Community Health Systems

House Healthcare

April 16, 2015

All-Insurer Payment Reforms

Local leadership, Practice Facilitators, Workgroups

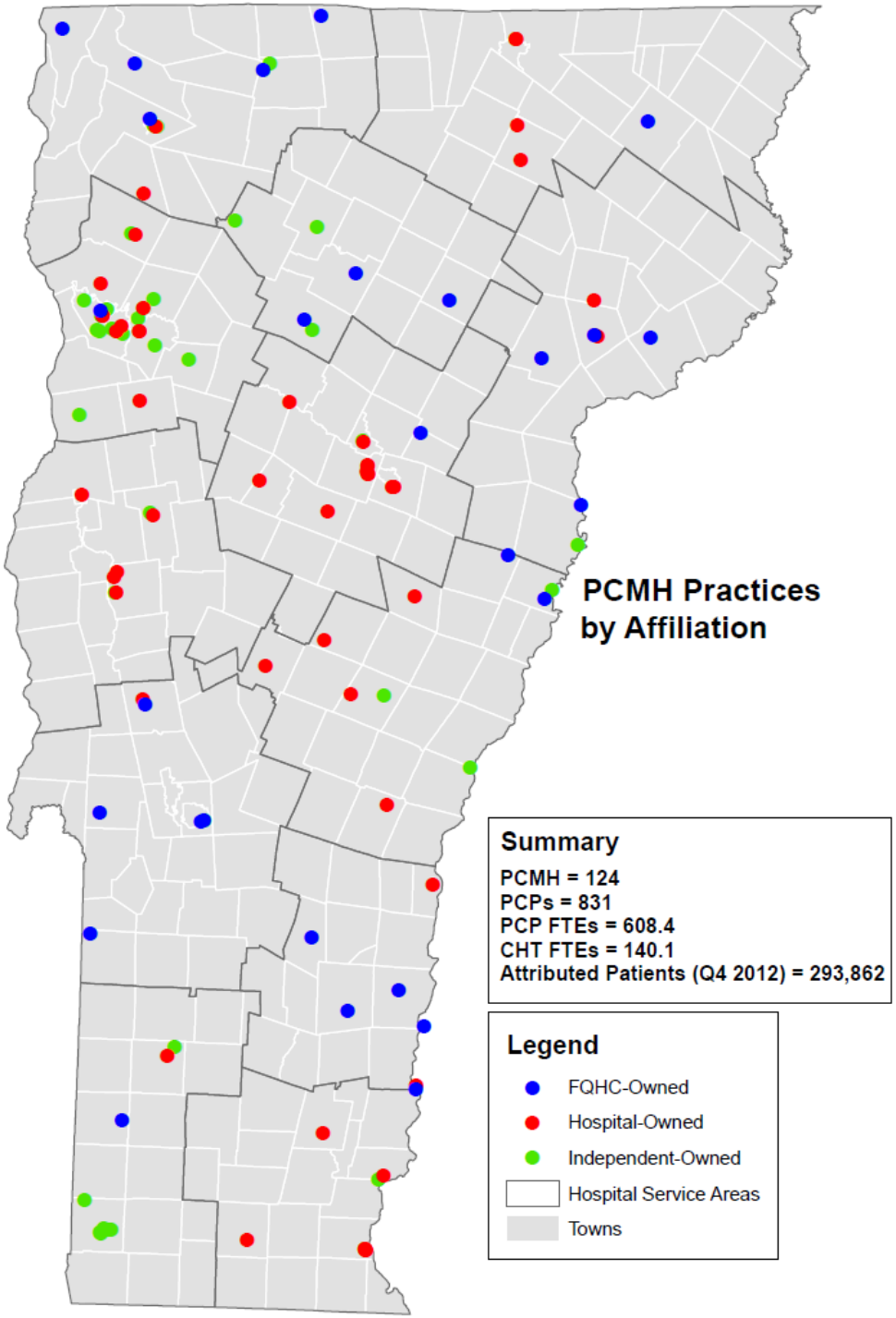
Local, Regional, Statewide Learning Forums

