Vermont Blueprint for Health

House Committee on Healthcare

February 5, 2016
Current State of Play – Path to Population Health

- Statewide foundation of primary care based on NCQA standards
- Community Health Teams providing supportive services to population
- Team extenders supporting key populations (SASH, Hub & Spoke, VCCI)
- Statewide transformation network (PMs, PFs, CHT leaders, ACO leaders)
- Statewide self-management network (HLWs, DPP, Tobacco Cessation)
- Maturing health information & data systems, comparative reporting
- Close work with ACOs on community collaboratives, new payment model
- Potential for a unified accountable health system and all payer model
# Health Services Network

<table>
<thead>
<tr>
<th>Key Components</th>
<th>June, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMHs (active PCMHs)</td>
<td>127</td>
</tr>
<tr>
<td>PCPs (unique providers)</td>
<td>698</td>
</tr>
<tr>
<td>Patients (Onpoint attribution) (Avg. 2014)</td>
<td>334,898</td>
</tr>
<tr>
<td>CHT Staff (core)</td>
<td>212 (132 FTEs)</td>
</tr>
<tr>
<td>SASH Staff (extenders)</td>
<td>~60 FTEs (54 panels)</td>
</tr>
<tr>
<td>Spoke Staff (extenders)</td>
<td>67 (42 FTEs)</td>
</tr>
</tbody>
</table>
Health IT Infrastructure
Evaluation & Comparative Reporting

All-Insurer Payment Reforms
Unified Community Collaboratives & Statewide Learning Forums
Transformation Network (Project Managers, Practice Facilitators, CHT Leaders, ACO Quality Leaders)

Health IT Infrastructure
Evaluation & Comparative Reporting
HSA Snapshots

BARRE HEALTH SERVICE AREA
Project Manager – Mark Young, RN

At a Glance:
- 33,002 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 14.3 FTE Community Health Team Staff
- 5.5 FTE Spoke Staff
- 13 Community Self-Management Workshops offered
- 5.5 SASH Teams; 414 Participants (Capacity = 530)
- 1835 CHT referrals
- 372 patients treated by MAT staff

MEDICAL HOME PRACTICES
OneCare Vermont
CVMC Adult Primary Care - Barre
CVMC Adult Primary Care - Berlin
CVMC Family Medicine – Berlin
CVMC Family Medicine – Mad River
CVMC Family Medicine – Waterbury
CVMC Green Mountain Family Practice
CVMC Integrative Family Medicine – Montpelier
CVMC Pediatric: Primary Care - Barre
CVMC Pediatric: Primary Care - Berlin
Green Mountain Natural Health
UVMMC Family Medicine - Berlin

Community Health Accountable Care
The Health Center - Plainfield

Highlights
UCC name: Community Alliance for Health Excellent (CAHE)
The majority of community partners are represented on the CAHE steering committee. Our group uses a decision matrix tool to help prioritize proposed projects. The state-wide learning collaboratives help guide active QI projects chosen by the CAHE. The CAHE community partner collaboration has created a balanced focus on health care and social determinants of health, both of which are crucial factors to recognize in the care management process.

Spotlight QI Project: Chronic Care Management Project
This project began as a six-month pilot involving a small panel of patients, half receiving care management and the other half receiving usual care. A certain set of criteria determined participants chosen. They received care management based on certain evidence-based guidelines. While the initial pilot patient population was small, results showed evidence of increased home health use, falls risk screening, care plan completion, and advance directive completion, as well as a decrease in PCP and inpatient utilization.
The CAHE voted to expand the pilot and use the regional Integrated Communities Care Management Collaborative as a venue for organizing and implementing the larger care management project.

