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

Key Components	June, 2015
PCMHs (active PCMHs)	127
PCPs (unique providers)	698
Patients (Onpoint attribution) (Avg. 2014)	334,898
CHT Staff (core)	212 (132 FTEs)
SASH Staff (extenders)	~60 FTEs (54 panels)
Spoke Staff (extenders)	67 (42 FTEs)

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

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

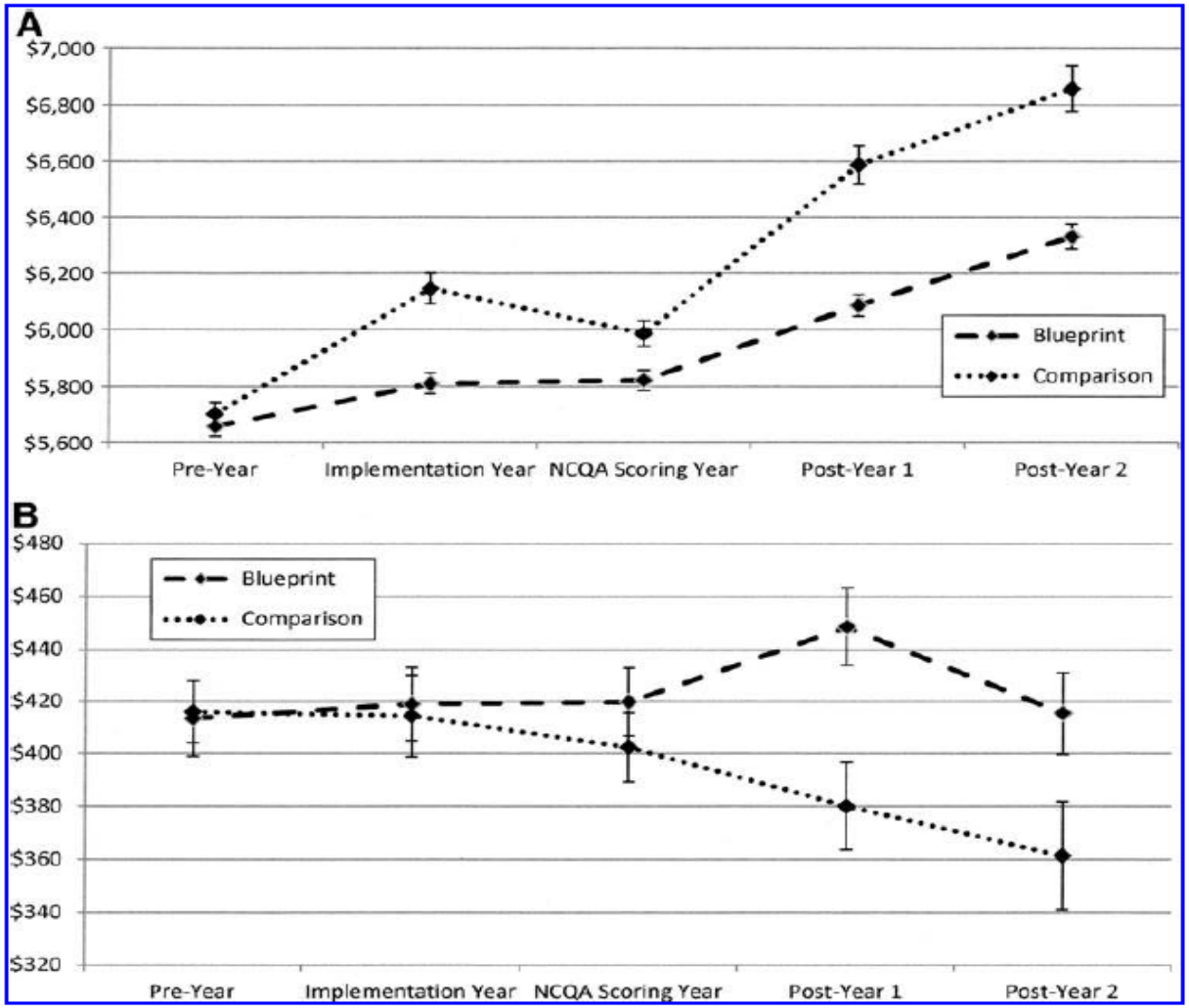
At a Glance:

