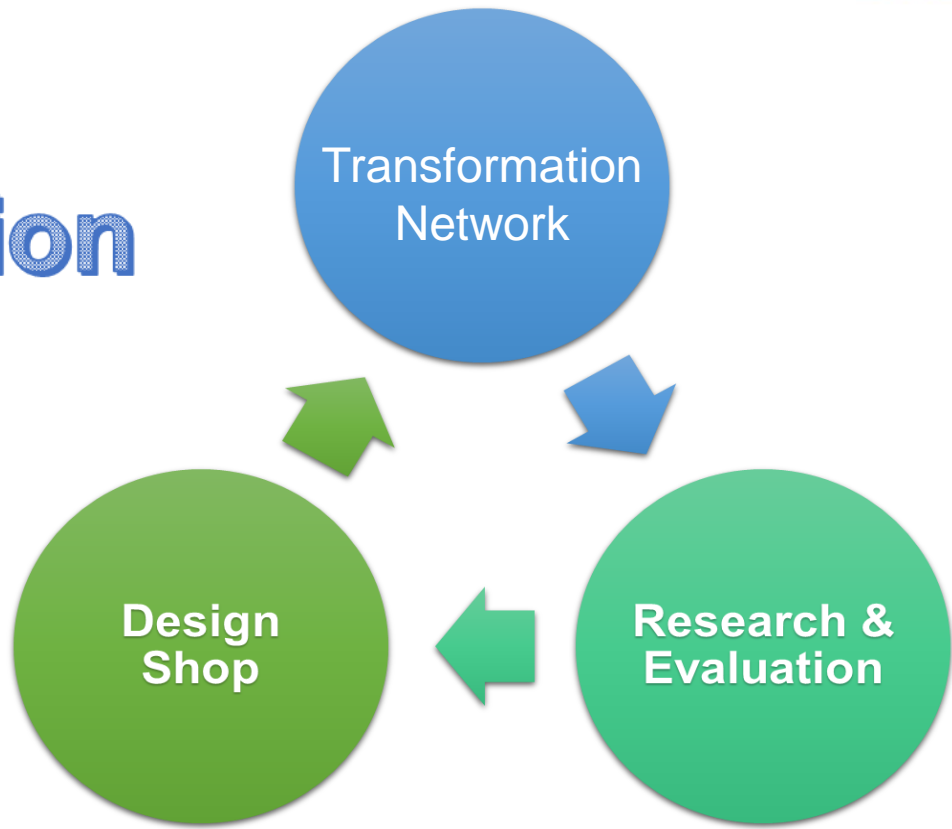


Blueprint for Health: Overview & Results

Senate Committee on
Health and Welfare
January 13, 2017

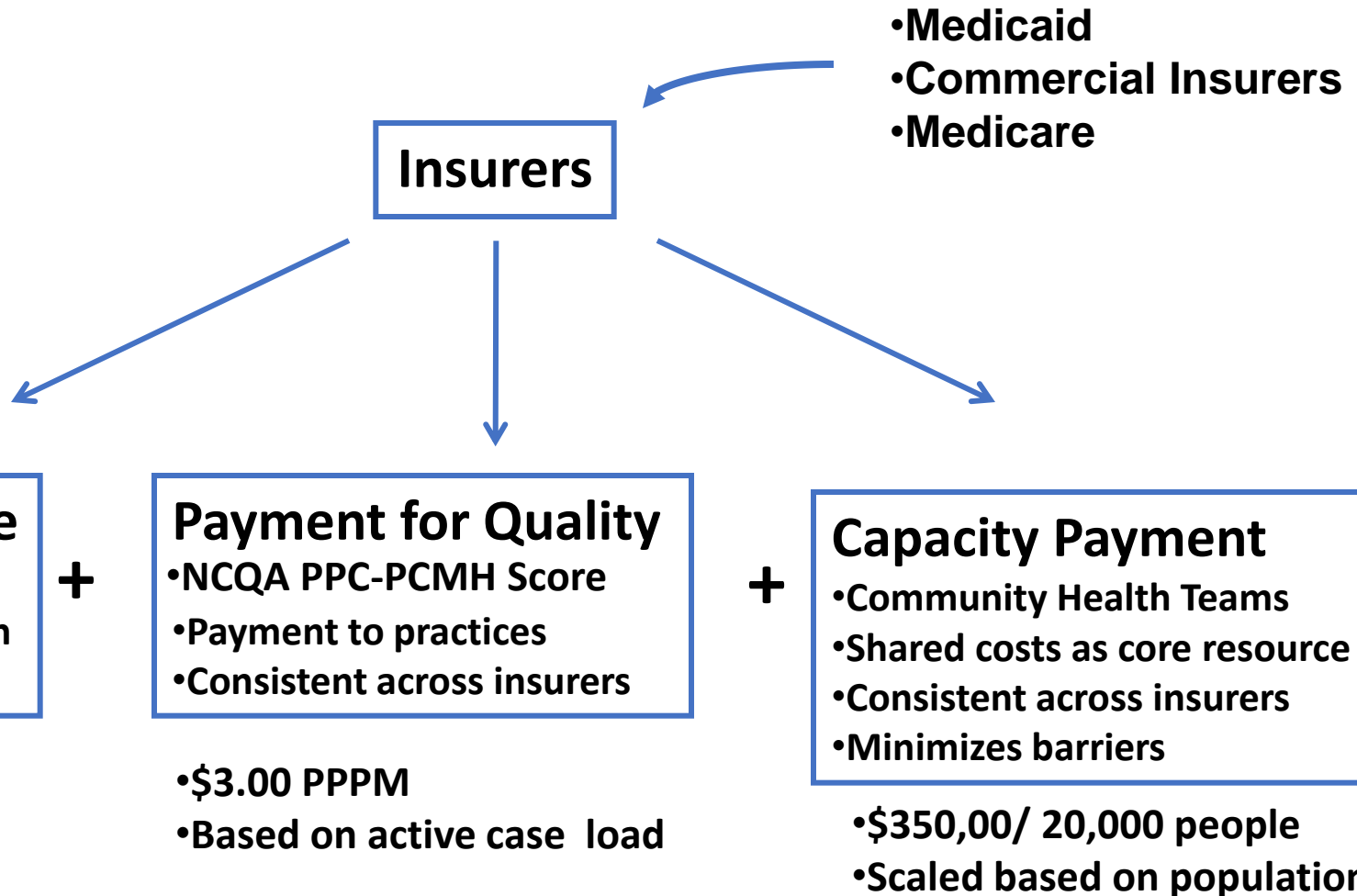
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Innovation Engine