Major achievement: CVMC received a grant to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) in medical homes. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for patients at risk for alcohol or other substance use dependence. Two (2) full-time SBIRT clinicians currently provide support to patients at six (6) of our medical homes.
Figure 2. Expenditures Per Person

Expenditures on healthcare for the whole population

Medicaid expenditures on special services
### Members by Stage of Program 2008 – 2014 All Insurers Ages 1 and Older

#### Blueprint

<table>
<thead>
<tr>
<th>Stage of Program</th>
<th>Member Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Year</td>
<td>267,327</td>
</tr>
<tr>
<td>Implementation Year</td>
<td>291,881</td>
</tr>
<tr>
<td>NCQA Scoring Year</td>
<td>333,470</td>
</tr>
<tr>
<td>Post year 1</td>
<td>343,373</td>
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<tr>
<td>Post year 2</td>
<td>300,770</td>
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<tr>
<td>Post Year 3</td>
<td>242,879</td>
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#### Non Blueprint

<table>
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<tr>
<th>Stage of Program</th>
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<tr>
<td>Pre-Year</td>
<td>181,628</td>
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<tr>
<td>Implementation Year</td>
<td>122,247</td>
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<tr>
<td>NCQA Scoring Year</td>
<td>160,196</td>
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<tr>
<td>Post year 1</td>
<td>100,107</td>
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<tr>
<td>Post year 2</td>
<td>81,855</td>
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<tr>
<td>Post Year 3</td>
<td>67,542</td>
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#### Blueprint

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<th>Stage of Program</th>
<th>Average Members</th>
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<tr>
<td>Pre-Year</td>
<td>246,214</td>
</tr>
<tr>
<td>Implementation Year</td>
<td>271,071</td>
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<tr>
<td>NCQA Scoring Year</td>
<td>311,245</td>
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<tr>
<td>Post year 1</td>
<td>320,586</td>
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<tr>
<td>Post year 2</td>
<td>279,064</td>
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<td>Post Year 3</td>
<td>225,974</td>
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</table>
Total Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and older

- Pre-Year: $5,600
- Implementation Year: $5,780
- NCQA Scoring Year: $5,822
- Post Year 1: $6,000
- Post Year 2: $6,200
- Post Year 3: $6,400
- Post Year 3: $6,600
- Post Year 3: $6,800
- Post Year 3: $7,000
- Post Year 3: $7,200
- Post Year 3: $7,400

- 2014 Blueprint Practices
- 2014 Comparison Practices
Inpatient Discharges Per 1000 Members 2008 – 2014 All Insurers Ages 1 and older

2014 Blueprint Practices
2014 Comparison Practices
Emergency Department Visits Per 1000 Members 2008 – 2014 All Insurers Ages 1 and older

- Pre-Year: 356.9
- Implementation Year: 368.2
- NCQA Scoring Year: 356.9
- Post Year 1: 375.8
- Post Year 2: 384.1
- Post Year 3:

Lines:
- 2014 Blueprint Practices
- 2014 Comparison Practices
Total SMS Expenditures Per Capita 2008 – 2014 Medicaid Ages 1 and older

- Pre-Year
- Implementation Year
- NCQA Scoring Year
- Post Year 1
- Post Year 2
- Post Year 3

2014 Blueprint Practices
- $424
- $438
- $476

2014 Comparison Practices
- $391
Table 2. Estimated Return on Investment for All Payers in Calendar Year 2014

<table>
<thead>
<tr>
<th>All-Payer</th>
<th>Investment</th>
<th>Reduction in total expenditures w/ SMS</th>
<th>Reduction in expenditures w/o SMS</th>
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</thead>
<tbody>
<tr>
<td>Reduction in expenditures</td>
<td>$123,142,342</td>
<td>$136,284,263</td>
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<tr>
<td>PCMH Payments</td>
<td>$6,590,964</td>
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<tr>
<td>Core CHT Payments</td>
<td>$8,893,643</td>
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<td>Total Payments</td>
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<td>Blueprint Program Budget</td>
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<td>Total investment</td>
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<td>Return on investment</td>
<td>5.8</td>
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<td>6.5</td>
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Note: Blueprint Program Budget is the average of the FY2014 and FY2015 budgets to estimate the calendar year 2015 budget. Also note the budgeted amount does not reflect actual programmatic expenditures, which may be lower.
Table 3: Estimated Return on Investment for Medicaid in Calendar Year 2014