- 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
- 15 Community Self-Management Workshops offered
- 5.5 SASH Teams; 414 Participants (Capacity = 550)
- 1835 CHT referrals
- 372 patients treated by MAT staff

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 Learning Collaborative as a venue for organizing and implementing the larger care management project.
Major achievement: CVMC received a great 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	
Stage of Program	Member Count
Pre-Year	267,327
Implementation Year	291,881
NCQA Scoring Year	333,470
Post year 1	343,373
Post year 2	300,770
Post Year 3	242,879

Non Blueprint	
Stage of Program	Member Count
Pre-Year	181,628
Implementation Year	122,247
NCQA Scoring Year	160,196
Post year 1	100,107
Post year 2	81,855
Post Year 3	67,542

Blueprint	
Stage of Program	Average Members
Pre-Year	246,214
Implementation Year	271,071
NCQA Scoring Year	311,245
Post year 1	320,586
Post year 2	279,064
Post Year 3	225,974

Non Blueprint	
Stage of Program	Average Members
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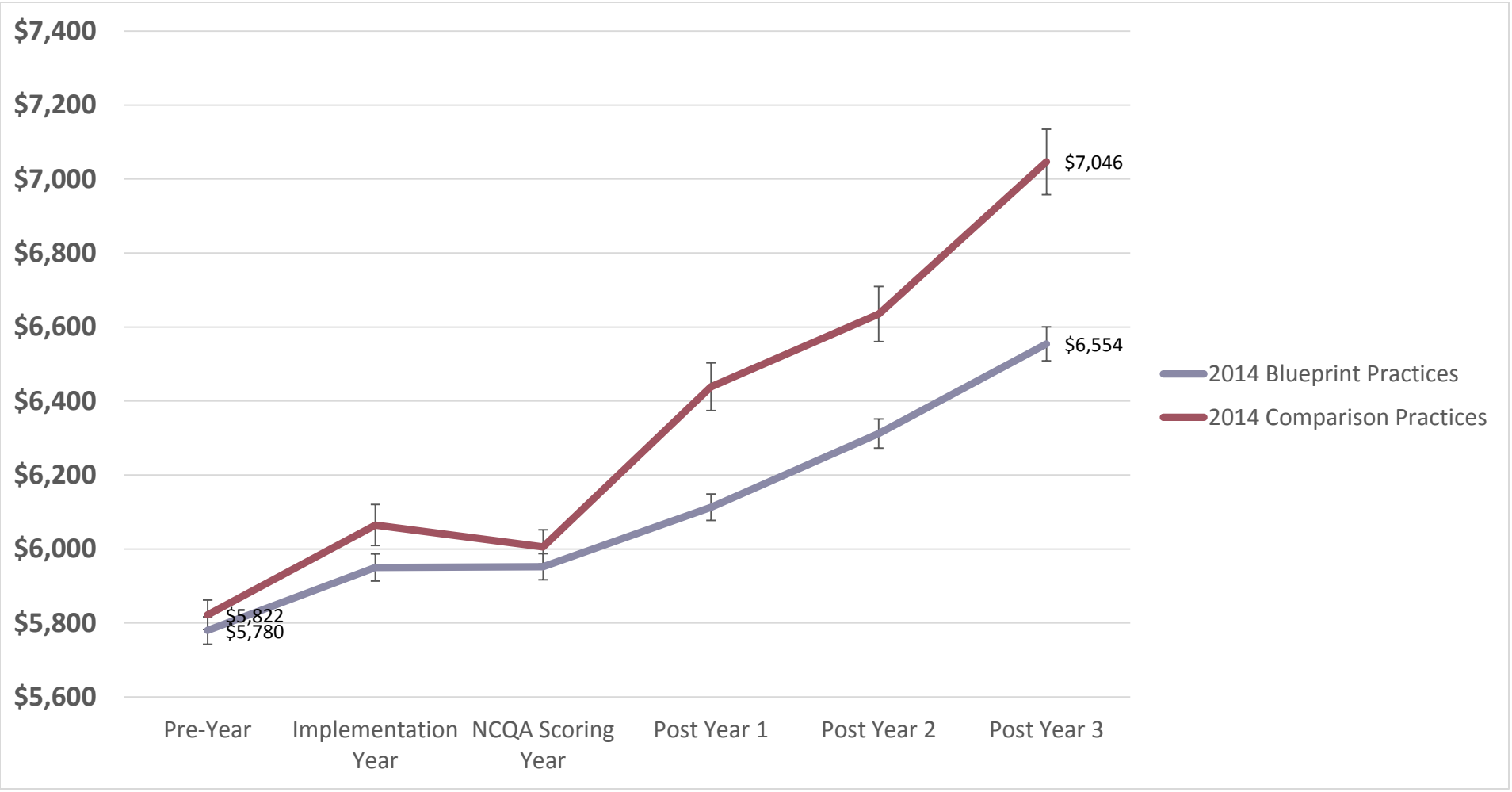
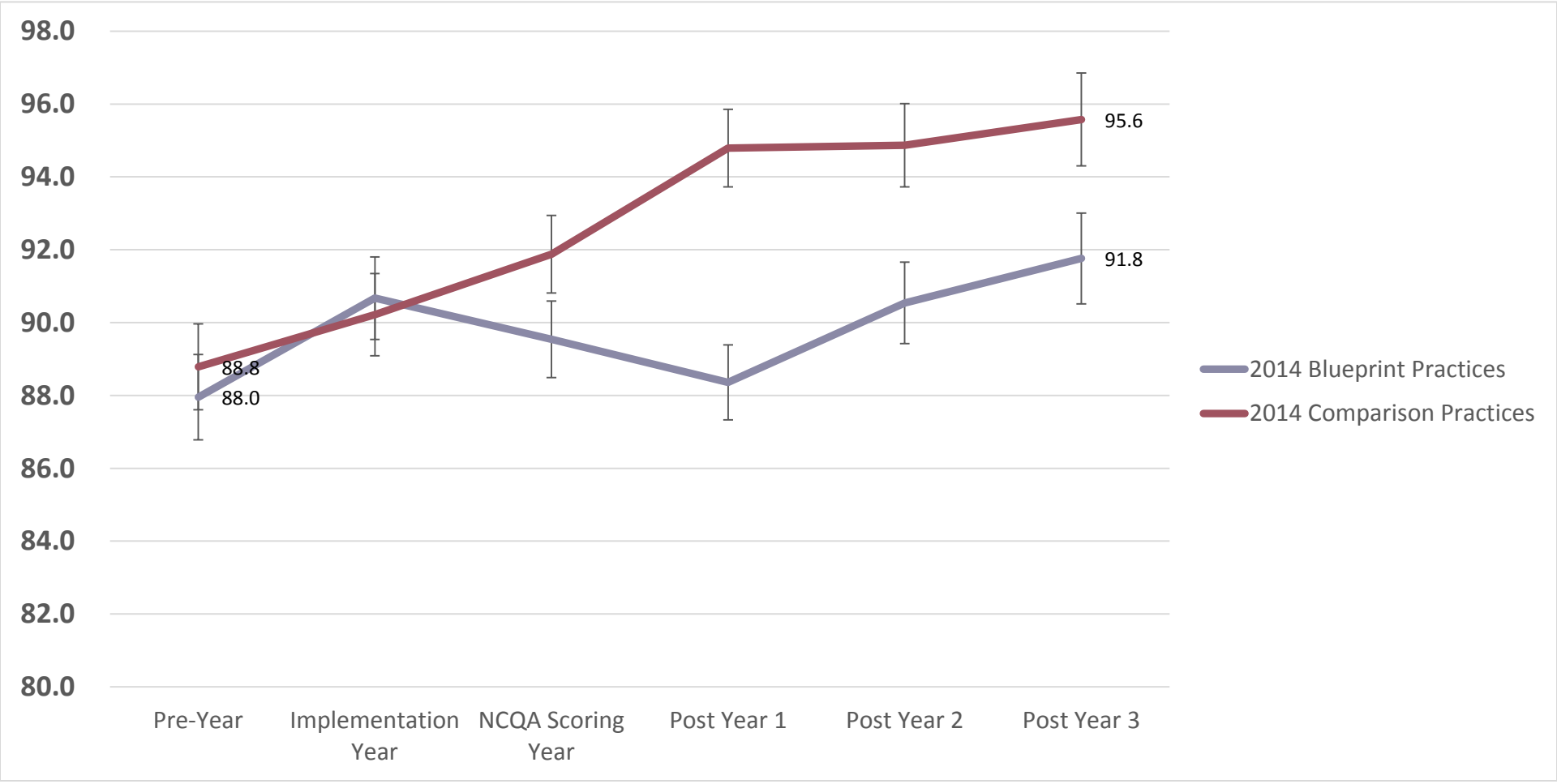
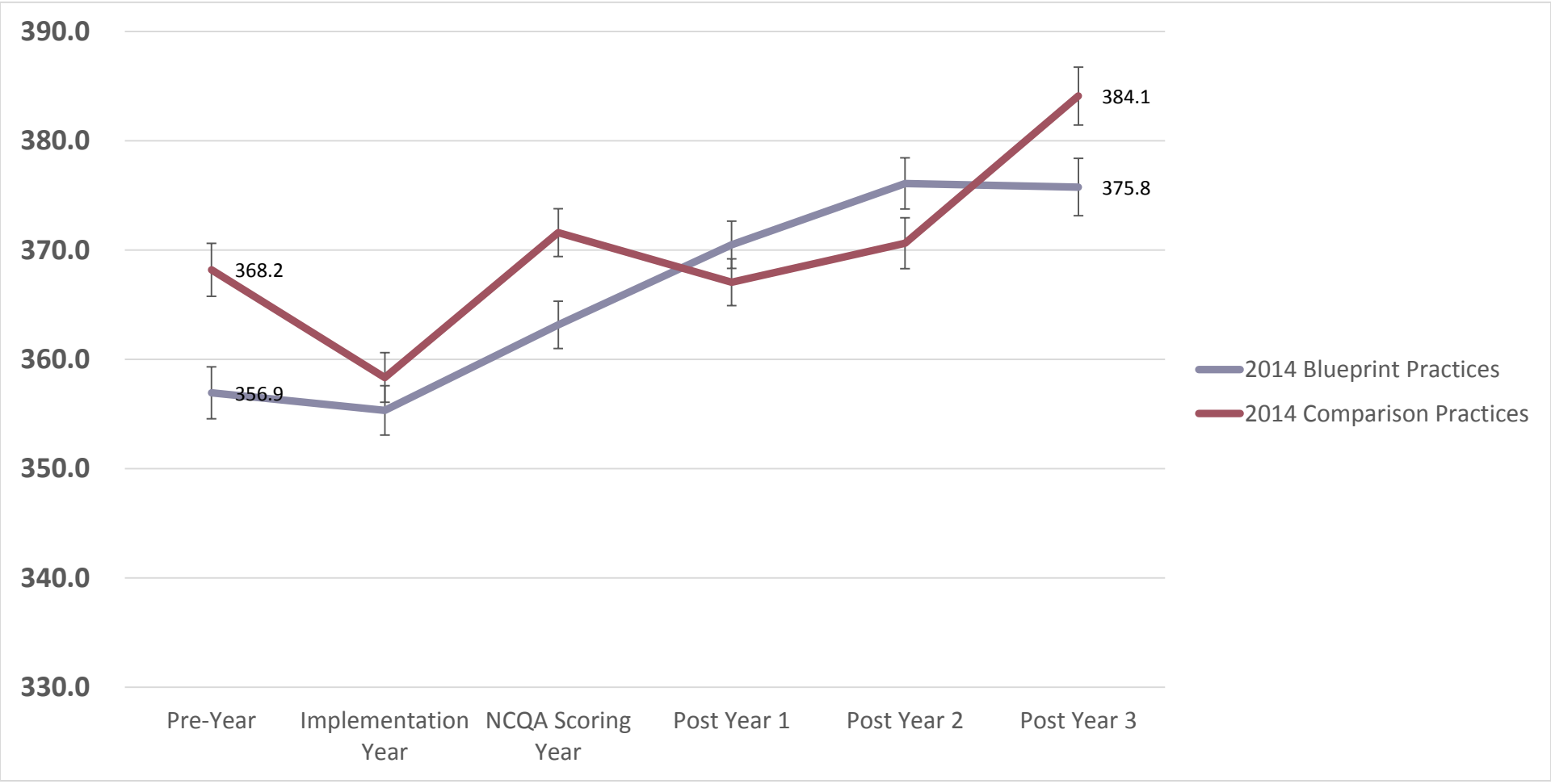
Total Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and older