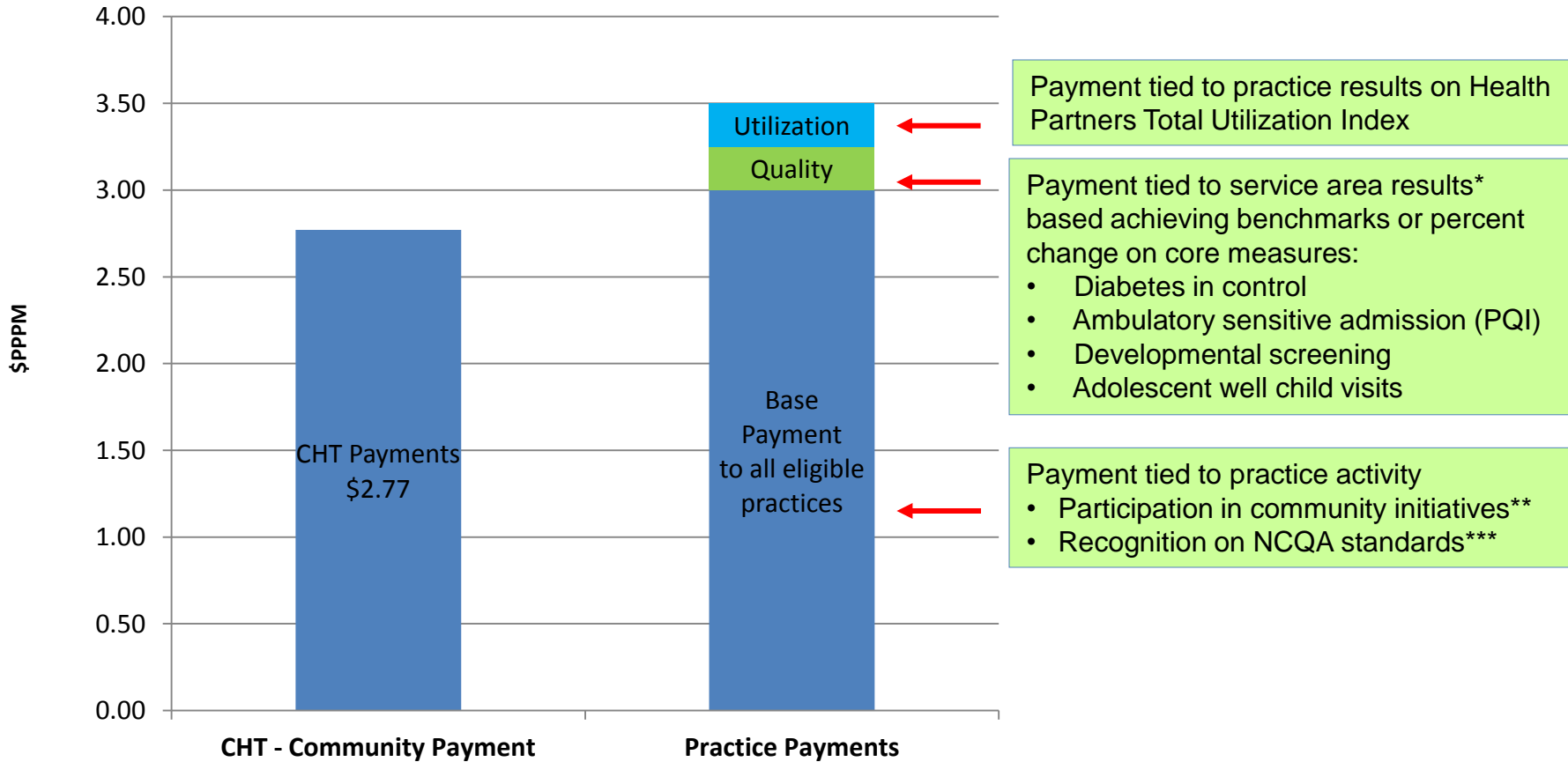


Patient Centered Medical Homes strong primary care foundation
Community Health Teams bridge health & social services **SASH**
for healthy aging-in-place, **Hub & Spoke** for opioid addiction
treatment, **Women's Health Initiative** increase pregnancy
intention, healthy families

Vermont Multi-insurer Payment Reforms for Primary Care



Payment Model



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

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

***Payment tied to recognition on NCQA PCMH standards with any qualifying score.

****Payments are for Commercial and Medicaid. Medicare pays a different rate

Practice Facilitators | Project Managers | Community Health Team Leaders

A trusted, community-based presence

