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Department of Vermont Health Access

VERMONT Blueprint for Health

Smart choices. Powerful tools.

House Committee on Healthcare

CMS Evaluation of the Multi-Payer Advanced Primary Care Practice Demonstration

HUD and ASPE Evaluation of Vermont's Support & Services at Home Program

February 25, 2015

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Department of Vermont Health Access

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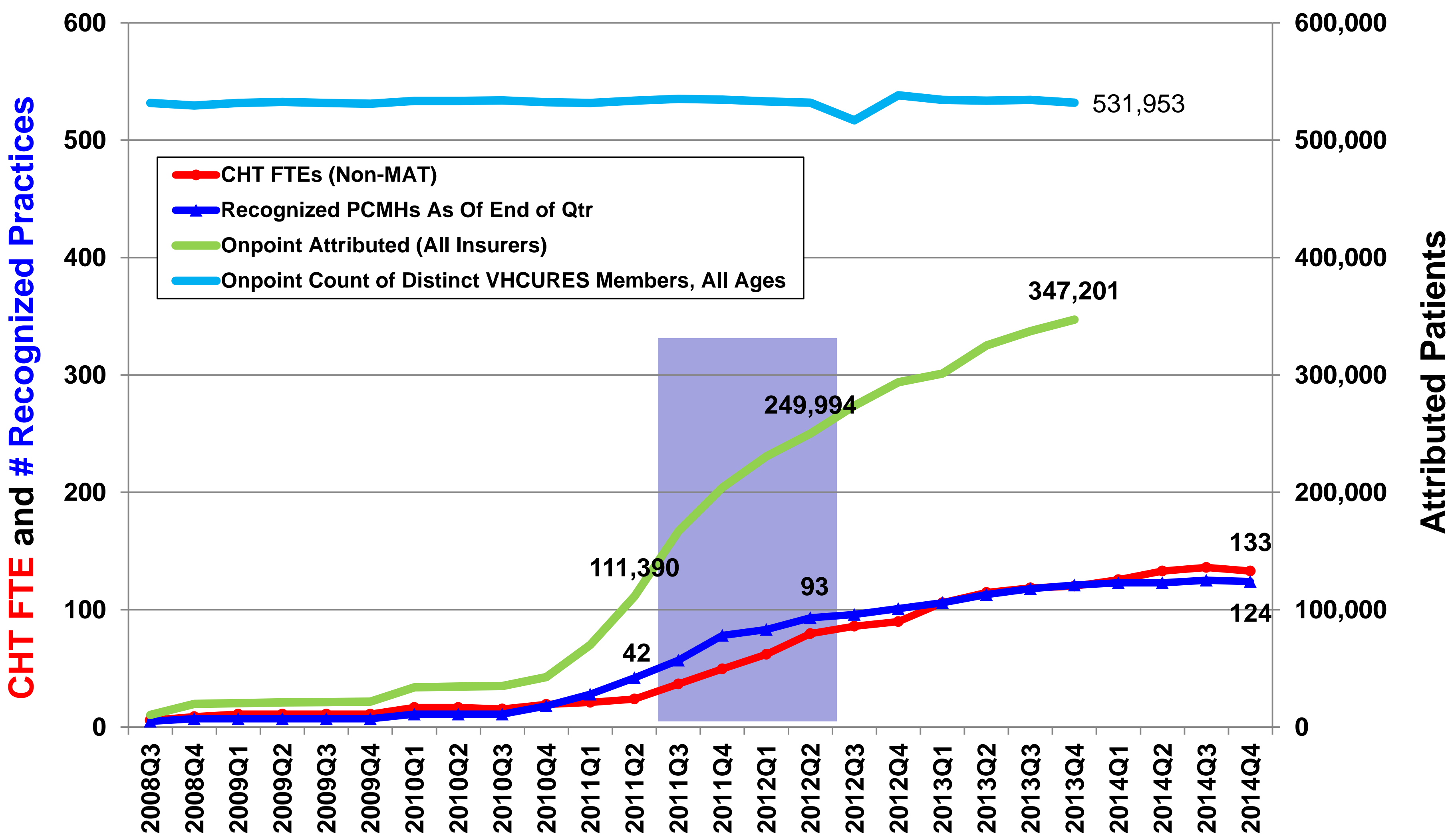
Smart choices. Powerful tools.