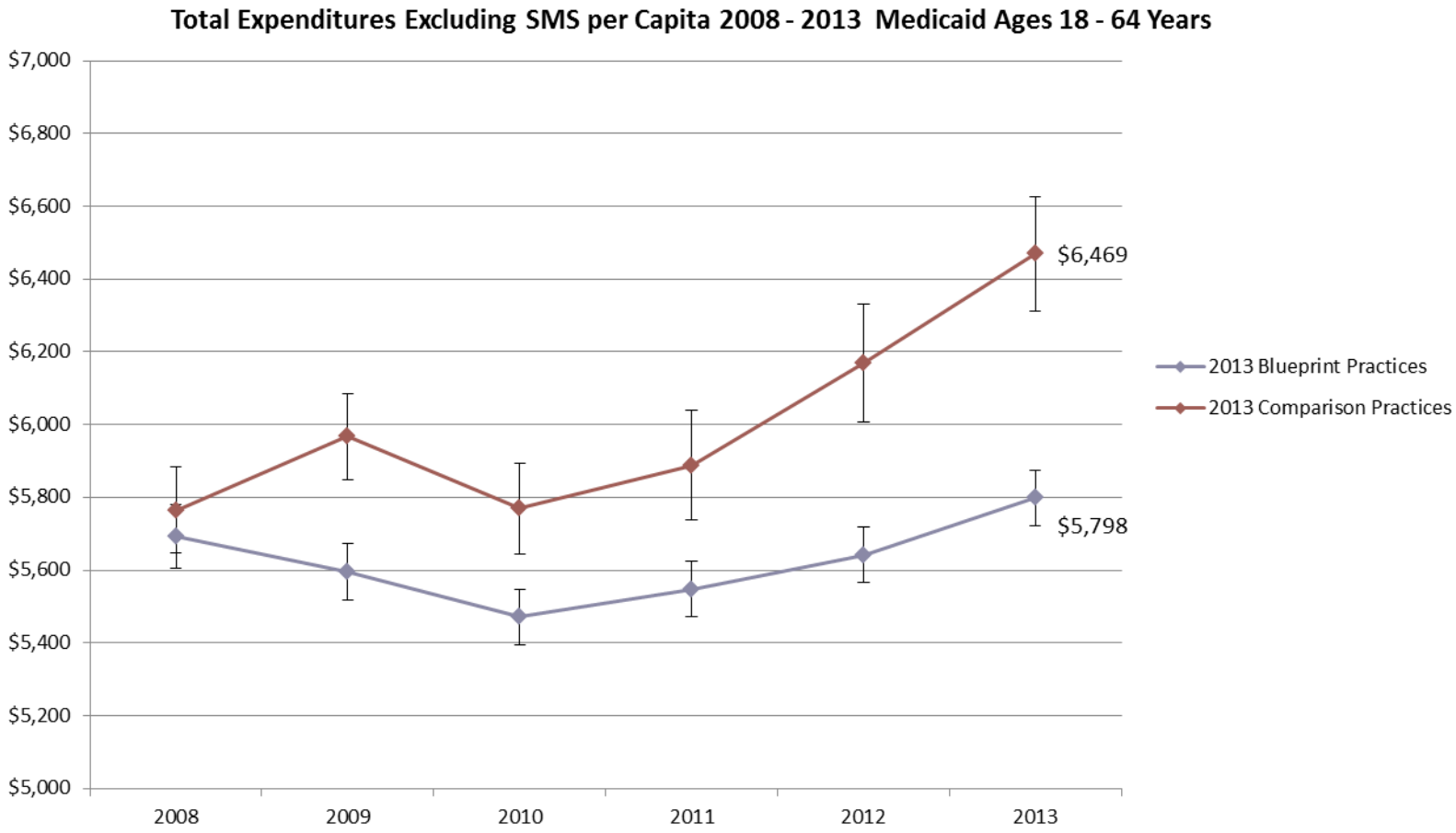
Health IT Infrastructure

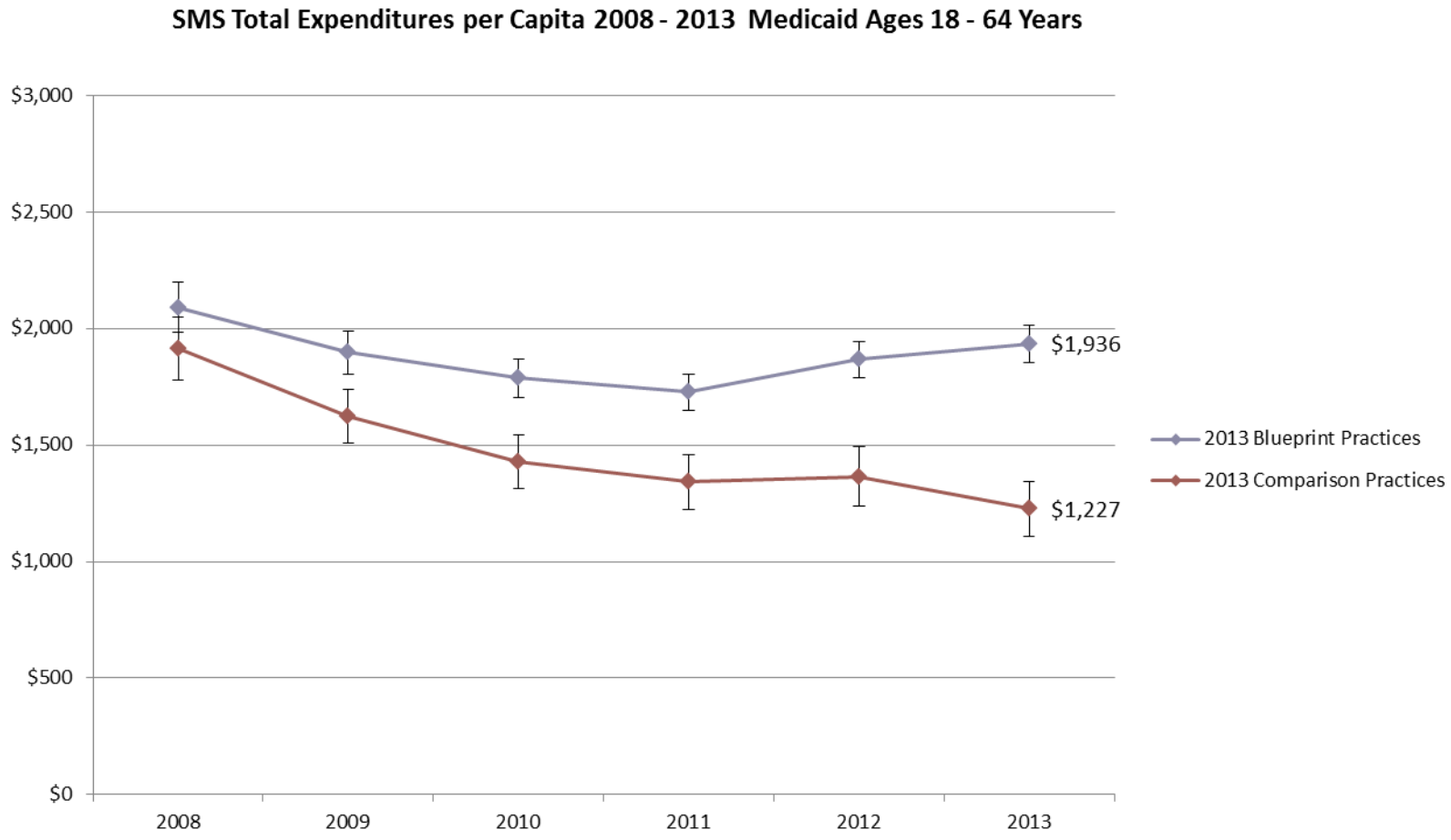
Evaluation & Comparative Reporting

Health Services Network

Key Components	December, 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)	58 staff (39 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