Supports data-guided quality improvement in practices and communities

Works across provider types, insurers

Convenes local health and human services for integrated reform

Enables rapid implementation of new initiatives in response to state priorities



Local Leadership by Community Collaboratives

Purpose: prepare to function as an Accountable Community for Health, responsible for the wellness of the whole population and its health care budget.

Convened by Blueprint Project Managers or OneCare staff, with Clinical Leadership

Spanning sectors, organizations, provider types, with participation from:

- All ACOs present in community

- Primary care clinical leader, pediatric clinical leader

- Hospital

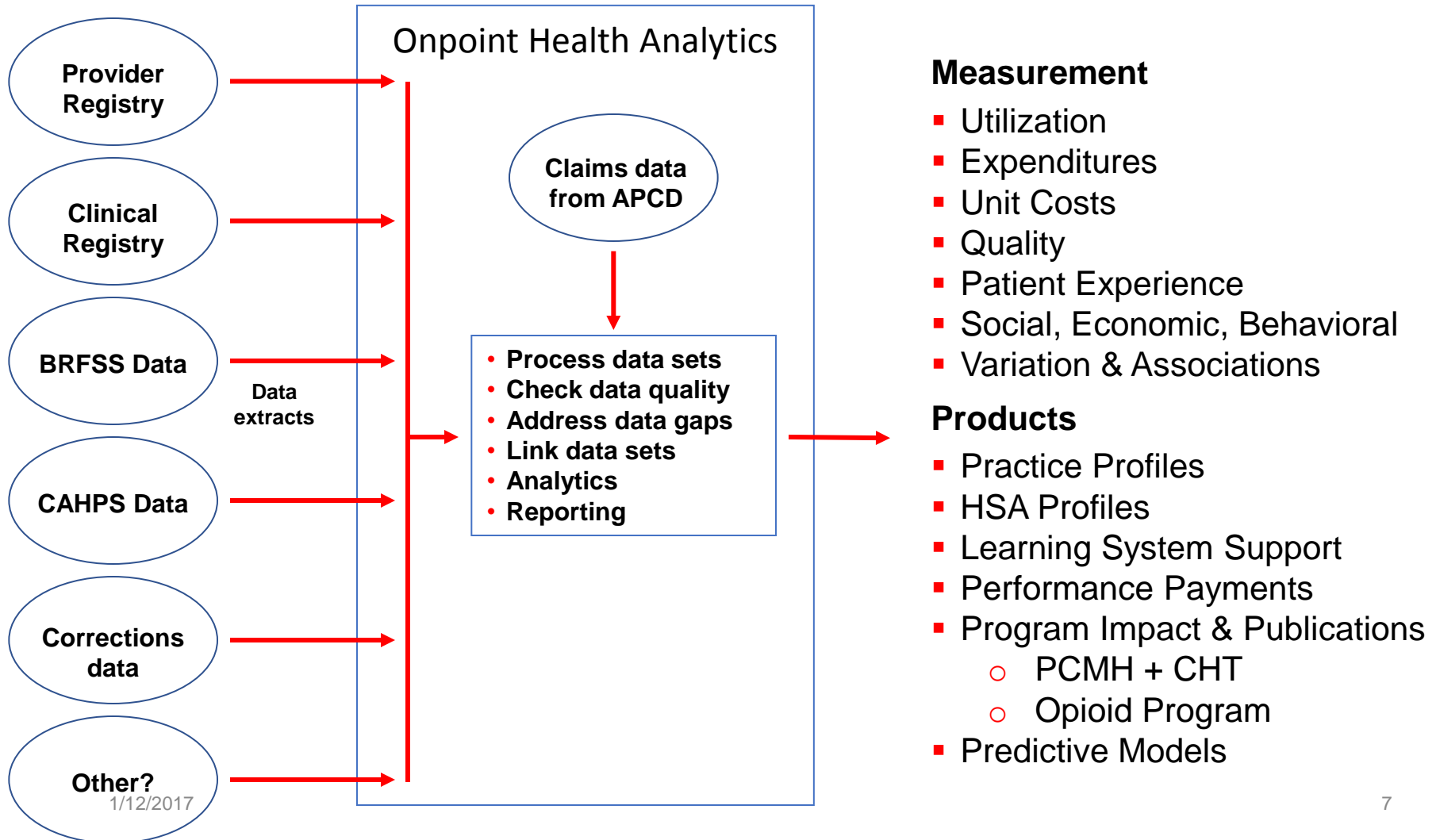
- Home Health/Visiting Nurse Association