Inpatient Discharges Per 1000 Members 2008 – 2014 All Insurers Ages 1 and older



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



Total SMS Expenditures Per Capita 2008 – 2014 Medicaid Ages 1 and older

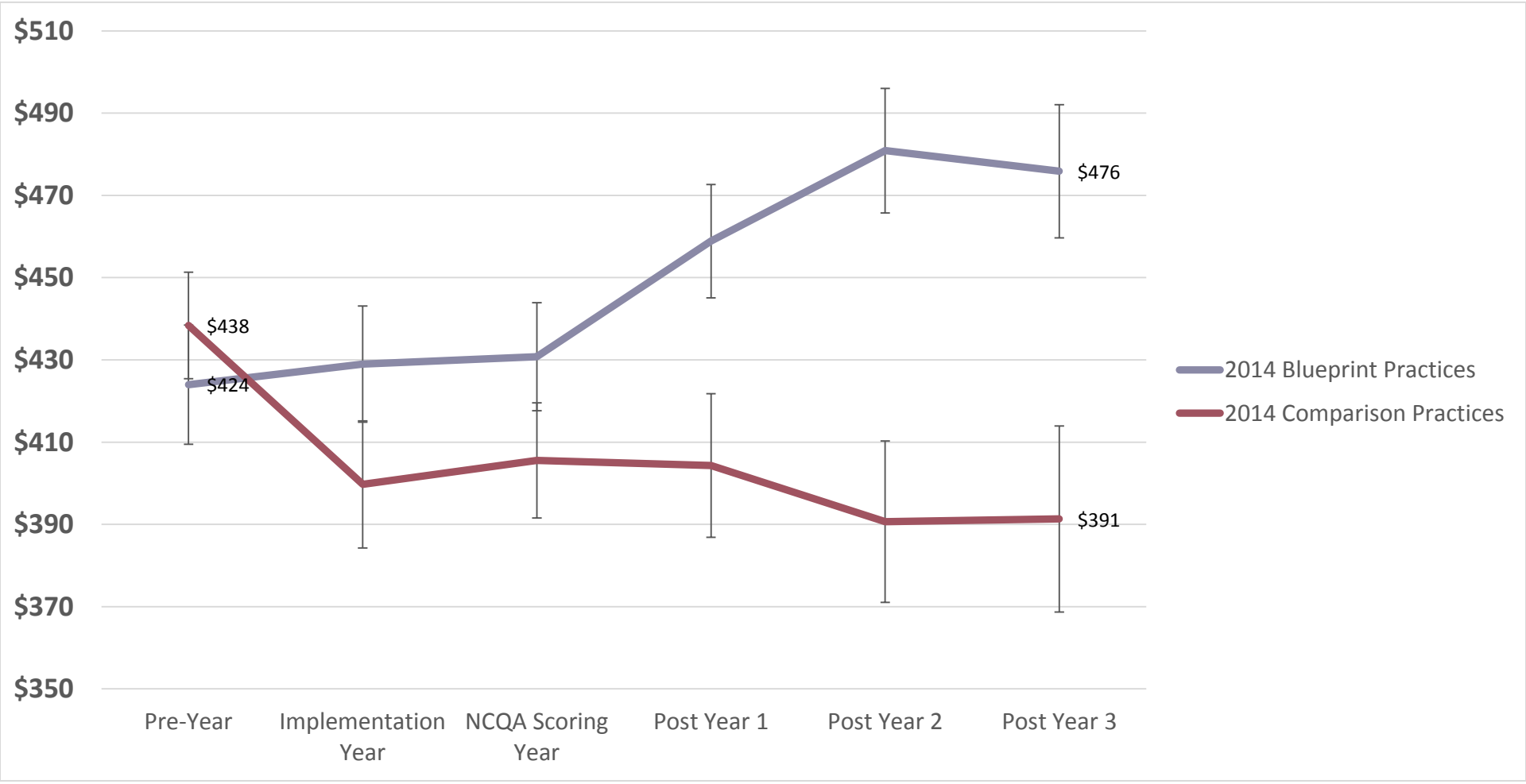


Table 2. Estimated Return on Investment for All Payers in Calendar Year 2014

All-Payer	Investment	Reduction in total expenditures w/ SMS	Reduction in expenditures w/o SMS
Reduction in expenditures		$123,142,342	$136,284,263
PCMH Payments	$6,590,964		
Core CHT Payments	$8,893,643		
Total Payments	$15,484,607		
Blueprint Program Budget	$5,633,236		
Total investment	$21,117,843		
Return on investment		5.8	6.5

