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Agency of Human Services

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Blueprint for Health: Overview & Results

Senate Committee on Health and Welfare
January 13, 2017

Beth Tanzman, MSW
Beth.Tanzman@Vermont.Gov
Blueprintforhealth.Vermont.Gov

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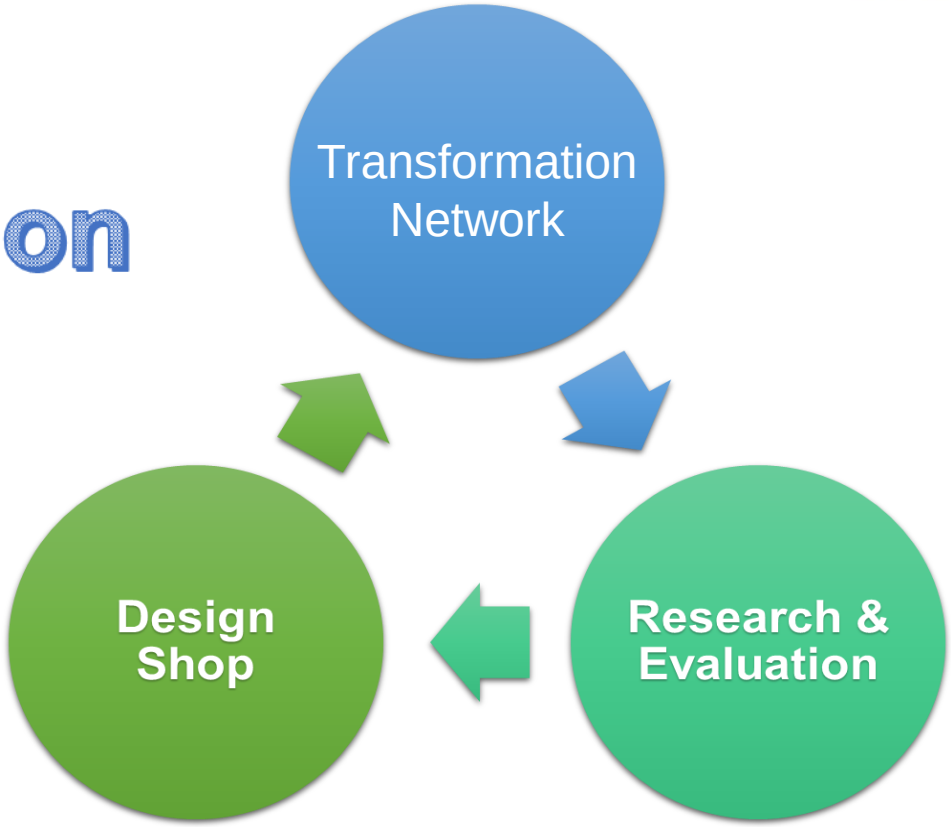
Innovation Engine



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

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Vermont Multi-insurer Payment Reforms for Primary Care

- Medicaid
- Commercial Insurers
- Medicare

Insurers

Fee for Service
- Unchanged
- Allows competition
- Promotes volume

+

Payment for Quality
- NCQA PPC-PCMH Score
- Payment to practices
- Consistent across insurers

- $3.00 PPPM
- Based on active case load

+

Capacity Payment
- Community Health Teams
- Shared costs as core resource
- Consistent across insurers
- Minimizes barriers

- $350,00/ 20,000 people
- Scaled based on population

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Department of Vermont Health Access