- Area Agency on Aging

- Designated (mental health) Agency

- Designated Regional Housing Authority

Data Use for a Learning Health System



Research & Evaluation

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare



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

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	2
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 & health status of your practice, all Blueprint practices in your Health Service Area (HSA) as a whole. Included measures reflect the types of information used to adjust 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 enrollment in Medicaid or Medicare, the member's practice, percentage of membership in Medicaid, Medicare eligibility or end-stage renal disease status, and the member's required special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

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

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



Smart choices. Powerful tools.

Practice Profile: ABC Primary Care

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

Total Expenditures per Capita

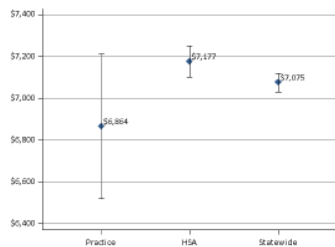


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

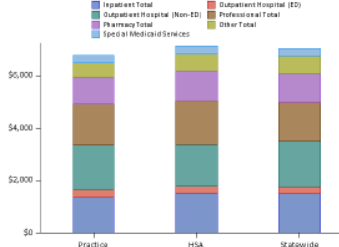


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

Total Expenditures Excluding SMS

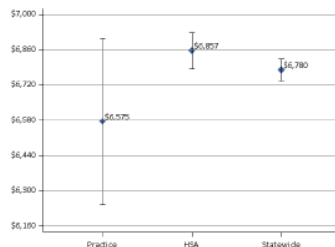


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medical Services, capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

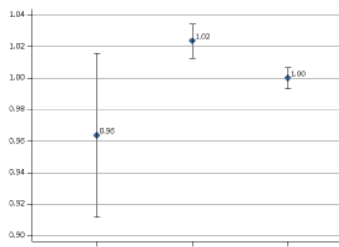


Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per resource varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects on aggregated cost based on utilization and intensity of services across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

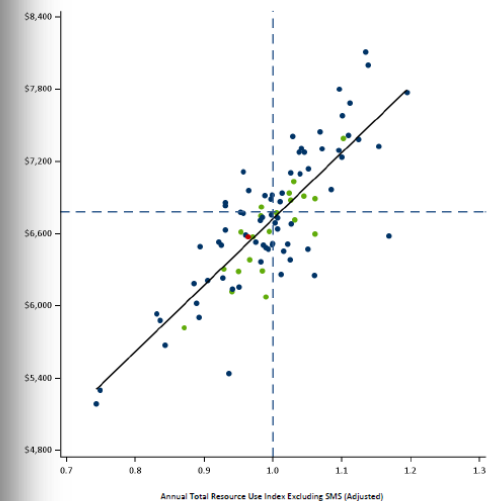
Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