Study Period in the MAPCP Report: July 2011 thru June 2012

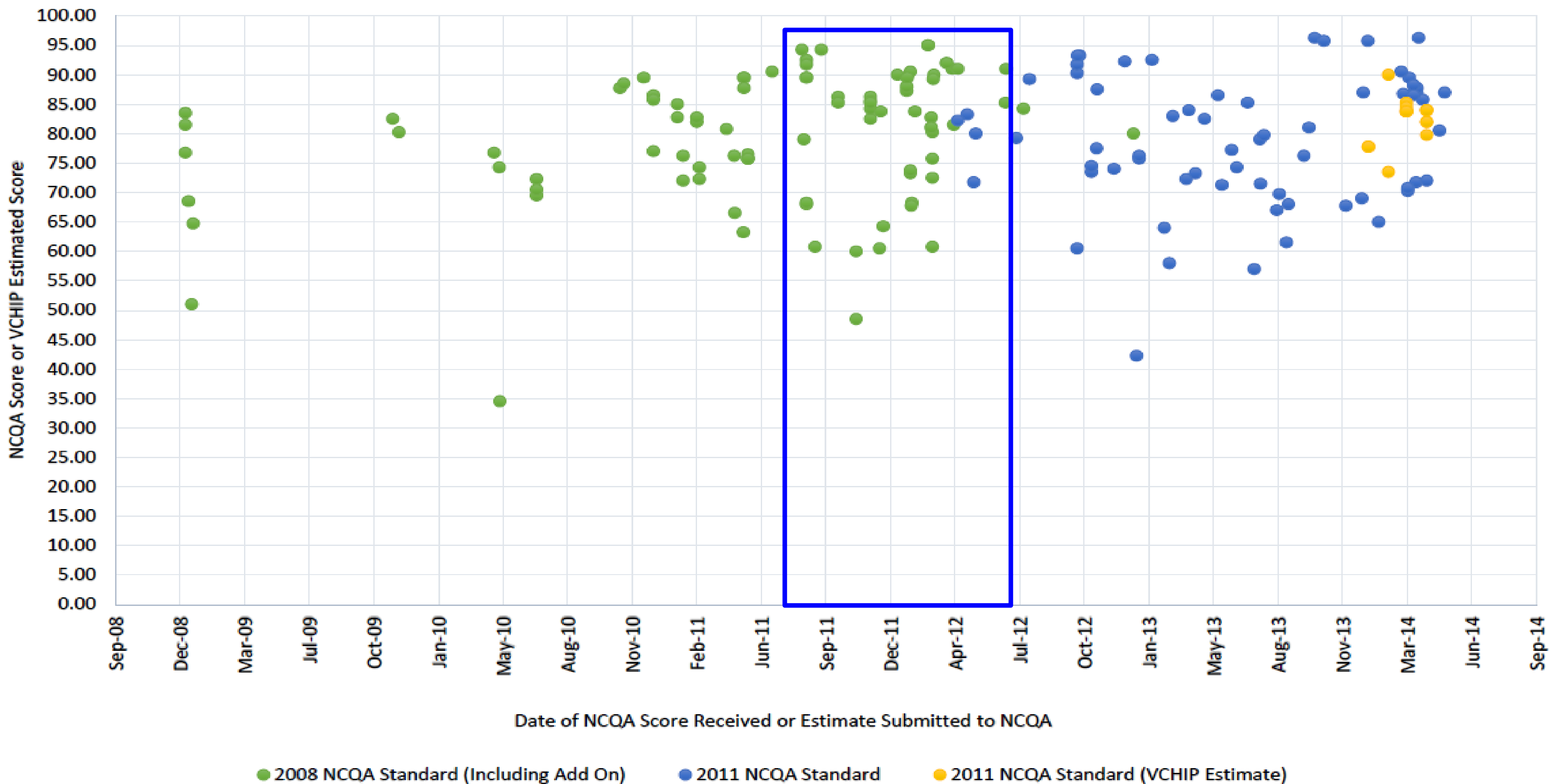


VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

St. Joseph's 7, UHC Campus, 1 South Prospect Street, Burlington, Vermont 05401
802 656 8210 TEL 802 656 8368 FAX

www.vchip.org

Figure 10. NCQA Scores[4] or VCHIP Estimates[5] Over Time (by NCQA's Patient-Centered Medical Home (PCMH) Standard)



2.2.2 Demonstration Scope

Table 2-2
MAPCP Demonstration scope as of the end of year 1 in each state

State	Geographic scope	Participants		Practices[2]	Providers[2]	Payers (including Medicare)
		All-payer	Medicare[1]			
Maine	Statewide	68,627	21,497	21	200	5
Michigan	Statewide	1,035,476	226,369	321	1404	4
Minnesota	Statewide	506,772	65,612	121	1027	—*
New York	Regional (4 counties)	94,690	21,441	39	180	9
North Carolina	Regional (7 counties)	84,860	26,438	43	138	4
Pennsylvania	Regional (2 regions)	198,733	28,236	57	385	9
Rhode Island	Statewide	46,212	7,912	16	73	5
Vermont	Statewide	190,167	48,848	86	430	5
TOTAL	—	2,225,537	408,007	704	3,837	41

1.2.2 Identification of Comparison Beneficiaries

Table 1-1
Intervention and comparison areas by MAPCP Demonstration state

State	Demonstration area	Proposed comparison area
Maine	11 counties in southern part of state	Same as demonstration counties
Michigan	40 counties	Same as demonstration counties
Minnesota	24 counties	Same as demonstration counties
New York	7 counties in Adirondacks region	16 counties in upstate area
North Carolina	7 mostly rural counties scattered across state	16 counties in remainder of state
Pennsylvania	4 counties in Northeast region, 5 counties in Southeast region	Same as demonstration counties
Rhode Island	3 westernmost counties in state	Same as demonstration counties
Vermont	All 14 counties in state	10 counties in New Hampshire and 1 county in Massachusetts

1.2.6 Quantitative Methods for Evaluation of Early Outcomes

Table 1-4
Baseline, pilot and demonstration period, by state

State	Pre-demonstration Baseline Period	Pre-demonstration Pilot Period	Demonstration Period
New York	Jan. 2006–Dec. 2009	Jan. 2010–Jun. 2011	Jul. 2011–Jun. 2012
Rhode Island	Jan. 2006–Sep. 2008	Oct. 2008–Jun. 2011	Jul. 2011–Jun. 2012
Vermont	Jan. 2006–Jun. 2008	Jul. 2008–Jun. 2011	Jul. 2011–Jun. 2012
North Carolina[1]	Jan. 2006–Sep. 2011	n/a	Oct. 2011–Sep. 2012
Minnesota	Jan. 2006–Jun. 2010	Jul. 2010–Sep. 2011	Oct. 2011–Sep. 2012
Maine	Jan. 2006–Dec. 2009	Jan. 2010–Dec. 2011	Jan–Dec. 2012
Michigan[2]	Jan. 2006–Dec. 2011	n/a	Jan–Dec. 2012
Pennsylvania[3]	Jan. 2006–Apr. 2008	May 2008–Dec. 2011	Jan–Dec. 2012

