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Department of Vermont Health Access

VERMONT Blueprint for Health

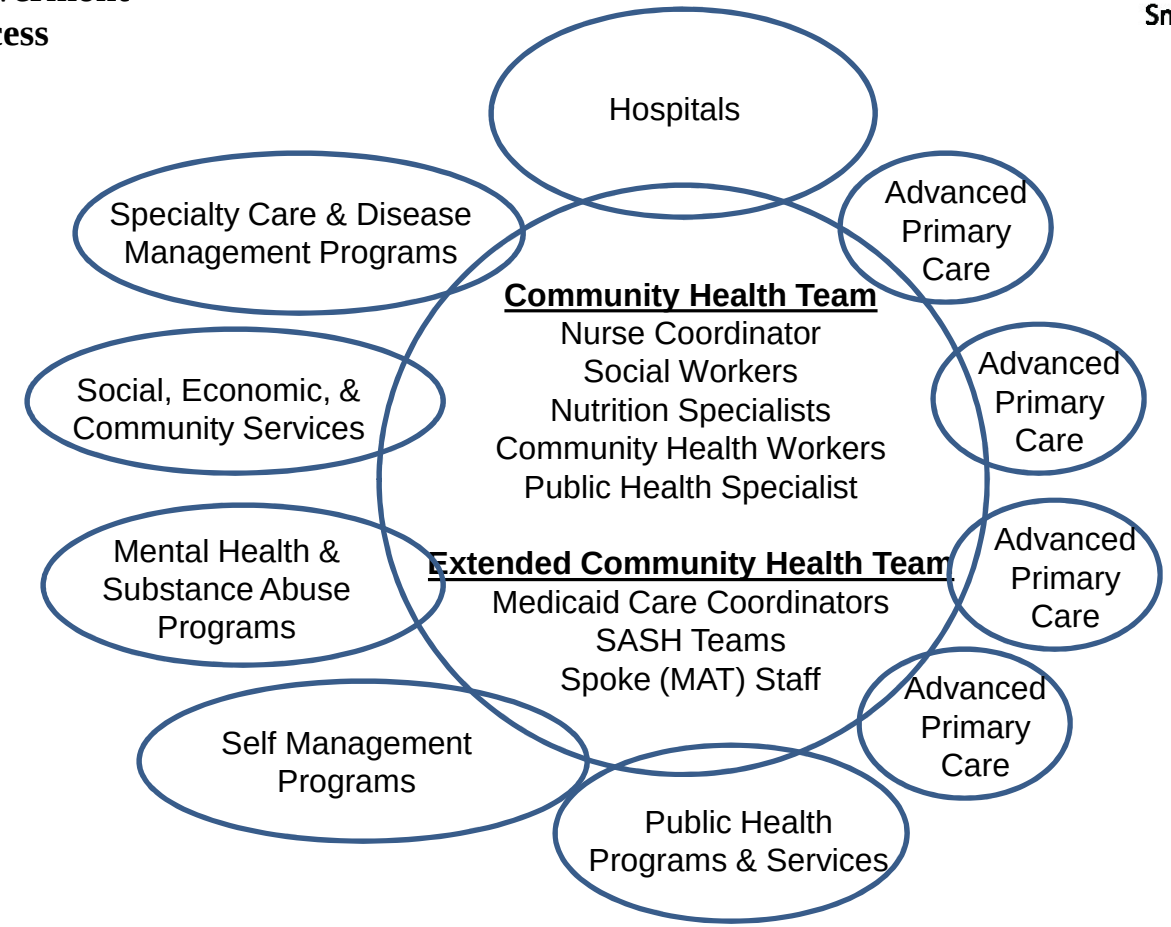
Smart choices. Powerful tools.