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

Medicaid	Investment:	Reduction in expenditures w/ SMS	Reduction in expenditures w/o SMS
Reduction in expenditures		$8,644,011	$29,554,703
PCMH Payments	$2,202,342		
Core CHT Payments	$2,172,308		
Total Payments	$4,374,650		
Blueprint Program Budget	$5,633,236		
Total investment	$10,007,886		
Return on investment		0.9	3.0

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.

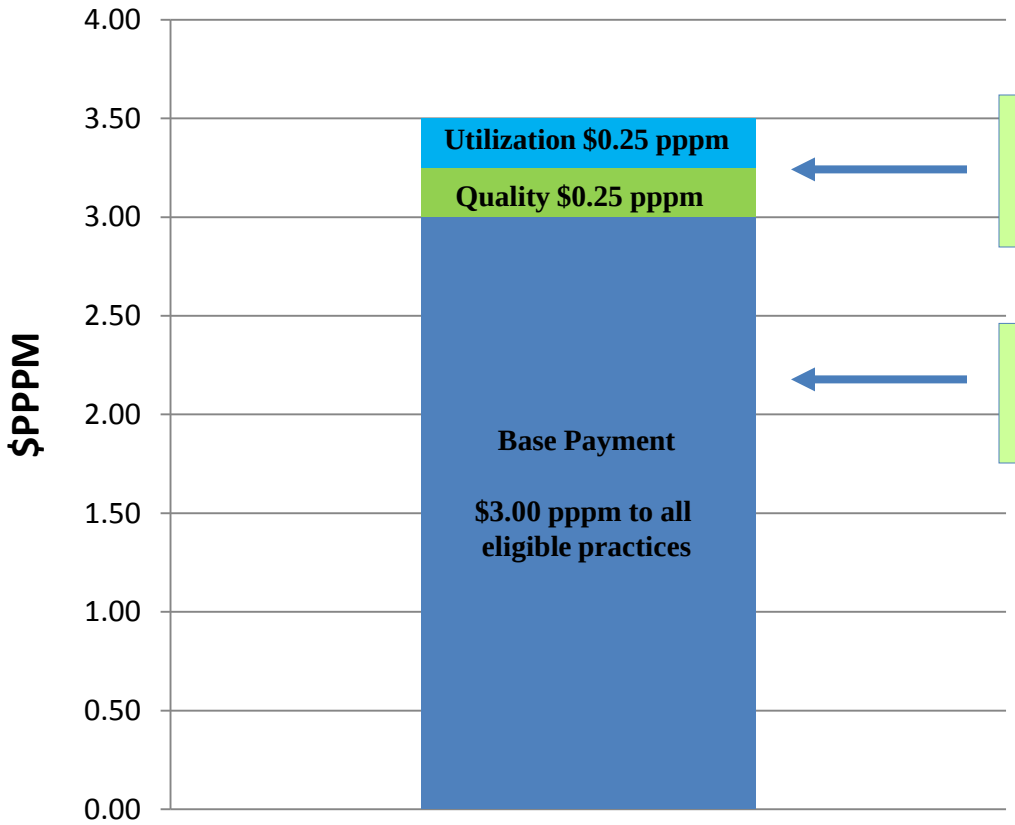
Table 6: Projected Impact on All Payers of Increased PCMH and CHT Payments in 2016

All-Payer	Investment	Reduction in total expenditures w/ SMS	Reduction in expenditures w/o SMS
Reduction in expenditures		$123,142,342	$136,284,263
PCMH Payments	$10,460,883		
Core CHT Payments	$9,498,458		
Total Payments	$19,959,341		
Blueprint Program Budget	$5,633,236		
Total investment	$25,592,577		
Return on investment		4.8	5.3

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 insurers portion of CHT costs based on market share