2.2.3 Practice Expectations

- All of the state initiatives established standards that practices must meet in order to participate in the demonstration and to receive payment (qualification standards).
- Six of the state initiatives (Maine, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont) based their standards primarily on the NCQA PPC® PCMH™ recognition standards.
- Minnesota developed its own state Health Care Home standards. Michigan allowed practices to choose whether they wanted to secure recognition from NCQA or through Blue Cross Blue Shield (BCBS) of Michigan's Physician Group Incentive Program (PGIP).

2.2.4 Support to Practices

- Six state initiatives also pay care management organizations that support participating practices and patients.
- Maine and Rhode Island have CCTs, Michigan has physician organizations, New York has pods, North Carolina has networks, and Vermont has community health teams (CHTs) and Support and Services at Home (SASH) teams.
- Although these organizations vary in structure, staffing, and payment, they are all intended to augment the care coordination provided by practices and improve the linkages between primary care practices and community services.
- Depending on the nature of their full responsibilities in supporting practices and patients, these organizations may employ dieticians, pharmacists, social workers, and others in addition to care managers.

2.6.4 Effectiveness (Utilization & Expenditures)

Table 2-6
Comparison of average demonstration effects for Medicare expenditures and utilization rates during the first year of the MAPCP Demonstration, comparing performance for Medicare FFS beneficiaries assigned to MAPCP Demonstration PCMHs, comparison PCMHs and comparison non-PCMHs

	Rhode Island		Vermont		New York		North Carolina	
Outcome	PCMH CG	non-PCMH CG	PCMH CG	non-PCMH CG	PCMH CG	non-PCMH CG	PCMH CG	non-PCMH CG
Total expenditures ($)	1.04	28.58	−35.21* (p) −8.86 (np)	−42.65* (p) −13.58 (np)	20.69*	17.27	50.36*	47.36*
Acute-care expenditures ($)	−6.11	10.58	−10.11 (p) 14.02 (np)	−21.05* (p) 5.62 (np)	10.32	4.83	27.95*	23.92*
ER expenditures ($)	−1.89	2.02	−1.87 (p) −0.05 (np)	−1.68 (p) −0.37 (np)	5.75*	5.17*	6.28*	4.66*
All-cause hospitalizations (per 1,000 beneficiaries)	2	4	2 (p) 8* (np)	2 (p) 8* (np)	3	4*	5*	4*
ER visits (per 1,000 beneficiaries)	1	4	4 (p) 9* (np)	8 (p) 15* (np)	−4	0	8*	6
Unplanned readmissions (per 1,000 beneficiaries)	22	18	18* (p) 38* (np)	7 (p) 24* (np)	15	10	25*	19*

(continued)

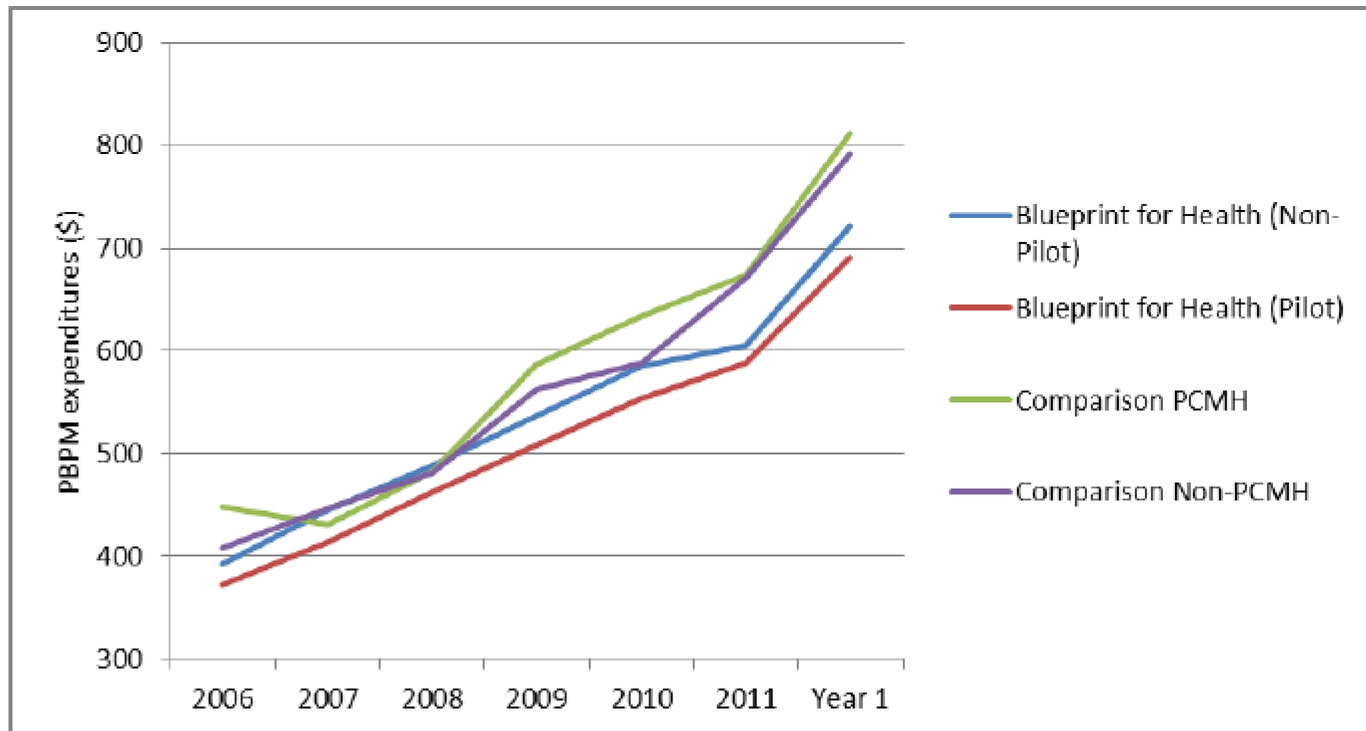
2.7 Budget Neutrality in Year 1 of the MAPCP Demonstration

