trends over 6 years (utilization, expenditures, quality)
- Reduced expenditures that offset investment (PCMH & CHT payments)

Stimulating a Unified Learning Health System

Transition to Green Mountain Care
Stimulating a Unified Health System



Strategy for the Transition to Green Mountain Care

1. Unified Community Health System Collaboratives
2. Unified Performance Reporting & Data Utility
3. Administrative simplification and efficiencies
4. Build the medical neighborhood
5. Implement new service models (e.g. ACE, ECHO)
6. Payment Modifications

Strategy for the Transition to Green Mountain Care

Unified Community Health System Collaborative

- Unified local quality collaboratives (blend BP & ACO groups)
- Focus on core ACO measures (add ACO measure dashboard)
- Review examples that are up and running
- Quarterly larger groups & leadership, Monthly workgroups
- Co-chairs including clinical leadership from ACOs
- Local groups adopt charter an select leadership

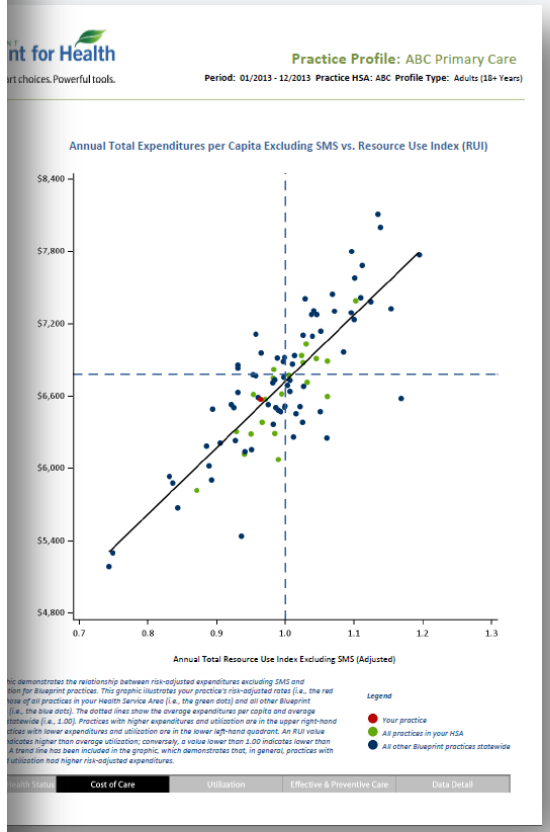
Strategy for the Transition to Green Mountain Care

Collaborative Performance Reporting

- Co-produce comparative profiles
- Include dashboard with results for ACO measures
- Possible thru a linkage of claims and clinical data
- Objective basis for planning & extension of best practices