Medical Home Payment Model



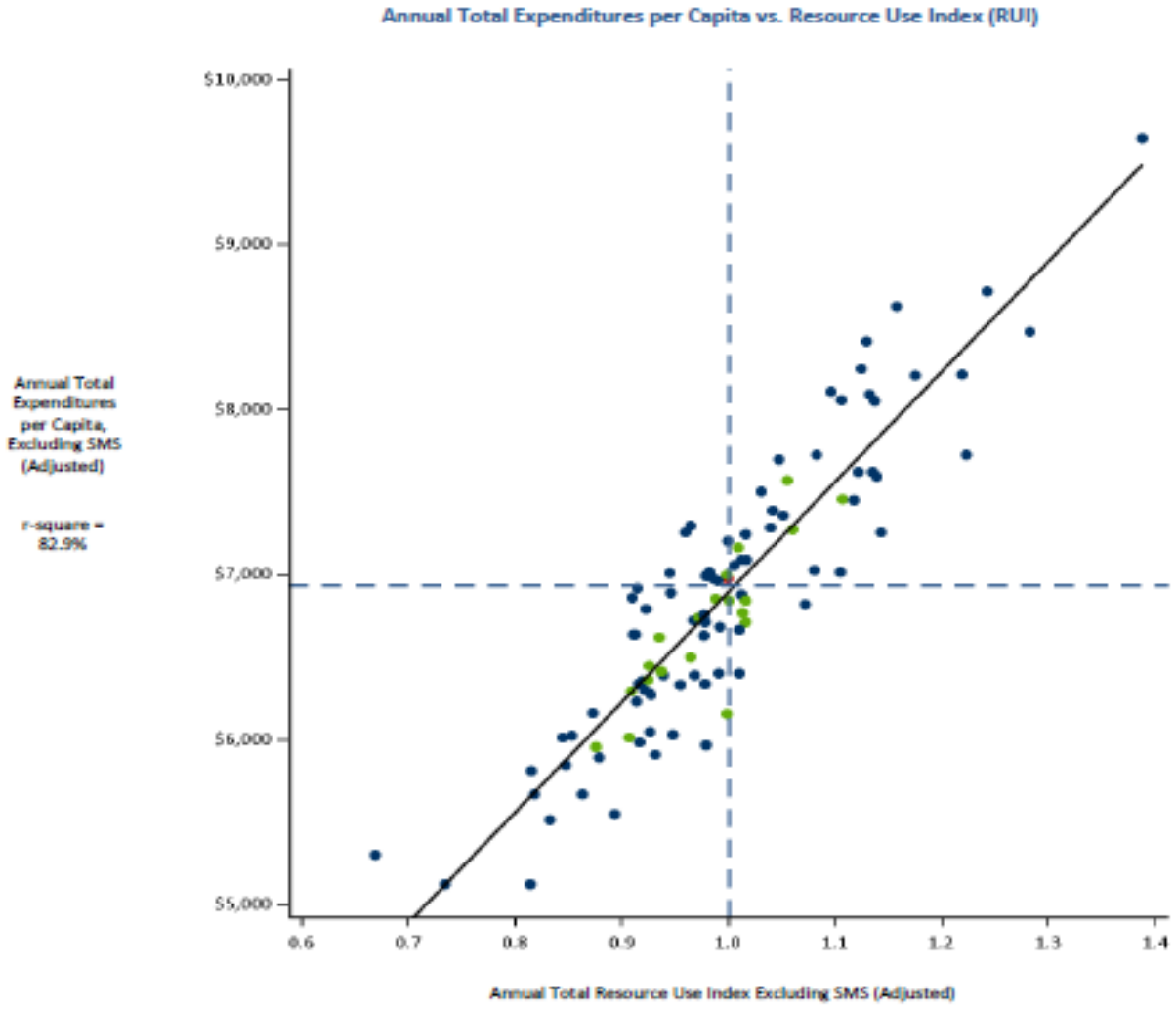
Performance tied to population outcomes
- **Utilization index payment based on practice level results**
- **Quality composite payment based on service area results**