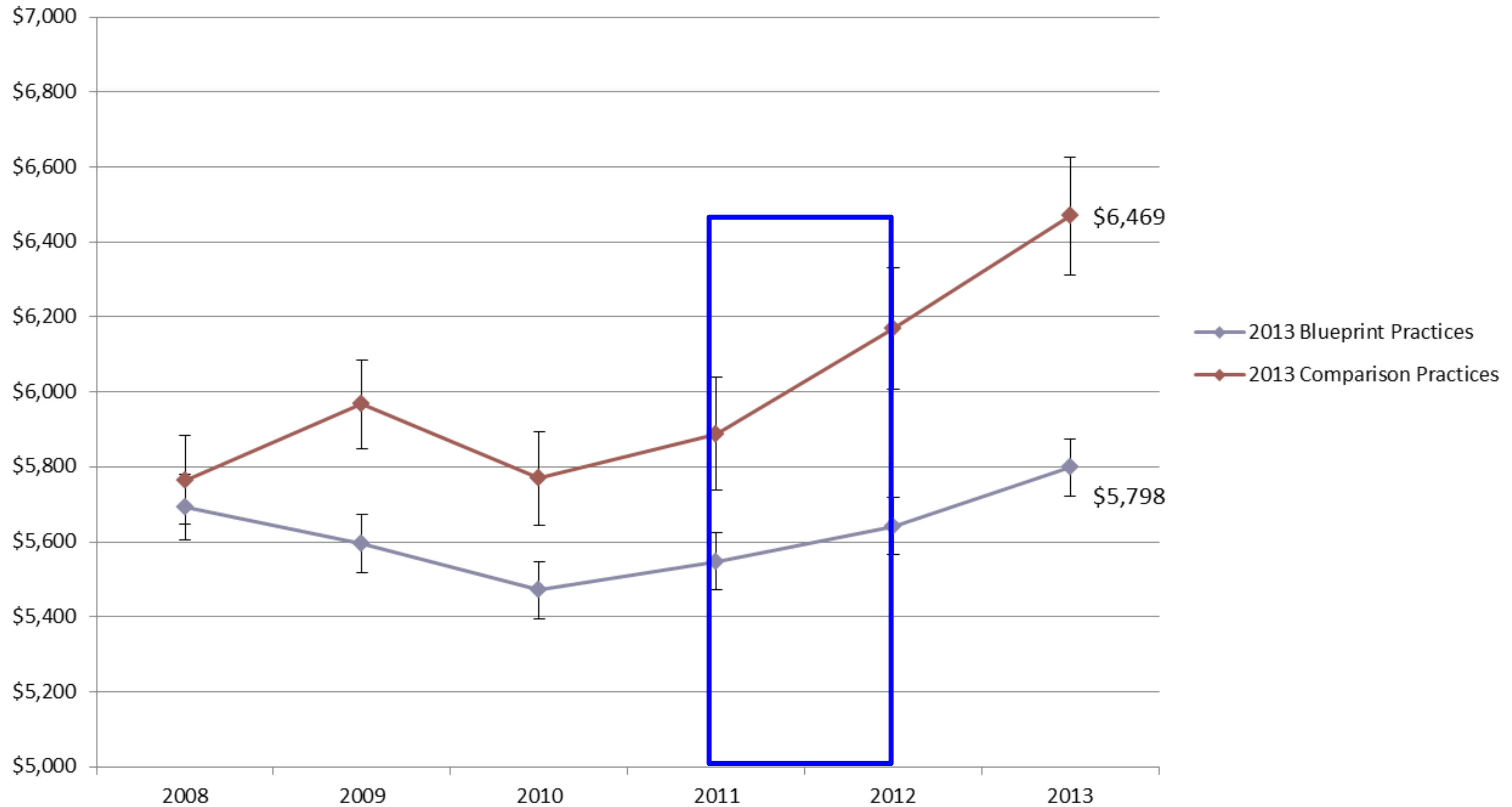
Table 2-7
Estimates of Gross Savings, MAPCP Demonstration Fees Paid, & Net Savings, Year 1 of the MAPCP Demonstration