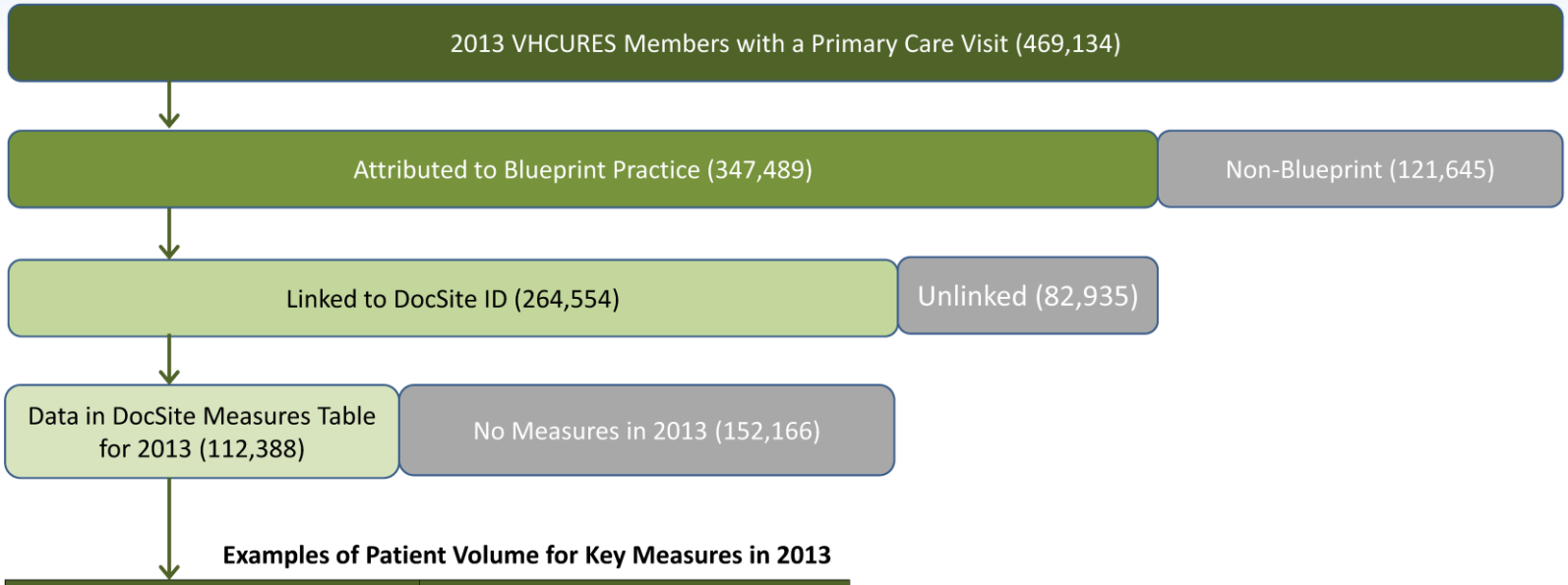
Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare



Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Clinical Outcomes



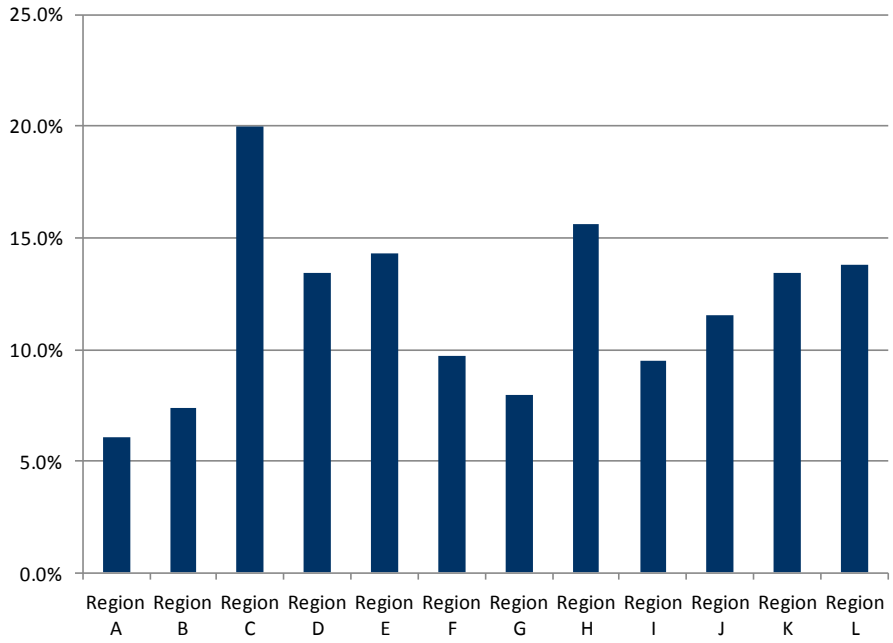
Examples of Patient Volume for Key Measures in 2013

Measure	Number of Patients with Data
Blood Pressure	93,230
Triglycerides	26,585
LDL-C	24,978
Tobacco Use	18,004
HbA1c	12,812