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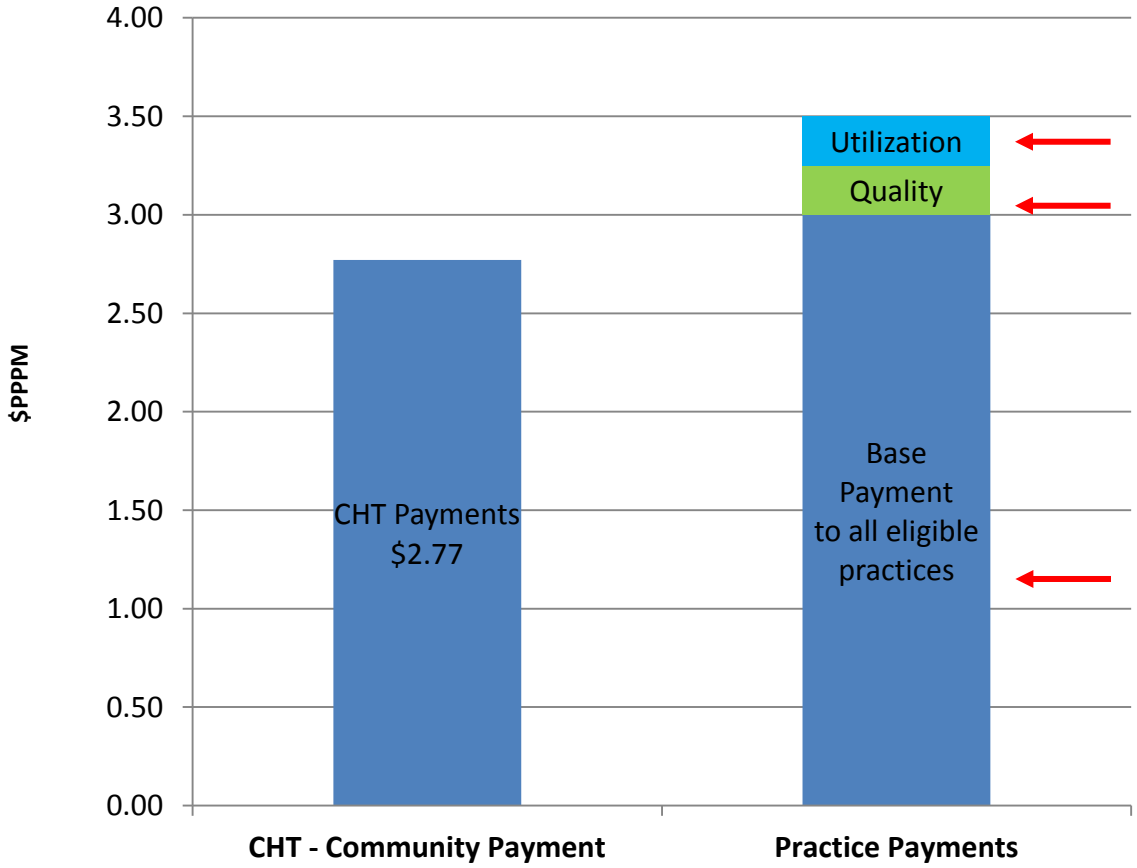
Payment Model



Payment tied to practice results on Health Partners Total Utilization Index

Payment tied to service area results* based achieving benchmarks or percent change on core measures:

- Diabetes in control
- Ambulatory sensitive admission (PQI)
- Developmental screening
- Adolescent well child visits

Payment tied to practice activity

- Participation in community initiatives**
- Recognition on NCQA standards***

*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

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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