Community Oriented Health Systems

House Committee on Healthcare

House Committee on Appropriations

February 10, 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	July, 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)

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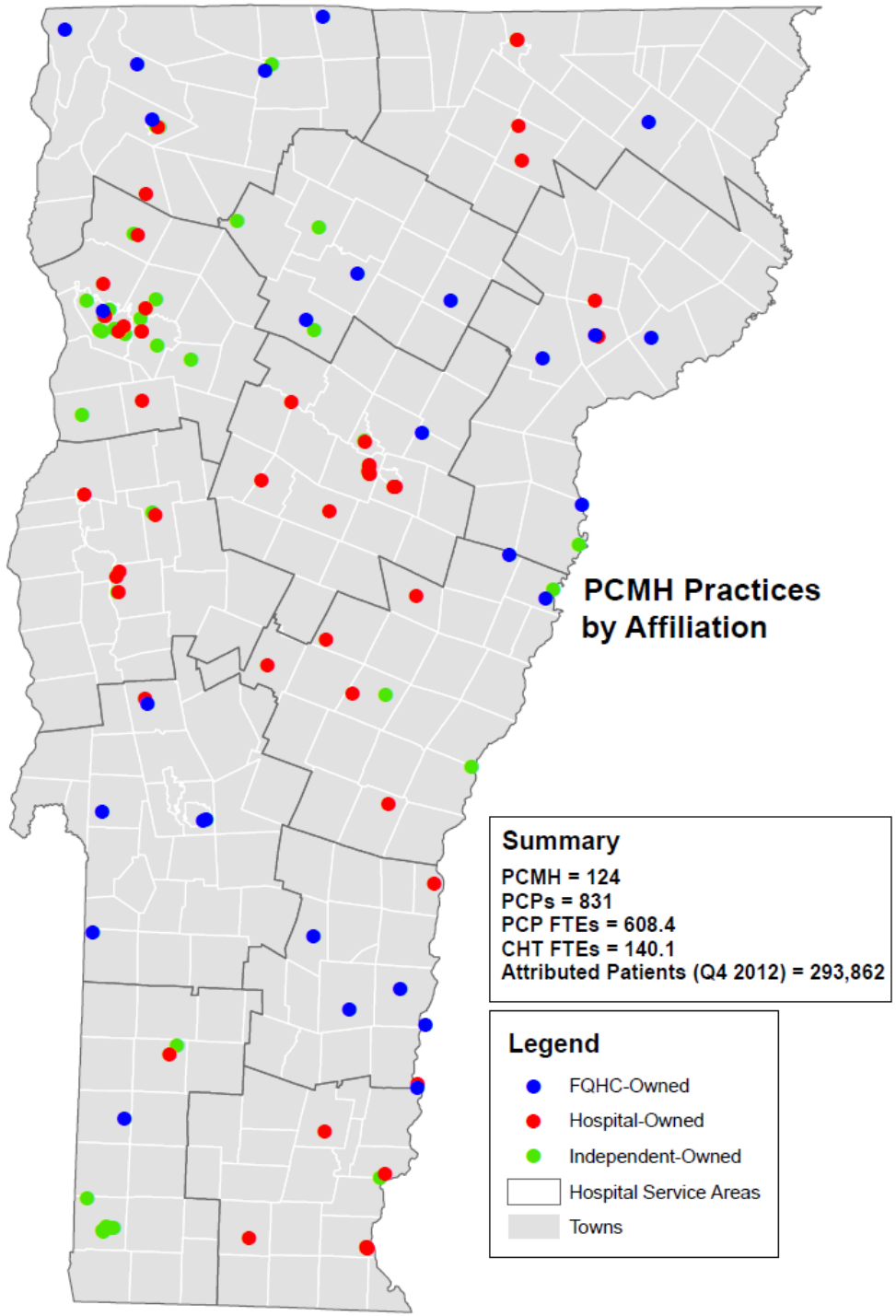