	Seven MAPCP Demonstration states				
State	Year 1 eligible beneficiary quarters	Gross savings	Total MAPCP Demonstration fees	Net savings	Return on fee investment
New York	76,800	−$4,765,447*	$1,594,939	−$6,360,386	−2.99
Rhode Island	28,038	−87,363	441,075	−528,438	−0.20
Maine	74,327	−5,032,379	2,182,490	−7,214,869	−2.31
North Carolina	70,698	−9,467,541*	1,908,341	−11,375,882	−4.96
Michigan	752,835	49,668,370	21,917,324	27,751,046	2.27
Pennsylvania	106,210	−5,795,682	$2,069,690	−$7,835,372	−2.80
Vermont					
Non-pilot	58,735	1,561,806	1,049,164	512,642	1.49
Pilot	106,911	11,294,447***	2,052,961	9,241,486	5.50
Combined	165,646	12,856,253	$3,102,125	$9,754,128	4.14
Total 7 States	1,274,554	40,314,752	33,215,984	4,190,227	1.21

5.6.2 Year 1 Findings on Effectiveness

Figure 5-2
Vermont: Trend in average total PBPM Medicare expenditures from 2006 through the first 12 months of the MAPCP Demonstration, for beneficiaries assigned to Vermont Blueprint for Health non-pilot practices, Vermont Blueprint for Health pilot practices, comparison PCMHs, and comparison non-PCMHs




Total Expenditures Excluding SMS per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years
$7,000
$6,800
$6,600
$6,400
$6,200
$6,000
$5,800
$5,600
$5,400
$5,200
$5,000
2008
2009
2010
2011
2012
2013
$6,469
$5,798
2013 Blueprint Practices
2013 Comparison Practices

2.6.4 Effectiveness (Utilization & Expenditures)

- In sum, with regard to total Medicare expenditures, we found evidence that the state initiatives reduced the rate of growth in two of the eight MAPCP Demonstration states (Vermont, Michigan). When present, the effect appears be driven by reduced growth in expenditures for short-stay, acute-care hospitals. There was even less evidence that the state initiatives were able to reduce utilization rates.

- Reductions in the rate ER visits were observed in Minnesota, and these were limited to beneficiaries receiving care from practices that participated in state pilot activities.

- The limited evidence of demonstration effects presented in this report is likely a result of the relatively short evaluation period. Because a strengthening of PCMH capacity, payment reforms and other transformation activities take time to implement and 85 become fully effective, more positive demonstration effects may emerge in the second annual report.

Blueprint ACO Integration Plan – Community Health Systems

- Increased medical home & community health team payments, as recommended by the Governor for January 2016, are essential maintain participation and drive advancements (Integration Plan).
- With broad stakeholder input, an integration plan has been drafted to enhance primary care and establish a formal structure to guide coordination and quality initiatives in each area of the state (Unified Community Collaboratives).
- The plan establishes a medical home payment structure that is tied to community level results on core ACO quality and performance measures.
- The advancements thru this plan will establish a primary care and community health system infrastructure that can support more global payment reforms in 2017 (e.g. new CMS payment models, federal waiver).

Hospitals

Specialty Care & Disease Management Programs

Social & Economic Services

Home & Long Term Support Services

Mental Health & Substance Abuse Programs

Self Management Programs

Public Health Programs & Services

Advanced Primary Care

Advanced Primary Care

Advanced Primary Care

Advanced Primary Care

Community Health Team
Nurse Coordinator
Social Workers
Nutrition Specialists
Community Health Workers
Public Health Specialist

Extended Community Health Team
Medicaid Care Coordinators
SASH Teams
Spoke (MAT) Staff

SASH a caring partnership

SUPPORT AND SERVICES at HOME

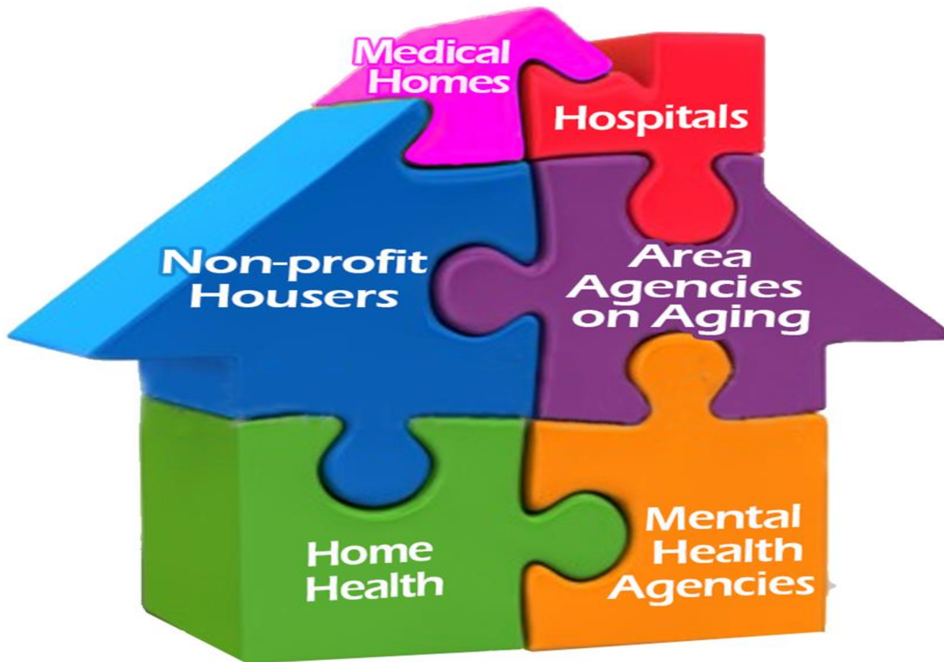
A caring partnership to help seniors and individuals with special needs stay at home and healthy

SASH is a population based care management model that harnesses the strengths of social service agencies, community health providers and non-profit housing organizations to **work together to support Vermonters** to live safely and healthfully at home.