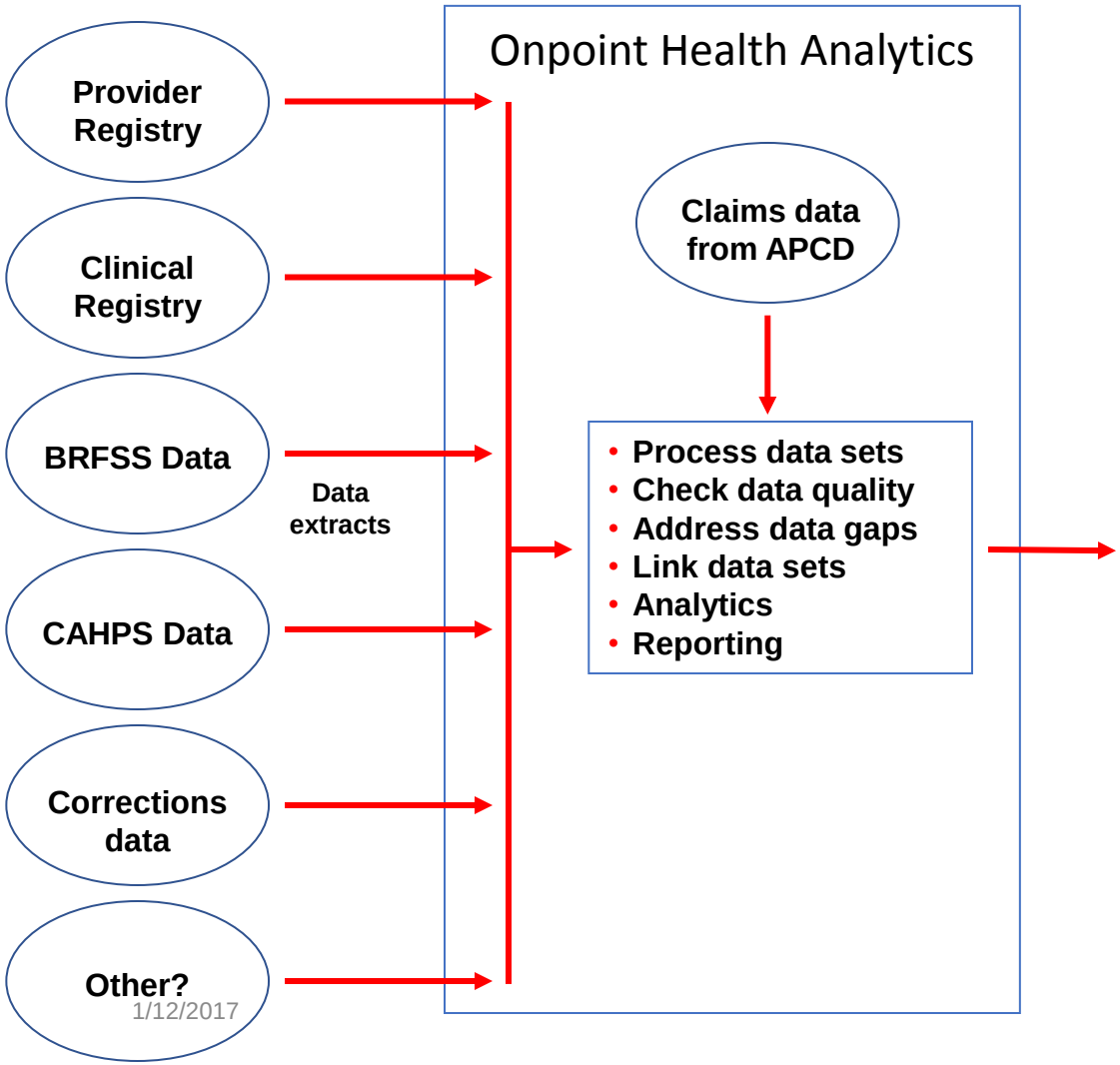
Enables rapid implementation of new initiatives in response to state priorities

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



Measurement

- Utilization
- Expenditures
- Unit Costs
- Quality
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

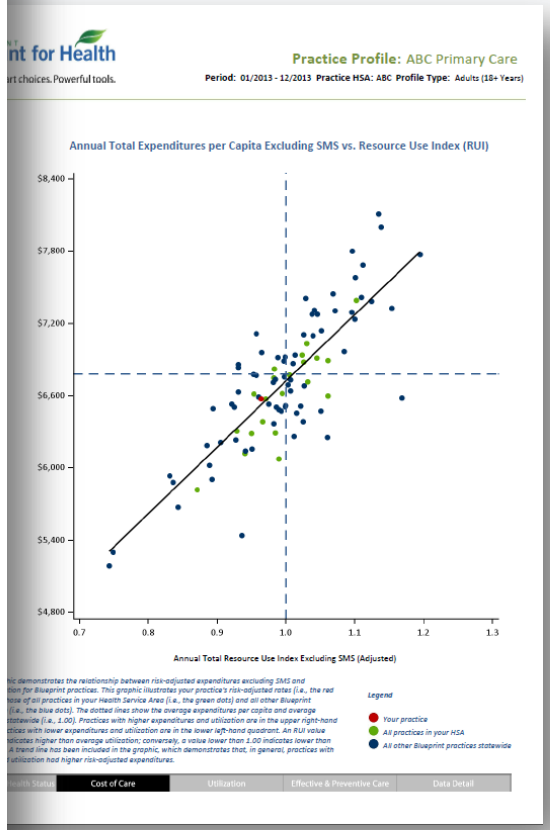
Products

- Practice Profiles
- HSA Profiles
- Learning System Support
- Performance Payments
- Program Impact & Publications
  - PCMH + CHT
  - Opioid Program
- Predictive Models