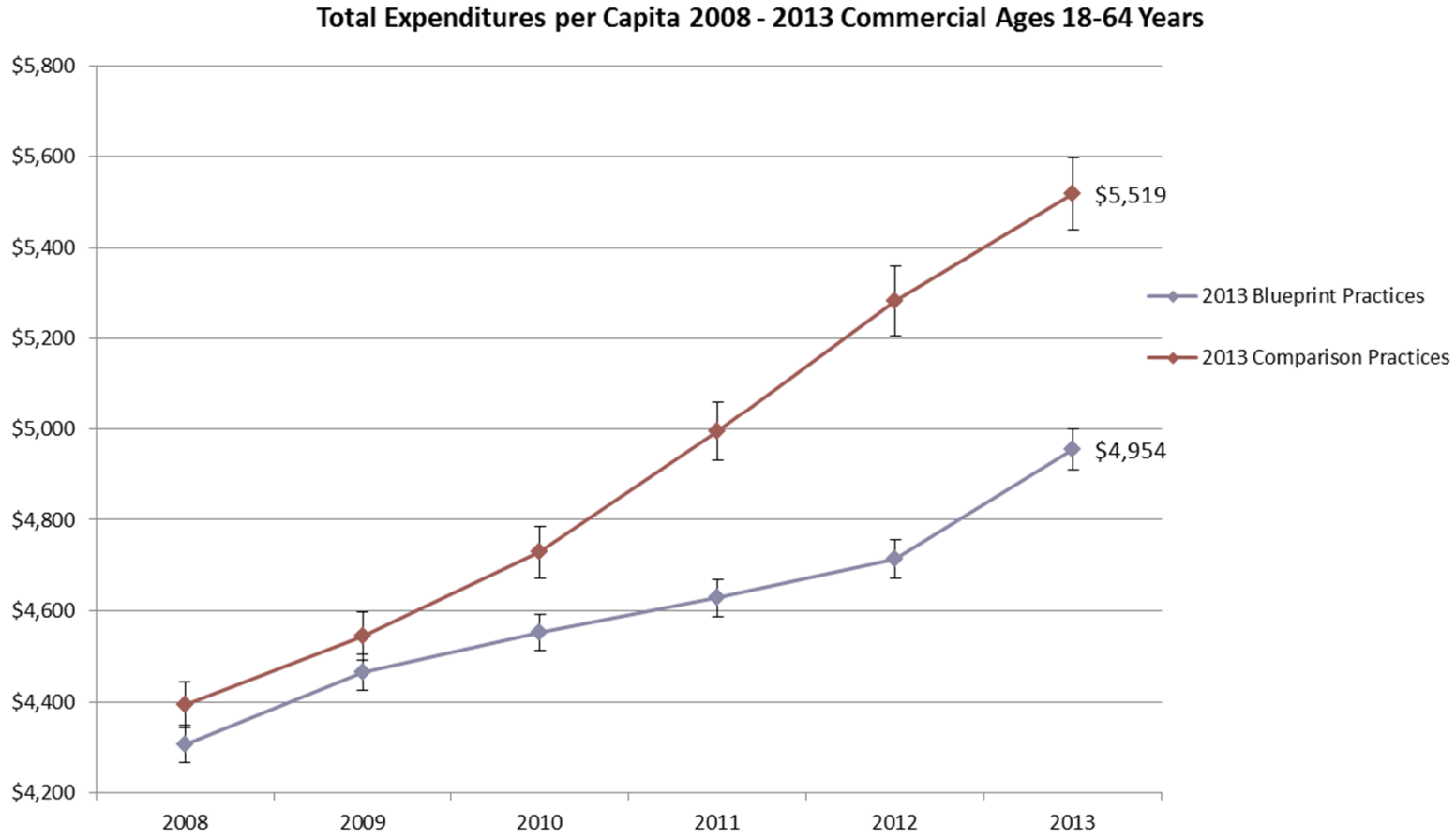
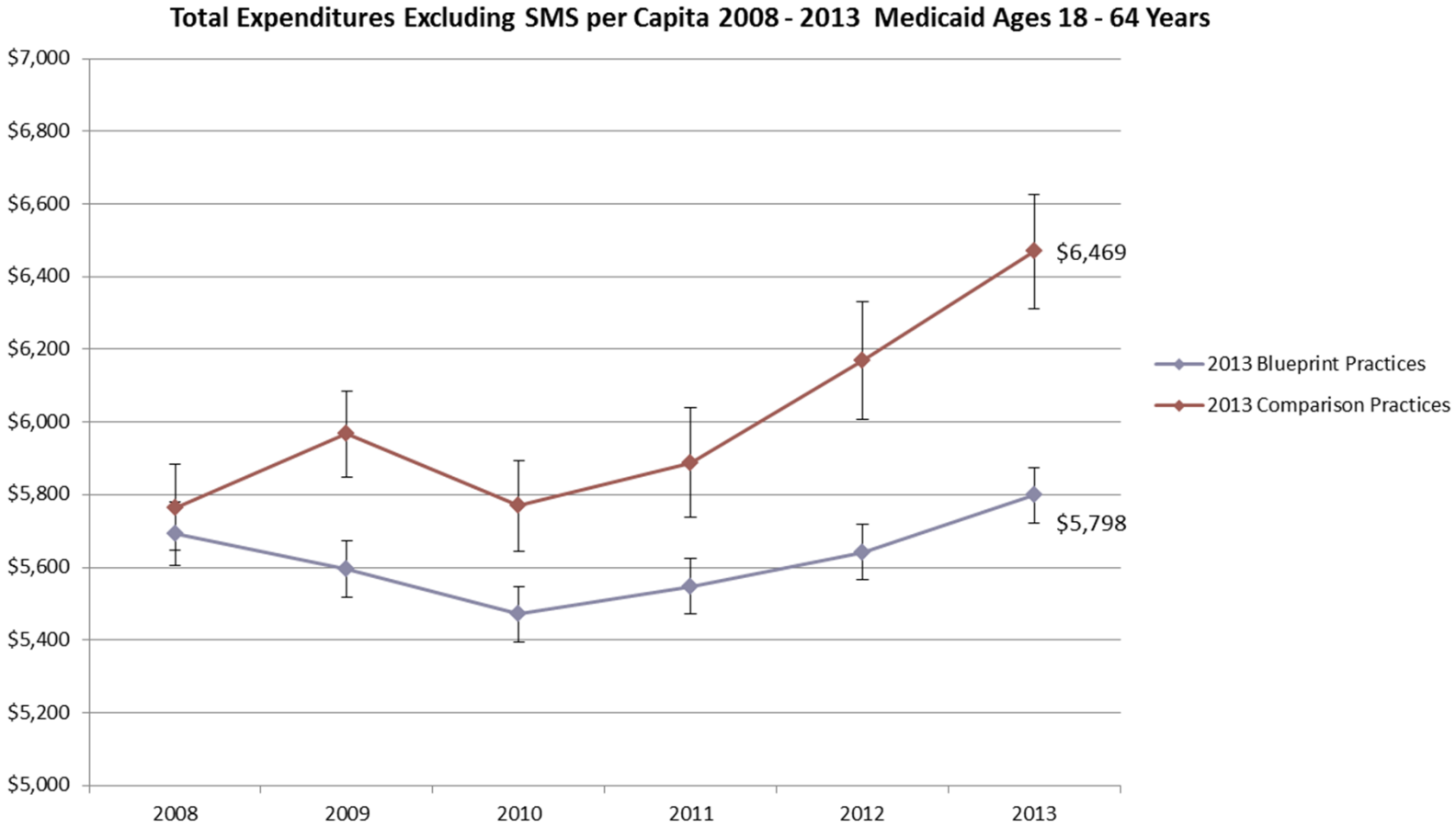
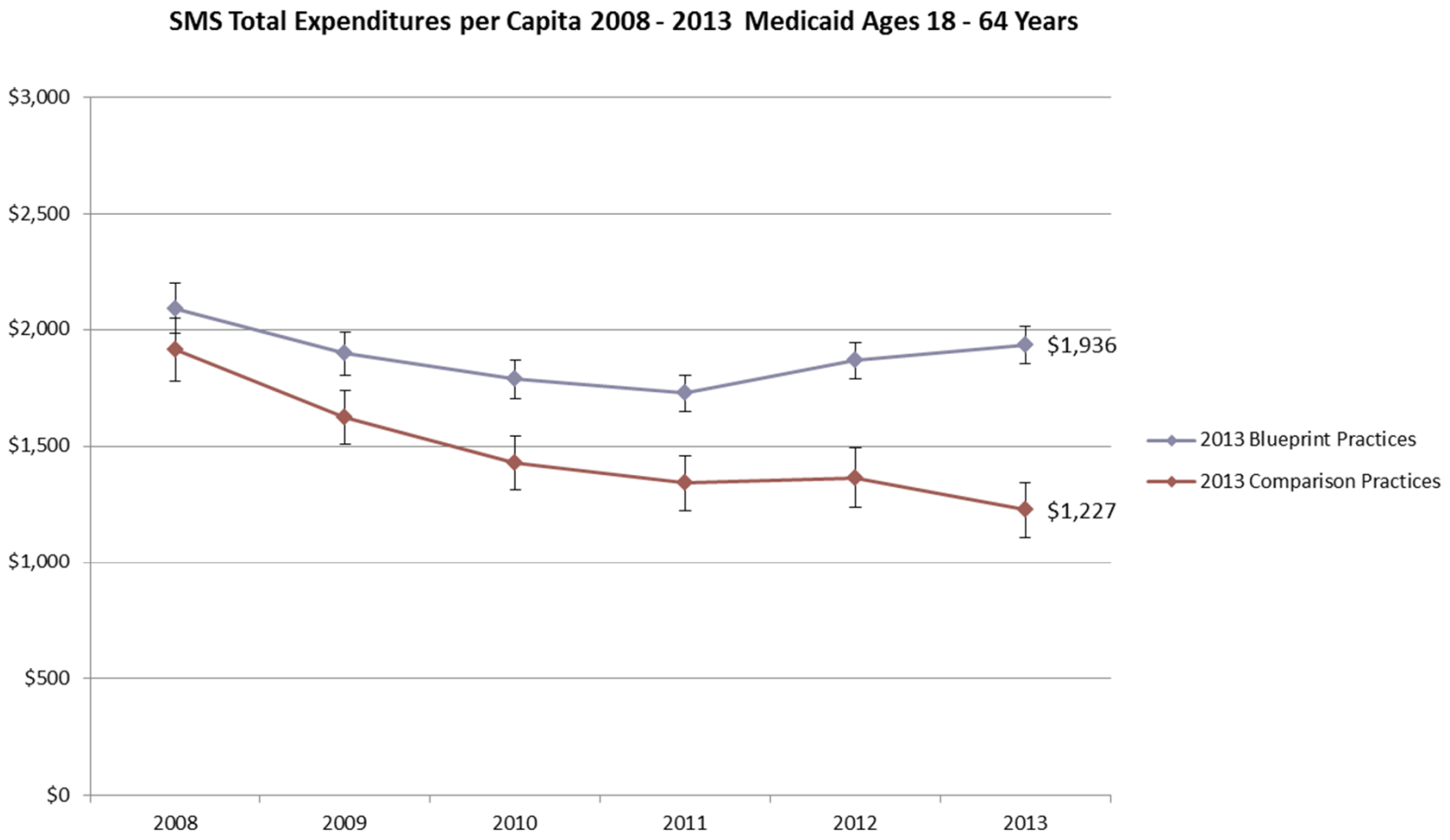



