Summary of Testimony by Mary Kate Mohlman, PhD,
Senate Committee on Health and Welfare
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The Vermont Blueprint for Health (Blueprint) supports H. 761 as passed by the House. In particular, the Blueprint supports the language "The plan's goal shall be to reduce the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate quality of and access to care adequately."

The Blueprint has taken efforts to reduce the burden on and time needed by practices to meet NCQA reporting requirements for recognition as a patient-centered medical home. Below is a summary of the new payment structure calculated by the Blueprint and paid directly to practices by Medicaid and commercial insurers. Medicare continues to pay the same rate initially negotiated for the Multi-Payer Advanced Primary Care Practice Demonstration, which ends December 31, 2016.

New Patient-Centered Medical Home (PCMH) Payment Summary

The new model moved from PMPM (per-member per-month) payment-levels based on a practice's NCQA recognition score (averaging $2.05 PMPM; ranging from $1.36 to $2.39 PMPM) to a base payment of $3.00 PMPM contingent on qualifying for or maintaining recognition as a PCMH and participation in the Community Collaboratives (CC). One reason for this decision was practice feedback indicated that the effort required to achieve the highest level of recognition did not result in a corresponding increase in the standard of care practices were able to provide. A shift to a pass/no-pass payment model allowed providers to focus on the must-pass elements in NCQA scoring, plus any additional areas they determined clinically relevant for their practice and patients. The other aspect of the base payment, the participation in CC development and quality improvement initiatives, was meant to further incent collaboration with other practices and other medical and social service providers in the service area.

The new payment model also included two performance-based payments, up to an additional $0.50 PMPM: one based on a composite of quality measures and the other based on health service utilization. The quality performance payment is based on a Health Services Area's outcomes in four measures that are part of the Centers for Medicare & Medicaid Services (CMS)-defined ACO core quality measures:

1. Adolescent Well-Care Visits
2. Developmental Screening in the First Three Years of Life
3. Diabetes in poor control (i.e. Hemoglobin A1c >9%)
4. Rate of Hospitalization for Ambulatory Care Sensitive Conditions[1]

Several fundamental decision points were used in the selection of these four measures:

[1] PQI Chronic Composite (which includes the admission rate per 1000 for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure)

- These measures reflect the priorities of each of the three provider networks (ACOs) in Vermont.
- Each measure can be generated at a service area level using Vermont's centralized data sources without any need for additional data collection or reporting by providers.
- Each measure is tied to prevalent underlying health concerns involving complex medical and social determinants.
- Each measure can be improved through better coordination, outreach, and transitions between medical and non-medical providers.

The blend of the four measures emphasizes improved coordination, quality, and prevention across a broad spectrum of conditions and over one's life span.

The utilization performance payment is based on Total Resource Utilization Index (TRUI). The TRUI is a standardized measure that reflects overall utilization and is endorsed by the National Quality Forum. Feedback from practices indicated a need for part of the performance payments to be based on a practice's performance over which the practice has direct influence. The Blueprint and ACOs agreed a mixed model would strike the necessary balance and modified the payment model so that utilization payments would be based on practice performance, as identified by the TRUI score listed in a practice's Blueprint practice profile.