Research & Evaluation

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare



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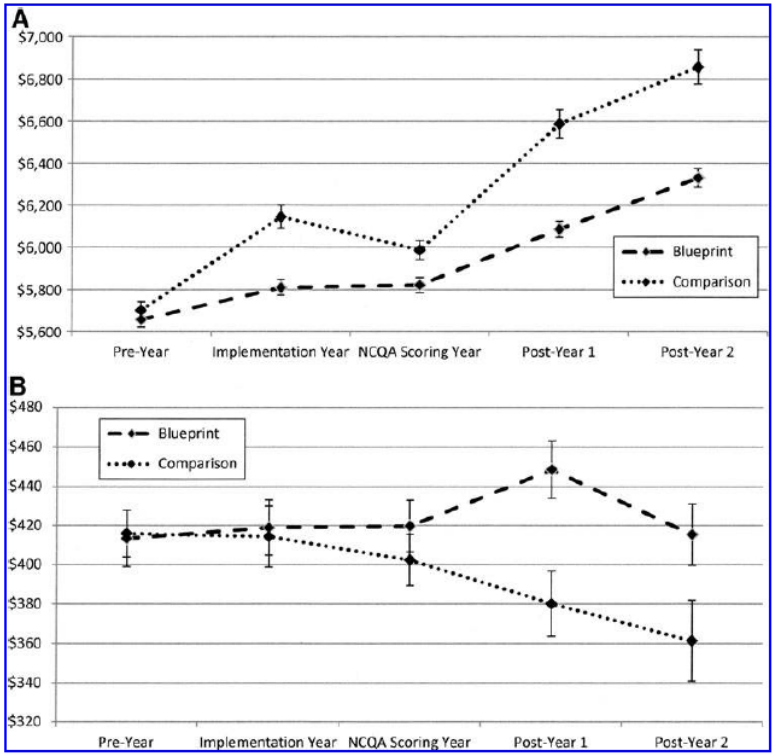
POPULATION HEALTH MANAGEMENT
Volume 0, Number 0, 2015
Mary Ann Liebert, Inc.
DOI: 10.1089/pop.2015.0055

Original Article

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, MS[1]



Journal of Substance Abuse Treatment 67 (2016) 9–14

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ELSEVIER

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

Mary Kate Mohlman, Ph.D. [a,*], Beth Tanzman, M.S.W. [a], Karl Finison, M.A. [b], Melanie Pinette, M.E.M. [b], Craig Jones, M.D. [a]

[a] Vermont Blueprint for Health, NOB 1 South, 280 State Drive, Waterbury, VT 05671, USA
[b] Onpoint Health Data, 254 Commercial Street, Suite 257, Portland, ME 04101, USA

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	<0.01
Buprenorphine expenditures	$2708	−$47	$2755	<0.01
Total prescription expenditures	$4461	$2166	$2295	<0.01
Inpatient expenditures	$2132	$3757	−$1625	<0.01
Outpatient expenditures	$345	$604	−$259	<0.01
Professional expenditures	$674	$981	−$307	<0.01
SMS expenditures[*]	$2872	$4160	−$1288	<0.01
Utilization (rate/person)				
Inpatient days	1.54	3.00	−1.46	<0.01
Inpatient discharges	0.30	0.52	−0.22	<0.01
ED visits	1.44	2.48	−1.04	<0.01
Primary care physician visits	15.27	9.81	5.46	<0.01
Advanced imaging	0.29	0.54	−0.25	<0.01
Standard imaging	0.76	1.43	−0.67	<0.01
Colonoscopy	0.01	0.02	−0.01	<0.01
Echography	0.46	0.53	−0.07	0.002
Medical specialist visits	0.49	0.82	−0.33	<0.01
Surgical specialist visits	3.04	1.89	1.15	<0.01

[*] 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