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


SMS Total Expenditures per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
2008
2009
2010
2011
2012
2013
$1,936
$1,227
2013 Blueprint Practices
2013 Comparison Practices

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Expenditures & Investments

Results for Calendar Year 2013	Medicaid	Estimated Medicaid State Portion (GF) (44.2%)	Commercial
Number of Participating Beneficiaries	83,939	83,939	143,961
Total Blueprint Medical Home Payments	$1,857,916	$821,199	$2,978,110
Total Blueprint CHT Payments	$2,010,348	$888,574	$4,717,136
Total Blueprint Payments Investment Annual	$3,868,264	$1,709,773	$7,695,246
Total Claims Expenditures per Capita (participants)	$7,776	$3,437	$4,954
Total Claims Expenditures per Capita (comparison)	$7,877	$3,482	$5,519
Claims Differential per Capita (participant vs. comparison)	($101)	($45)	($565)
Total Claims Differential (participants vs. comparison) *Includes expenditures for special Medicaid services (SMS)	($8,477,839)	($3,747,205)	($81,337,965)
Blueprint Actual Costs for Admin, Grants & Contracts for SFY13	$4,890,827	$2,161,745	
Total Investment for Blueprint Program (payments + program costs)	$8,759,091	$3,871,518	$7,695,246
Net Cost for Blueprint Program (Changes in Healthcare Expenditures + Payments + Program Costs).	$281,252	$124,313	($73,642,719)

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

Expenditures & Investments

1. In CY 2013, total claims based expenditures were $101 ($45 GF) lower for each Medicaid participant vs. a similar comparison group (includes special Medicaid services).

2. In CY 2013 this resulted in a total savings of $8,477,839 ($3,747,205 GF) for the participant group vs. the comparison group.

3. In 2013, the total state and federal investment in the program was $8,759,091 ($3,871,518 GF). This includes medical home payments, community health team payments, and Blueprint Program costs.

4. In 2013, the net cost to the State of Vermont for the Blueprint Program was $281,252 ($124,313 GF). This is the annual cost to the state of Vermont for the Blueprint to help organize and guide statewide reforms (primary care, community health system, self management, data systems, dashboards and reporting, learning health system activities, etc).