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



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)

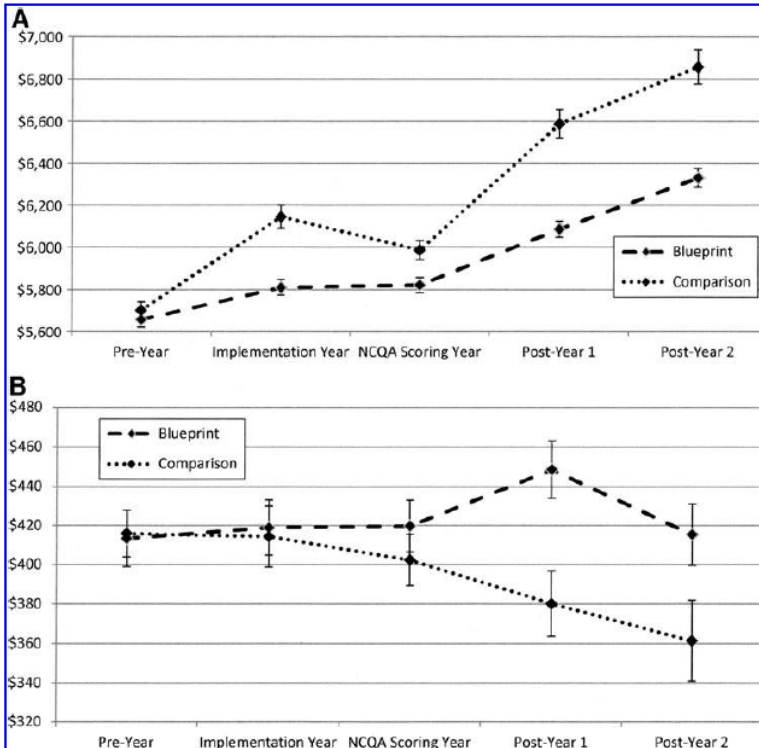


This graphic demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint practices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

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

Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care

Craig Jones, MD,¹ Karl Finison, MA,² Katharine McGraves-Lloyd, MS,² Timothy Tremblay, MS,¹ Mary Kate Mohlman, PhD,¹ Beth Tanzman, MSW,¹ Miki Hazard, MA,¹ Steven Maier, MSL,¹ and Jenney Samuelson, MS¹



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Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont



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Table 2
Adjusted average annual expenditures and utilization rates[†].

	MAT group	Non-MAT	Difference [‡]	P-value
Expenditures				
Total expenditures	\$14,468	\$14,880	−\$412	0.07
Total expenditures without treatment	\$ 8794	\$11,203	−\$2409	<.01
Buprenorphine expenditures	\$2708	−\$47	\$2755	<.01
Total prescription expenditures	\$4461	\$2166	\$2295	<.01
Inpatient expenditures	\$2132	\$3757	−\$1625	<.01
Outpatient expenditures	\$345	\$604	−\$259	<.01
Professional expenditures	\$674	\$981	−\$307	<.01
SMS expenditures [*]	\$2872	\$4160	−\$1288	<.01
Utilization (rate/person)				
Inpatient days	1.54	3.00	−1.46	<.01
Inpatient discharges	0.30	0.52	−0.22	<.01
ED visits	1.44	2.48	−1.04	<.01
Primary care physician visits	15.27	9.81	5.46	<.01
Advanced imaging	0.29	0.54	−0.25	<.01
Standard imaging	0.76	1.43	−0.67	<.01
Colonoscopy	0.01	0.02	−0.01	<.01
Echography	0.46	0.53	−0.07	0.002
Medical specialist visits	0.49	0.82	−0.33	<.01
Surgical specialist visits	3.04	1.89	1.15	<.01

* SMS refers to special Medicaid services and include transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services.

[†] Multivariable regression analysis, adjusted for gender, age, calendar year, clinical risk groups, Medicaid in the prior year, hepatitis C virus (HCV) status, and pre- and perinatal care.

[‡] Difference = MAT – non-MAT.

Slowing Growth in Health Care Costs



total expenditures per capita, excluding Special Medicaid Services, 2008-2015, all insures, for individuals ages one and up

Funding & ROI

All Payer	Investment	Reduction in Total Expenditures
Reduction in expenditures		\$(73,413,205)
PCMH Payments	\$7,968,509	
Core CHT Payments	\$8,977,055	
Total Payments	\$16,945,564	
Blueprint Program Budget	\$5,071,363	
Total investment	\$22,016,927	

Reduction in Total Expenditures / Total Investment = Return on Investment

3.3 Return on Investment

Discussion