RTI Evaluation Results

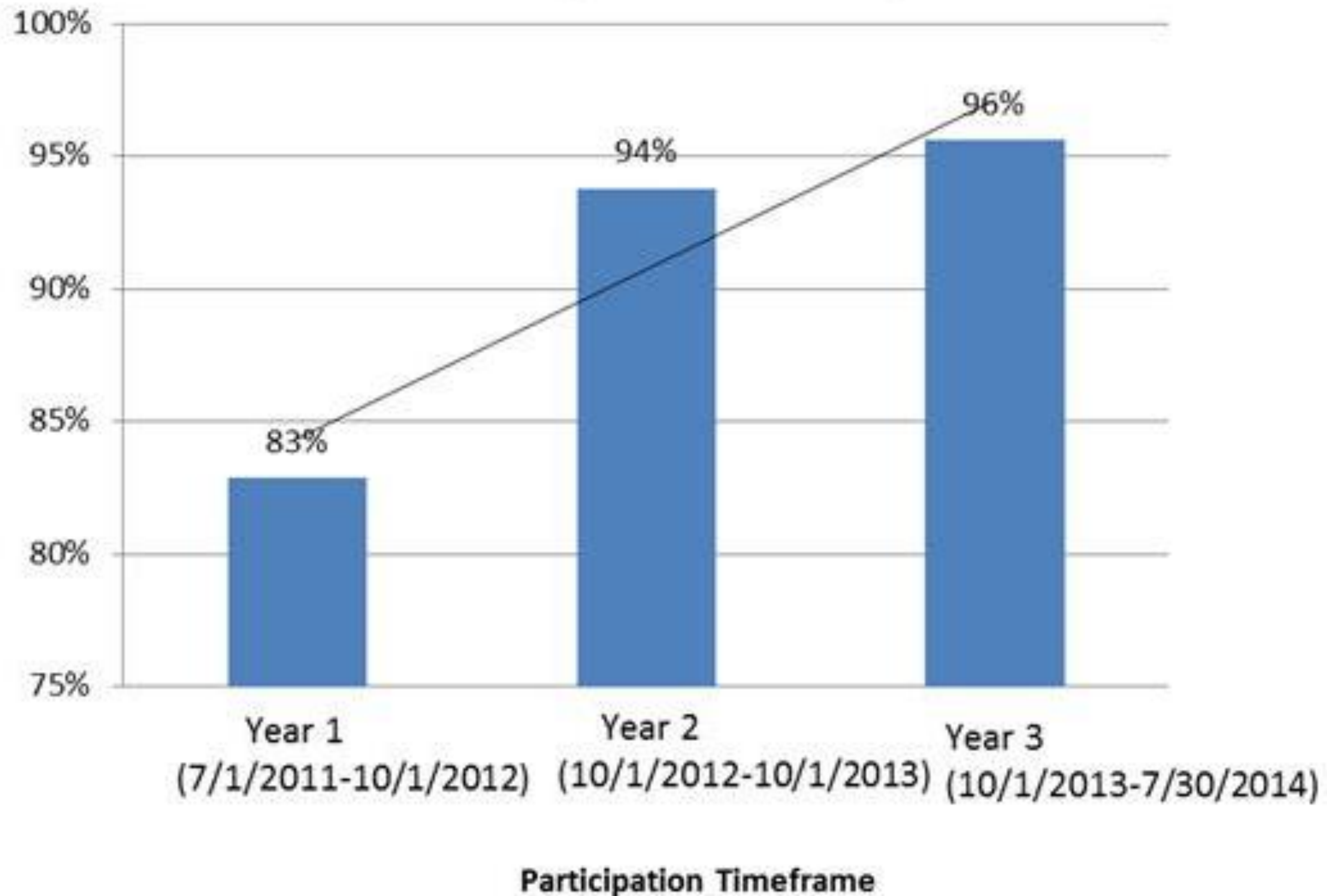
- For Vermonters receiving care from a medical home, supplemented by SASH services provided by experienced, well-established panels, the growth in annual total Medicare expenditures was ***$1,756 - $2,197 lower*** than the growth in expenditures among Medicare fee-for-service beneficiaries in the two comparison groups.