Total Expenditures per Capita 2008 - 2013 Commercial Ages 18-64 Years
$5,800
$5,600
$5,400
$5,200
$5,000
$4,800
$4,600
$4,400
$4,200
2008
2009
2010
2011
2012
2013
$5,519
$4,954
2013 Blueprint Practices
2013 Comparison Practices


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

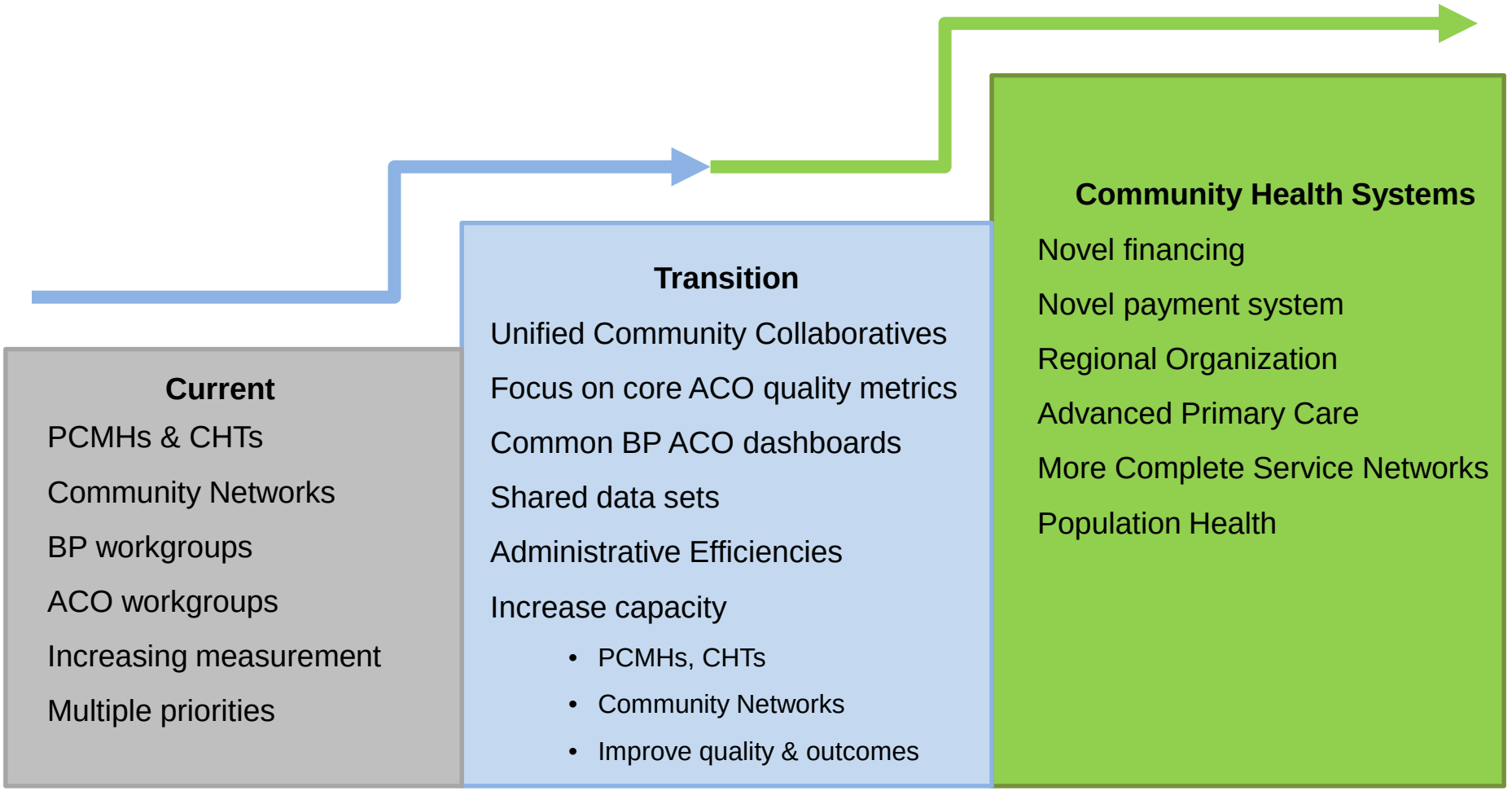
Expenditures & Investments

Results for Calendar Year 2013	MCAID	Commercial
Number of Participating Beneficiaries	83,939	143,961
Total Medical Home Payments	$2,085,035	$3,576,002
Total CHT Payments	$2,343,603	$5,182,633
Total Investment Annual	$4,428,638	$8,758,635
Total Expenditures per Capita (participants)	$7,776	$4,954
Total Expenditures per Capita (comparison)	$7,877	$5,519
Differential per Capita (participant vs. comparison)	$101	$565
Total Differential (participants vs. comparison)	$8,477,839*	$81,337,965

Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & evolving community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Three ACO provider networks (OneCare, CHAC, HealthFirst)
- Opportunity to unify work, strengthen community health system structure

Transition to Community Health Systems



Strategy for Building Community Health Systems

Design Principles

- Services that improve population health thru prevention
- Services organized at a community level
- Integration of medical, social, and long term support services
- Enhanced primary care with a central coordinating role
- Coordination and shared interests across providers in each area
- Capitated payment that drives desired outcomes

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
- Strengthen services using the health home model
- Administrative simplification and efficiencies

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 enrolli... 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 comma... 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.