Expenditures & Investments

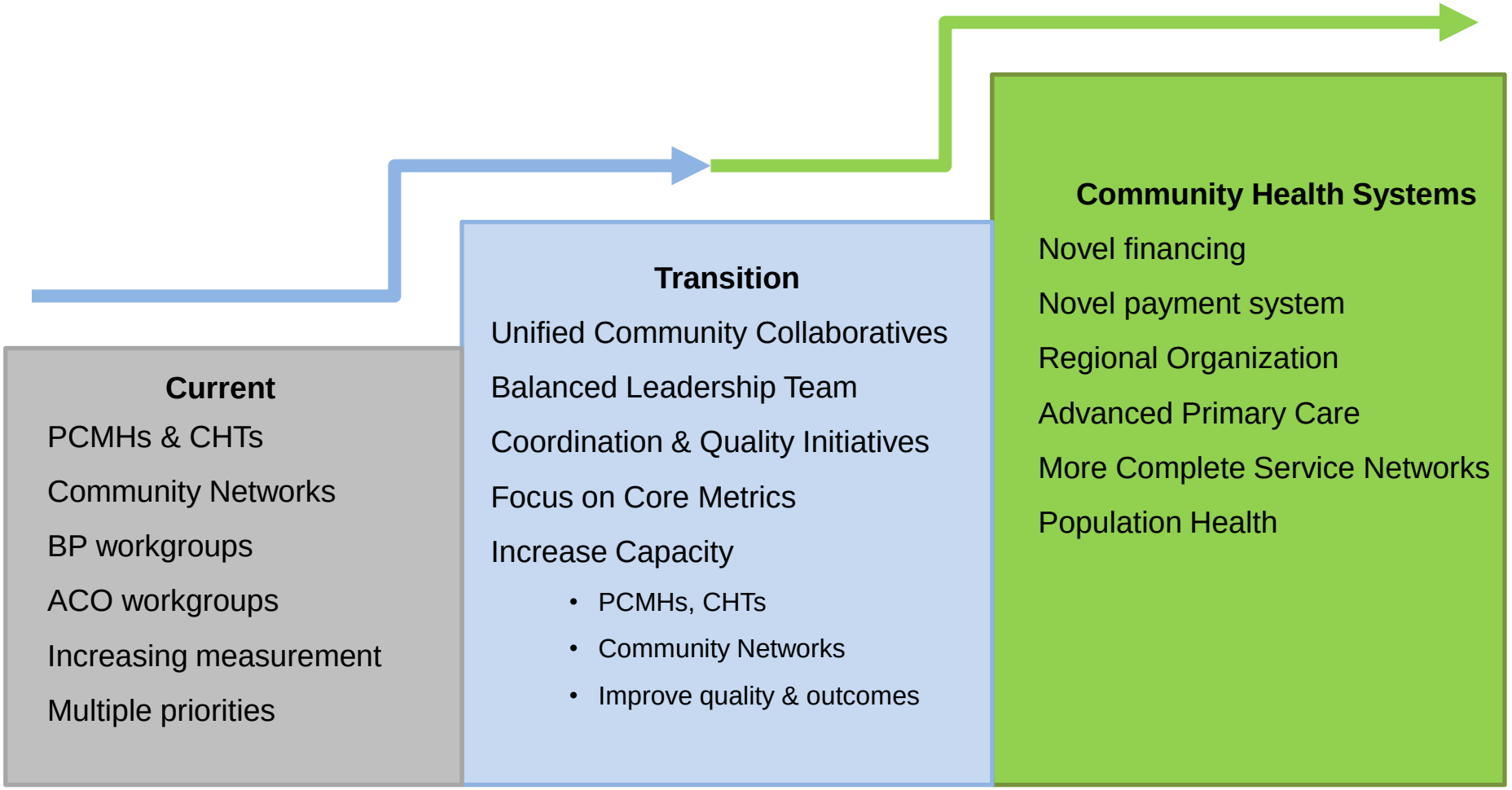
1. The program has been heavily measured and evaluated. The Blueprint evaluation has demonstrated a growing trend in reduced healthcare expenditures for MCAID and Commercial beneficiaries. The independent CMS evaluation conducted by RTI has demonstrated similar savings for MCARE beneficiaries.

2. At an exceptionally low cost, the program has helped to establish the basis for a novel statewide community health system structure, advanced primary care, better integration of medical and non-medical services, and a foundation to operate under novel financial models in 2017.

3. Momentum will be lost and some providers will pull out without more adequate support thru an increase in medical home and community health team payments.

4. Although savings have been demonstrated, these savings have not been captured. A mechanism is needed to assure that savings are available for targeted use such as re-investment in essential services, reduced premiums, or reduced out of pocket costs.

Transition to Community Health Systems



Strategy for Building Community Health Systems

Action Steps

- Unified Community Collaboratives (quality, coordination)
- Unified Performance Reporting & Data Utility
- Increase support for medical homes and community health teams
- Novel medical home payment model
- Administrative efficiencies (insurer quality requirements)

Unified Community Collaborative (UCC)

Overview

- Leadership Team (up to 11member team)
  - 1 local clinical lead from each ACO (2 to 3)
  - 1 local representative from VNA, DA, SASH, AAA, Peds
  - Additional ad hoc members chosen locally
- Use measure results and comparative data to guide planning
- Planning & coordination for quality initiatives & service models
- Project managers provide support (convening, coordination)
- PCMHs & CHTs participate in quality initiatives

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare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Practice Profile: ABC P

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Typ

Welcome to the *2014 Blueprint Practice Profile* from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services.

Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

Demographics & Health Status

	Practice	H.S.A.	St
Average Members	4,081	84,070	1
Average Age	50.6	50.1	
% Female	55.6	55.5	
% Medicaid	14.5	13.0	
% Medicare	23.7	22.2	
% Maternity	2.1	2.1	
% with Selected Chronic Conditions	50.1	38.8	
Health Status (CRG)			
% Healthy	39.0	43.9	
% Acute or Minor Chronic	18.8	20.5	
% Moderate Chronic	27.9	24.5	
% Significant Chronic	15.4	12.3	
% Cancer or Catastrophic	1.4	1.3	

Table 1: This table provides comparative information on the demographics ... status of your practice, all Blueprint practices in your Hospital Service Area ... state as a whole. Included measures reflect the types of information used to ... adjusted rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial ... enrollment during the year. In addition, special attention has been given to ... Medicaid and Medicare: This includes adjustment for each member's enrollm... Medicaid or Medicare, the member's practices' percentage of membership ... or Medicare, Medicare disability or end-stage renal disease status, and the ... the member required special Medicaid services that are not found in comm... populations (e.g. day treatment, residential treatment, case management, ... services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of memb... through the claims data as having one or more of seven selected chronic co... asthma, chronic obstructive pulmonary disease, congestive heart failure, co... disease, hypertension, diabetes, and depression.

The Health Status measure aggregates 3M™ Clinical Risk Grouper (CRG) cla... the year for the purpose of generating adjusted rates. Aggregated risk class... include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic ... chronic joint pain). Moderate Chronic (e.g., diabetes), Significant Chronic (... CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (... dystrophy, cystic fibrosis).

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Da...


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Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Total Expenditures per Capita

Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services.

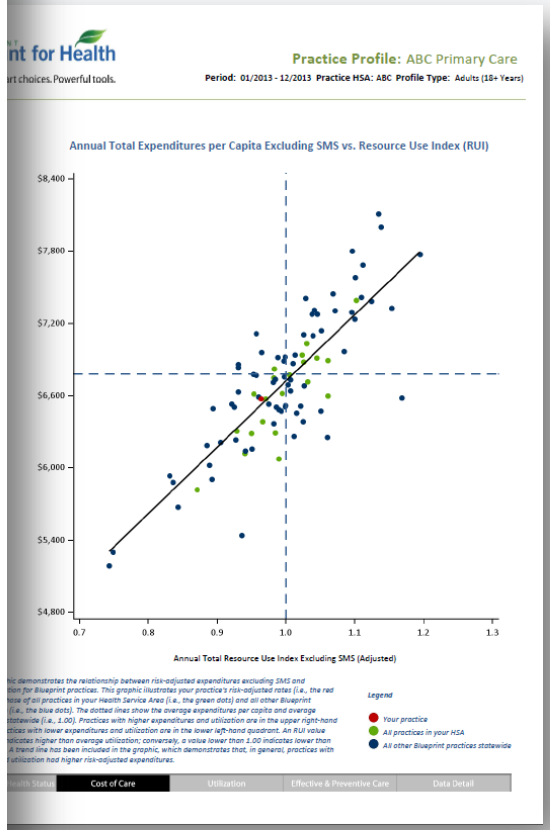
Total Expenditures Excluding SMS

Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medicaid Services capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medicaid Services. The practice and HSA are indexed to the statewide average (1.00).

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail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Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)

...ic demonstrates the relationship between risk-adjusted expenditures excluding SMS and ... for Blueprint practices. This graphic illustrates your practice's risk-adjusted rates (i.e., the red ... of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint ... (i.e., the blue dots). The dotted lines show the average expenditures per capita and average ... statewide (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand ... with lower expenditures and utilization are in the lower left-hand quadrant. An RUI value ...dicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than ... A trend line has been included in the graphic, which demonstrates that, in general, practices with ... utilization had higher risk-adjusted expenditures.