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

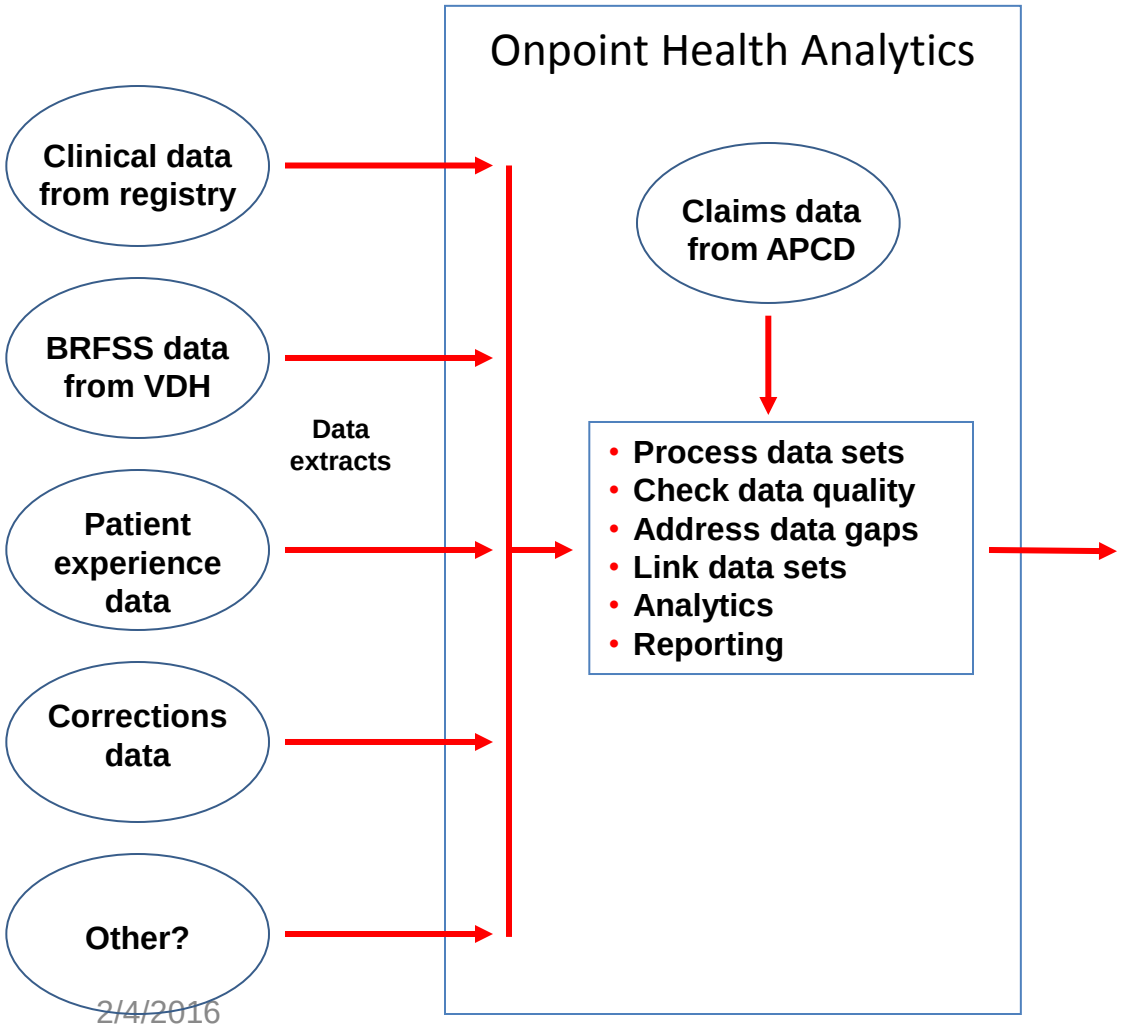


A 0.01 change in TRUI is associated with a $66.80 change in expenditures per person

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

Unified Accountable Health System, All Payer Model

Formation of ACOs, shared savings, unified community collaboratives

PCMHs, CHTs, community oriented services, targeted capitated payments

Traditional payment, healthcare patterns, and quality

Reality (federal accelerators)

SIM

MAT Health Home

Shift to GC

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

Multi Payer Advanced Primary Care Demonstration

Medicaid Global Commitment Waiver

ARRA (Stimulus), HITECH Act

2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

PCMH & CHT pilots. Multi-insurer payment reforms. Develop transformation network, data infrastructure, and analytic capacity.

SIM stakeholder groups. ACOs form and develop statewide networks. Shared savings programs. Core measure selection. Collaboratives. Data system enhancements.

Community oriented accountable health system? Universal primary care?

Statewide hub & spoke program

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

Community collaborative structure. Population health focus & new PCMH payment model.

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