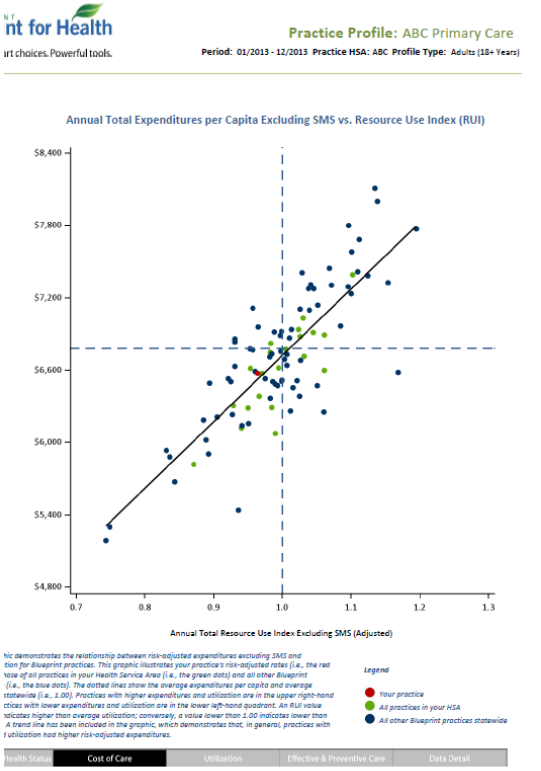
Total Expenditures Excluding SMS

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., copy, 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)

Annual Total Resource Use Index Excluding SMS (Adjusted)

hic demonstrates the relationship between risk-adjusted expenditures excluding SMS and ... tion for Blueprint practices. This graphic illustrates your practice's risk-adjusted rates (i.e., the red ... ose 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 ... ctices with lower expenditures and utilization are in the lower left-hand quadrant. An RUI value ... ndicates 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.

Legend
- Your practice
- All practices in your HSA
- All other Blueprint practices statewide