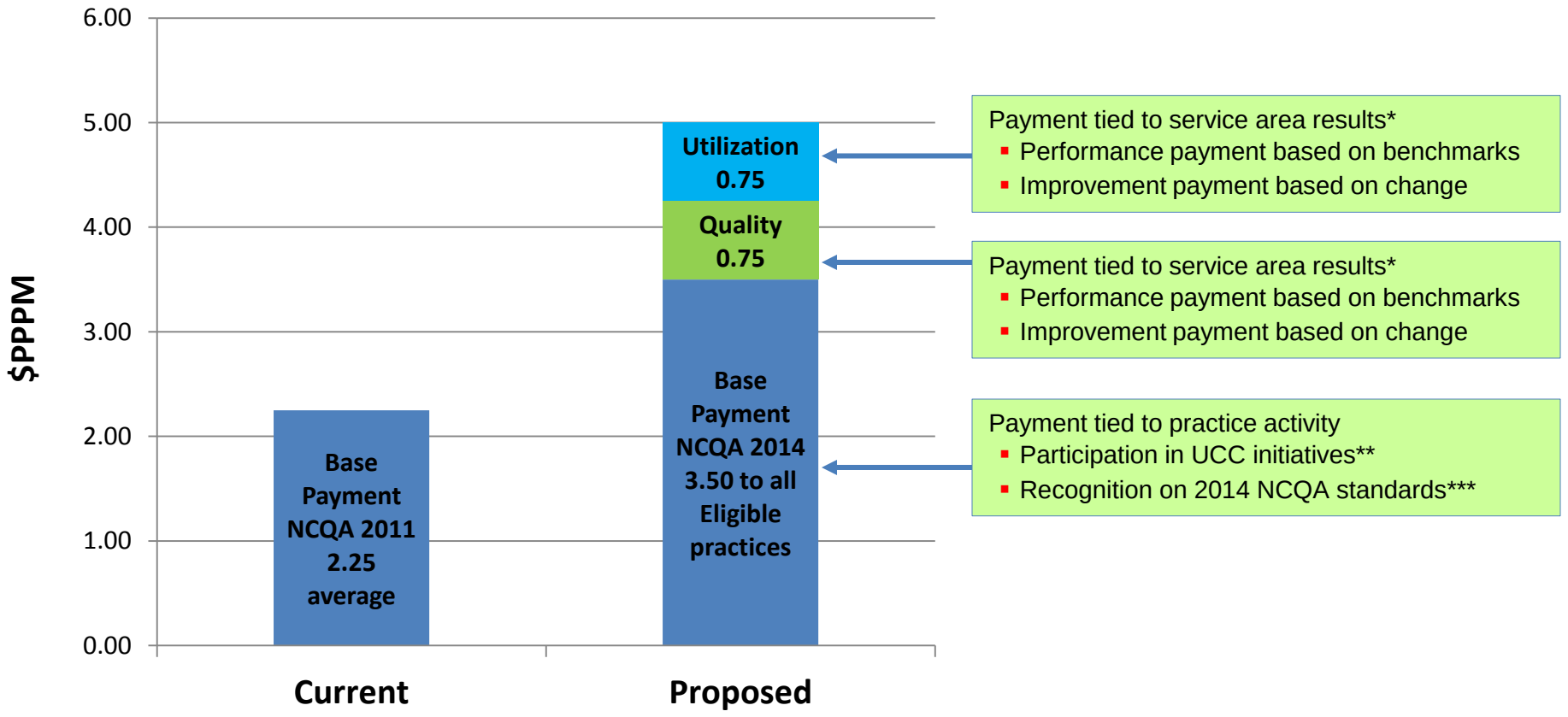
...Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail

Payment Modifications

Recommendations

1. Increase PCMH payment amounts
2. Shift to a composite measures based payment for PCMHs
3. Increase CHT payments and capacity
4. Adjust insurer portion of CHT costs to reflect market share

Proposed Payment Modifications



*Incentive to work with UCC partners to improve service area results.

**Organize practice and CHT activity as part of at least one UCC quality initiative per year.

***Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

Community Oriented Health Systems

- Core measures set priorities and provide a statewide framework
- Portion of medical home payment model tied to community outcomes
- Community collaboratives guide quality & coordination initiatives
- Shared interests stimulate goal oriented health services & networks
- Health System (Accessible, Equitable, Patient Centered, Preventive, Affordable)