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Investment:</th>
<th>Reduction in expenditures w/ SMS</th>
<th>Reduction in expenditures w/o SMS</th>
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<td>Reduction in expenditures</td>
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<tr>
<td>PCMH Payments</td>
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<td>Core CHT Payments</td>
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<td>Total Payments</td>
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<tr>
<td>Blueprint Program Budget</td>
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<tr>
<td>Total investment</td>
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<td>$10,007,886</td>
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<tr>
<td>Return on investment</td>
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<td>0.9</td>
<td>3.0</td>
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Note: Blueprint Program Budget is the average of the FY2014 and FY2015 budgets to estimate the calendar year 2015 budget. Also note the budgeted amount does not reflect actual programmatic expenditures, which may be lower.
### Table 6: Projected Impact on All Payers of Increased PCMH and CHT Payments in 2016

<table>
<thead>
<tr>
<th>All-Payer</th>
<th>Investment</th>
<th>Reduction in total expenditures w/ SMS</th>
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<td></td>
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<tr>
<td>PCMH Payments</td>
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<tr>
<td>Core CHT Payments</td>
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<td>Total Payments</td>
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<tr>
<td>Blueprint Program Budget</td>
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<tr>
<td>Total investment</td>
<td>$25,592,577</td>
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<tr>
<td>Return on investment</td>
<td></td>
<td>4.8</td>
<td>5.3</td>
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Payment Modifications

- Increase medical home payments (range from $3.00 to $3.50 pppm)
- All eligible practices receive $3.00 pppm base payment
- Practices earn up to $0.50 pppm based on 2 performance payments
  - 1 payment tied to service area performance on core measures
  - 1 payment tied to practice performance on utilization index
- Each insurer's portion of CHT costs based on market share
Medical Home Payment Model

- **Utilization $0.25 pppm**
- **Quality $0.25 pppm**
- **Base Payment $3.00 pppm to all eligible practices**

**Performance tied to population outcomes**
- Utilization index payment based on practice level results
- Quality composite payment based on service area results

**Base Payment tied to practice activity**
- Participation in ≥ 1 UCC initiative per year
- Current Recognition on NCQA standards
Core ACO Measures Selected

- Core- 2: Adolescent Well-Care Visit
- Core- 8: Developmental Screening in the First Three Years of Life
- Core- 12: Rate of Hospitalization for ACS Conditions (PQI Chronic Composite)
- Core- 17: Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)
Total Resource Use Index

A 0.01 change in TRUI is associated with a $66.80 change in expenditures per person.
Data, Evaluation, & Reporting

- Linkage of claims, clinical, and other data sets
- Production of standard measure results including core ACO measures
- Public monitoring, comparative evaluation, performance reporting
- Associations & predictive modeling
- Migration of Blueprint clinical registry to VITLs hosted environment

Work with VITL to optimize data capture, quality, and availability
Data Use for a Learning Health System

- Utilization Measures
- Expenditure Measures
- Unit Costs
- Quality Measures
- Patient Experience Measures
- Comparative Evaluation
- Practice Profiles
- HSA Profiles
- PCMH + CHT Evaluation
- Hub & Spoke Evaluation
- Associations & Predictive Models
- Planning, Coordination, Quality
- Performance Payments
Storybook Version

Traditional payment, healthcare patterns, and quality

PCMHs, CHTs, community oriented services, targeted capitated payments

Formation of ACOs, shared savings, unified community collaboratives

Unified Accountable Health System, All Payer Model
Reality (federal accelerators)

Medicaid Global Commitment Waiver

Multi Payer Advanced Primary Care Demonstration

MAT Health Home

SIM

Shift to GC

Next Gen ACO
Unified ACO
New CMS Waivers
(All Payer Model)

ARRA (Stimulus), HITECH Act


Statewide PCMHs, CHTs, SASH, self management programs. All-insurer payment reforms. Comparative evaluation, dashboards, learning activities.


Community oriented accountable health system? Universal primary care?

Expansion of EHR use, VITL HIE development, Data quality & aggregation, Comparative performance monitoring & evaluation, Use of data driven information to guide a learning system
Planning for the Future

Priorities for Next Phase of Reforms

- The foundation continues to improve (primary care, community services)
- Next generation payment models (primary care, community services)
- Best use of the transformation network (PFs, PMs, CHT leaders)
- Self management programs strengthened (HLWs, DPP, Tobacco)
- The data utility continues to develop (quality, aggregation, linkage)
- The use of data continues to advance (learning, QI, predictive models)
Questions & Discussion