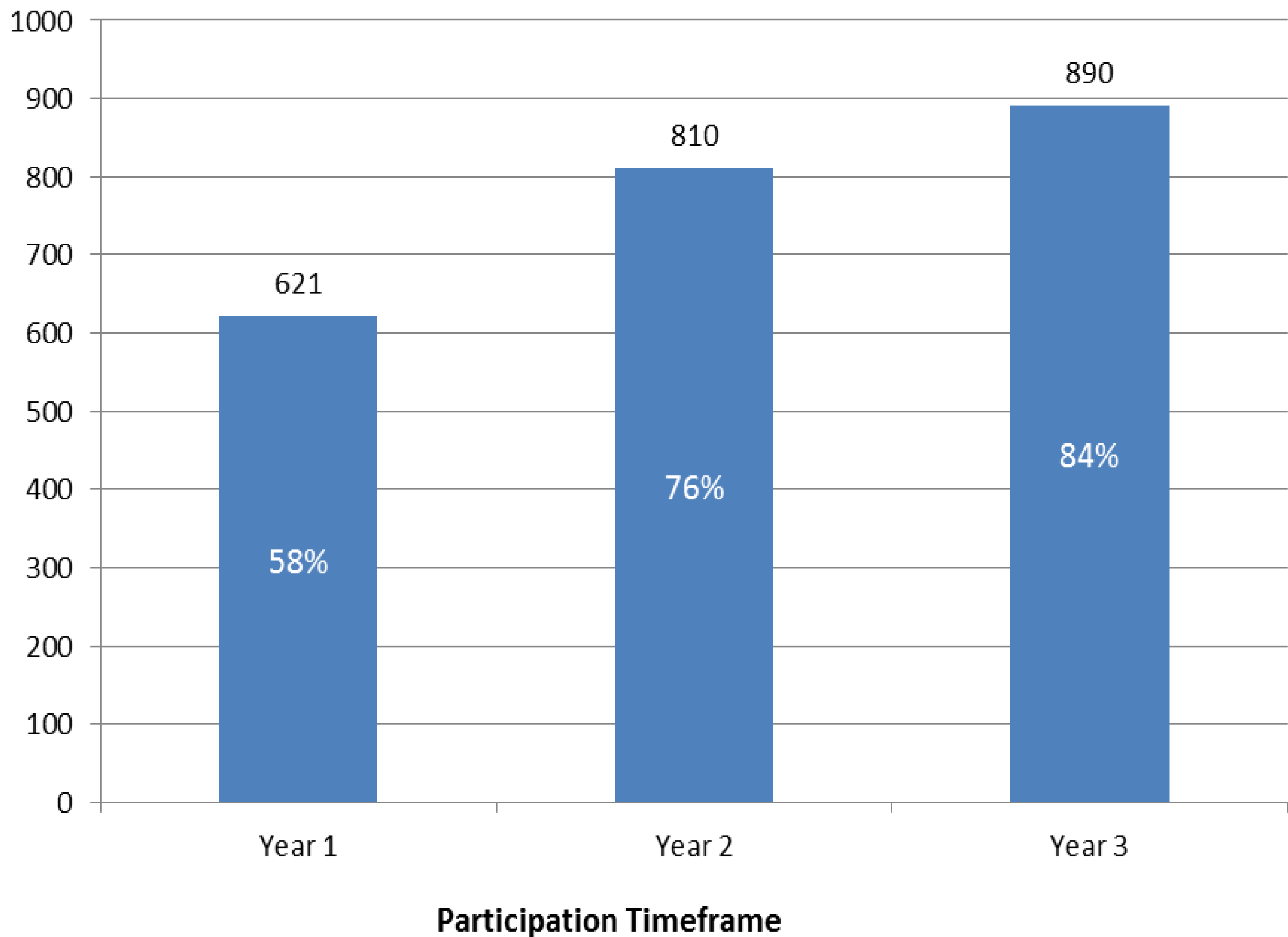
Interprofessional Team Approach



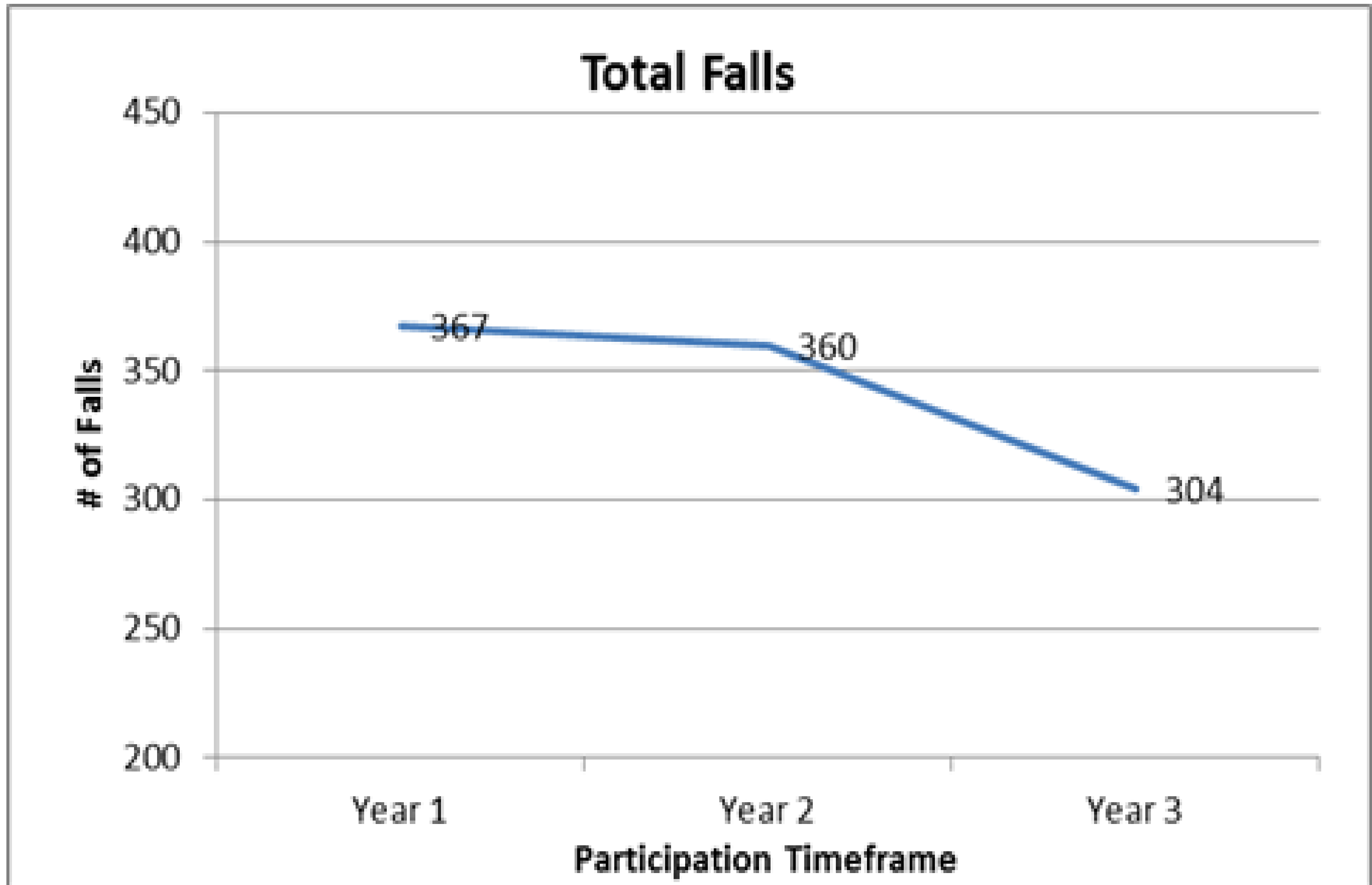
"The major SASH program implementation success has been the linkages the program has created among different community organizations."