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

ONPOINT Health Data

Payment Modifications

Need for Modifications

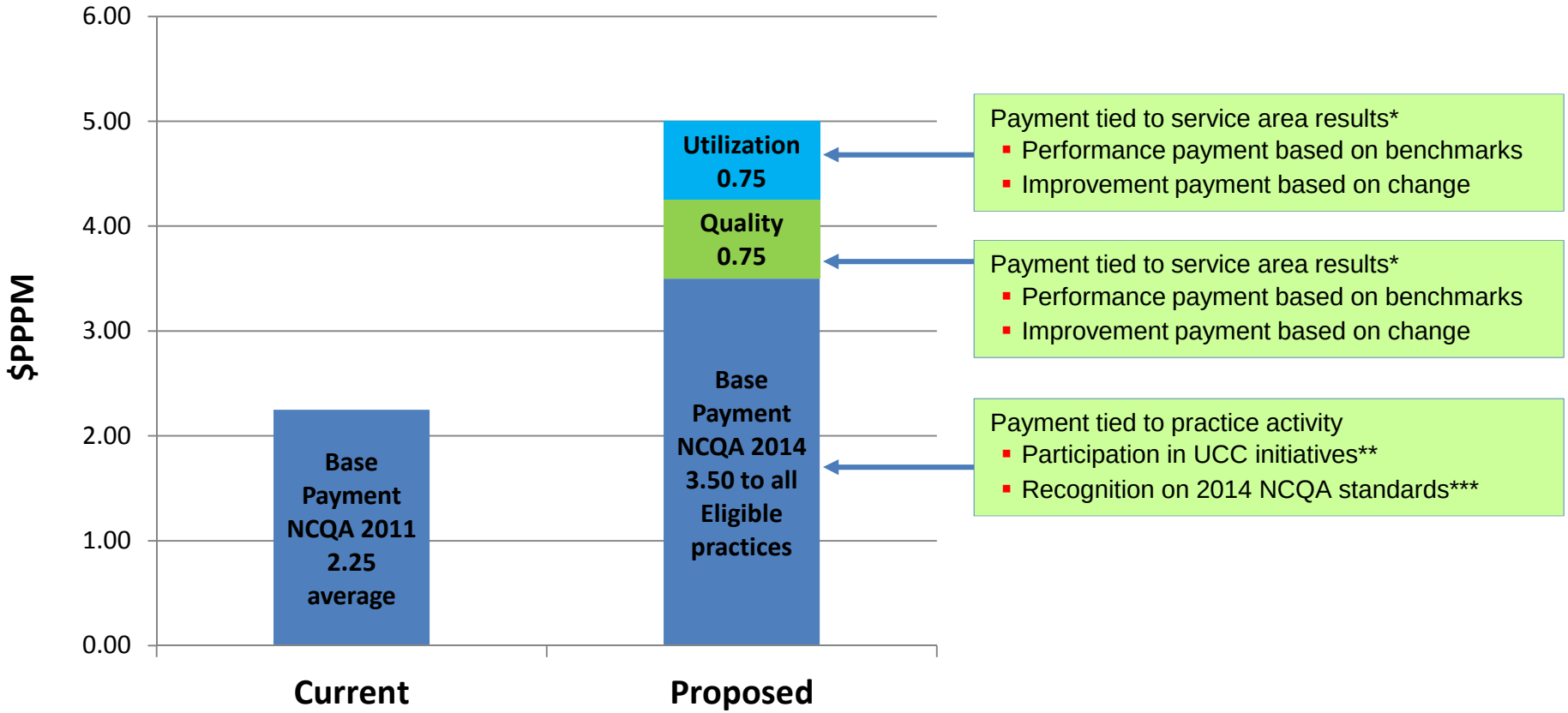
- Current payments have stimulated substantial transformation
- Improved healthcare patterns, linkage to services, local networks
- Reduced expenditures offset investments in PCMHs and CHTs
- Modifications are needed for further advancement
- Proposed modifications will support UCCs & quality improvement

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 PCMH Payment Modifications (working version)



*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.

Proposed Modifications to PCMH Payments

	Current PCMH Cost (annual)	Proposed PCMH Cost (annual)	Differential (annual)
Medicare	$1,549,949	$1,549,949	$0
Medicaid	$2,085,035	$4,170,070	$2,085,035
BCBS	$2,345,330	$4,690,660	$2,345,330
MVP	$404,000	$808,000	$404,000
Cigna	$826,672	$1,653,344	$826,672
Total	$7,210,986	$12,872,023	$5,661,037

Proposed Modifications to CHT Payments

	Current Share of CHT Costs	Current Annual CHT Cost	Proposed Share of CHT Costs	Proposed Annual CHT Cost	Differential (annual)
		Based on $1.50 PPPM and current cost allocations	Based on percentages of attributed beneficiaries	Based on $3.00 PPPM for non-Medicare, and new cost allocations	
Medicare*	22.22%	$2,150,229	22.22%	$2,150,229	$0
Medicaid	24.22%	$2,343,768	35.66%	$6,901,634	$4,557,865
BCBS	24.22%	$2,343,768	36.92%	$7,145,494	$4,801,725
MVP	11.12%	$1,076,082	4.71%	$911,573	-$164,509
Cigna	18.22%	$1,763,149	0.49%	$94,835	-$1,668,314
Total	100.00%	$9,676,996	100.00%	$17,203,763	$7,526,767

*Medicare share of CHT patient allocation remains unchanged at 22.22% and payment level remains unchanged at $1.50 PPPM.

Community Oriented Health Systems

- Core measures & NCQA standards provide a statewide framework
- PCMH payment model incents quality & coordination
- Community collaboratives guide quality & coordination initiatives
- More effective health services & community networks
- Health System (Accessible, Equitable, Patient Centered, Preventive, Affordable)