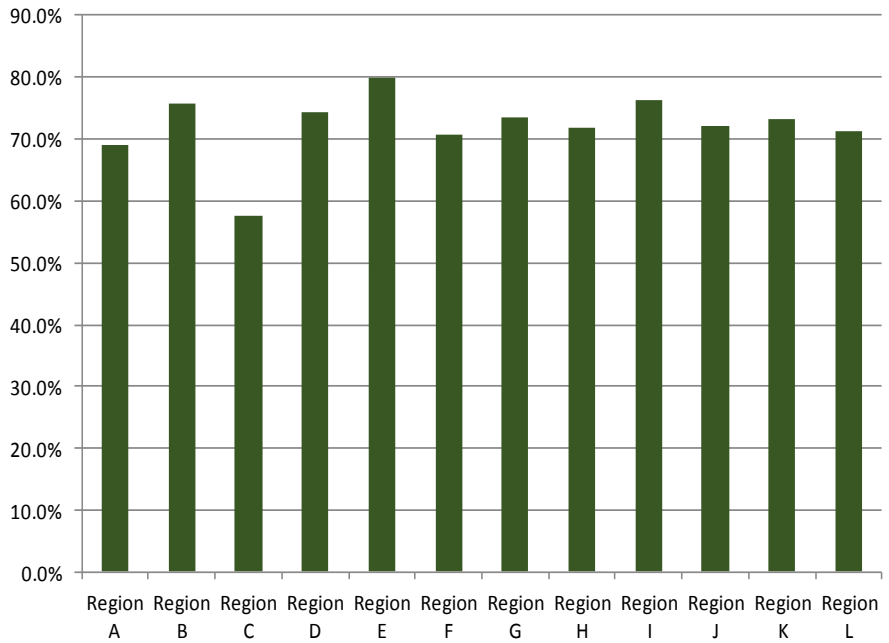
Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Outcomes Data

(ACO 27) % of Members with Diabetes, Glucose Not in Control (A1c >9%)



(ACO 28) % of Members with Hypertension, Blood Pressure in Control (<140/90 mm Hg)



Strategy for the Transition to Green Mountain Care

Data Utility

- Integration of diverse data sets for advanced measurement
- Produce analytic data sets to meet ACO measurement needs
- Share analytic data sets with ACOs
- Collaborative work with VITL and others to build data infrastructure

Strategy for the Transition to Green Mountain Care

Administrative Simplification, Efficiencies, & Cost Offsets

- Reduce insurer medical management programs (e.g. diabetes, hypertension)
- Insurer referrals to enhanced Community Health Teams
- BP participation meets insurer quality requirements for rule 9-03
- Approach NCQA regarding insurer requirements (quality, care management)
- Unified attribution process using VHCURES data

Strategy for the Transition to Green Mountain Care

Medical Neighborhood

- Prepare and score specialty practices against NCQA standards
- Assures high quality care across the continuum (primary, specialty care)
- Establishes statewide foundation aligned with NCQA ACO standards
- Predicts improvement in quality, utilization, and expenditures
- Alternative thru primary care attestation (no measurement against standards)

Recommended Payment Modifications

Basis for Recommendations

- 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
- Strengthen foundation during transition to GMC