- Research Triangle International (RTI)


Number of SASH Participants w/Primary Care Provider
100%
95%
90%
85%
80%
75%
83%
94%
96%
Year 1
(7/1/2011-10/1/2012)
Year 2
(10/1/2012-10/1/2013)
Year 3
(10/1/2013-7/30/2014)
Participation Timeframe

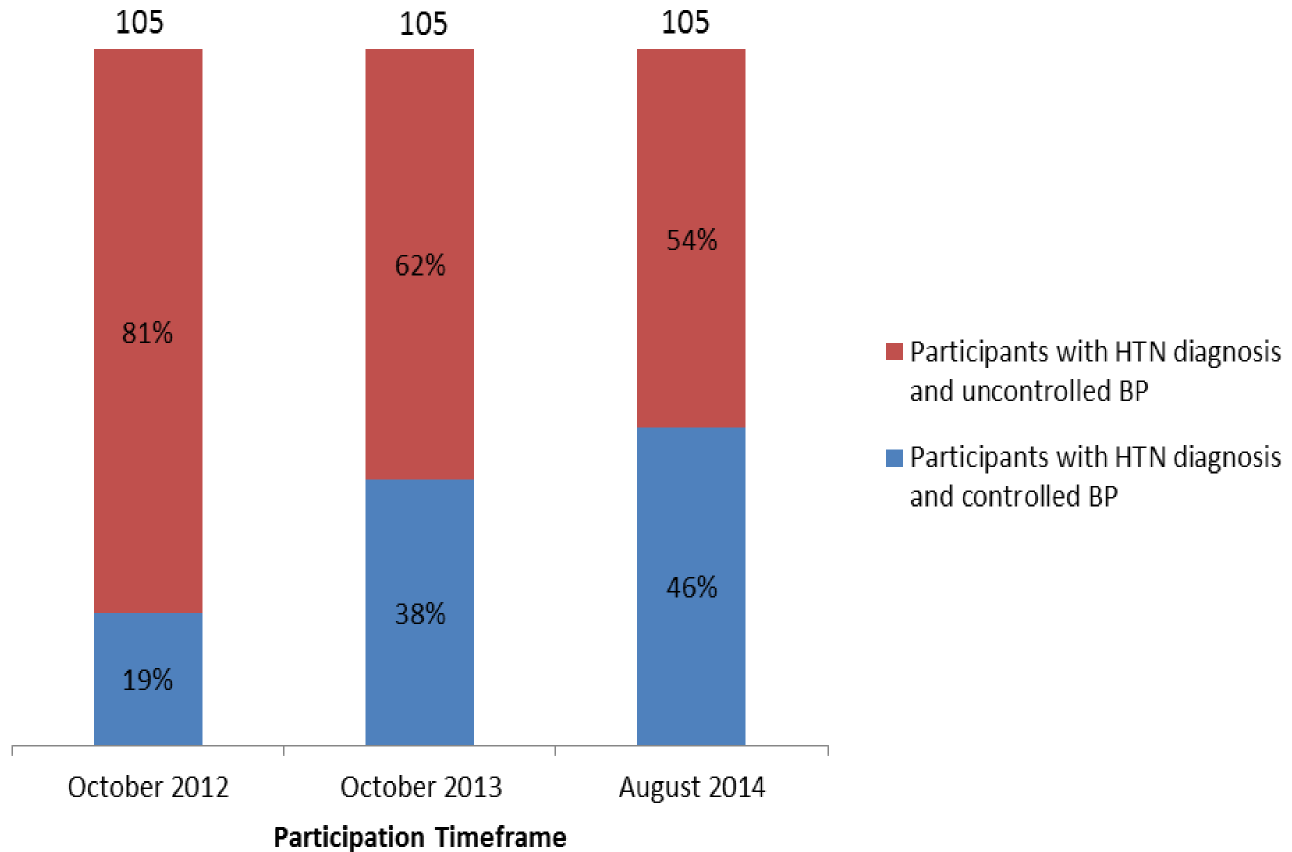

Number of SASH Participants with Reported Flu Vaccinations
1000
900
800
700
600
500
400
300
200
100
0
621
810
890
58%
76%
84%
Year 1
Year 2
Year 3
Participation Timeframe

Reduced Falls



SASH a caring partnership
SUPPORT AND SERVICES at HOME

Percent of SASH Participants with HTN Diagnosis and Controlled BP *



*National Quality Forum NQF Measure 18:Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled(<140/90 mmHg)during the measurement period

Questions & Discussion