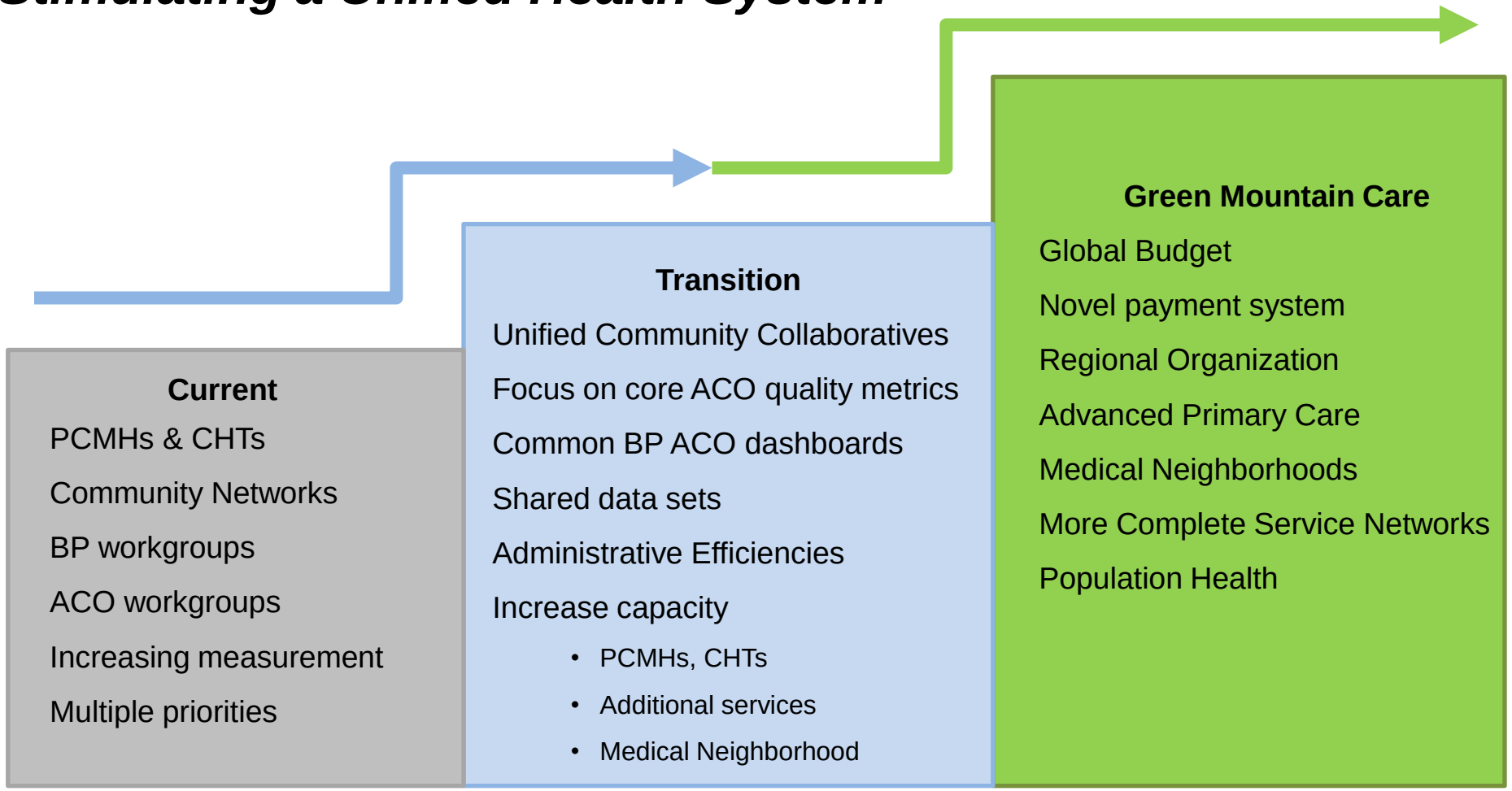
Options for Payment Modifications – Report to Legislature

1. Adjust insurer portion of CHT costs to reflect market share
2. Increase CHT payments
   - From $1.50 to $2.00 PPPM
   - From $1.50 to $3.00 PPPM
   - Health Home Model (add capacity)
3. Increase PCMH payments
   - From an average of $2.00-$2.50 to $4.00-$5.00 PPPM
4. Increase CHT and PCMH payments
5. Test new models (e.g. fully capitated PC payment, Health Home)

Goals for the Transition to Green Mountain Care

- Assure that Vermonters have unhindered access to the highest quality primary care and team based services
- Stimulate unified cohesive networks of medical and non-medical services in each community
- Demonstrate measurable improvement in the quality of preventive services that Vermonters receive (core measures, additional measures)
- Demonstrate measurable improvement in key outcomes in each community (health status, experience, utilization, costs)
- Formalize a community oriented and data guided health system, ready to operate under Green Mountain Care.

Transition to Green Mountain Care
Stimulating a Unified Health System



Questions & Discussion