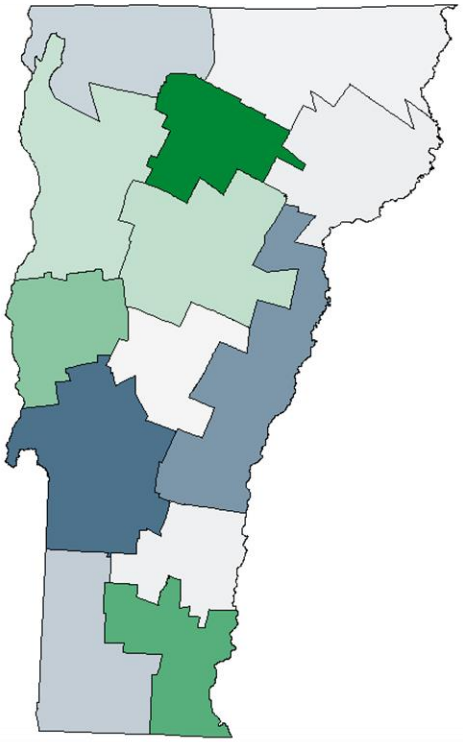

Green Mountain Care Board

Measurement of Primary Care Spend - Background

April 3, 2019

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Today's Agenda

1. Background and purpose of GMCB work thus far
2. Overview of GMCB definition
3. Total Cost of Care data
4. Considerations

Vermont's Work to Advance Primary Care Investments

Blueprint for Health (PCMH)

- Multi-payer patient-centered medical home (PCMH) program launched in 2008
- Nearly every primary care practice in the state participates
- PMPM payments to advanced primary care practices (NCQA recognition required), with incentive payments based on community-wide quality performance
- Multi-payer regional community health teams support primary care practices across the state

All-Payer ACO Model

Access to primary care is a foundational goal embedded in the All-Payer Model Agreement between the State of Vermont and CMMI

- ACO investments are primary care centered (18 V.S.A. § 9551):
  - PMPMs (Basic/PCMH, Complex Care Coordination, Independent Primary Care)
  - Value-Based Incentive Fund (VBIF) 70% of earnings returned to attributing primary care providers, 30% to specialists within the network
- 2019 will serve as a test year for evaluating primary care spending within the ACO

GMCB Work to Date

February 2018: GMCB staff met weekly to discuss scope of the provider taxonomy and codes to use in defining primary care spending.

March 2018: Rachel Block of Milbank Memorial Fund presented to the Board and the Primary Care Advisory Group (PCAG); GMCB's draft measure was vetted with the Board and the PCAG.

April 2018: GMCB analytics staff tested the measure.

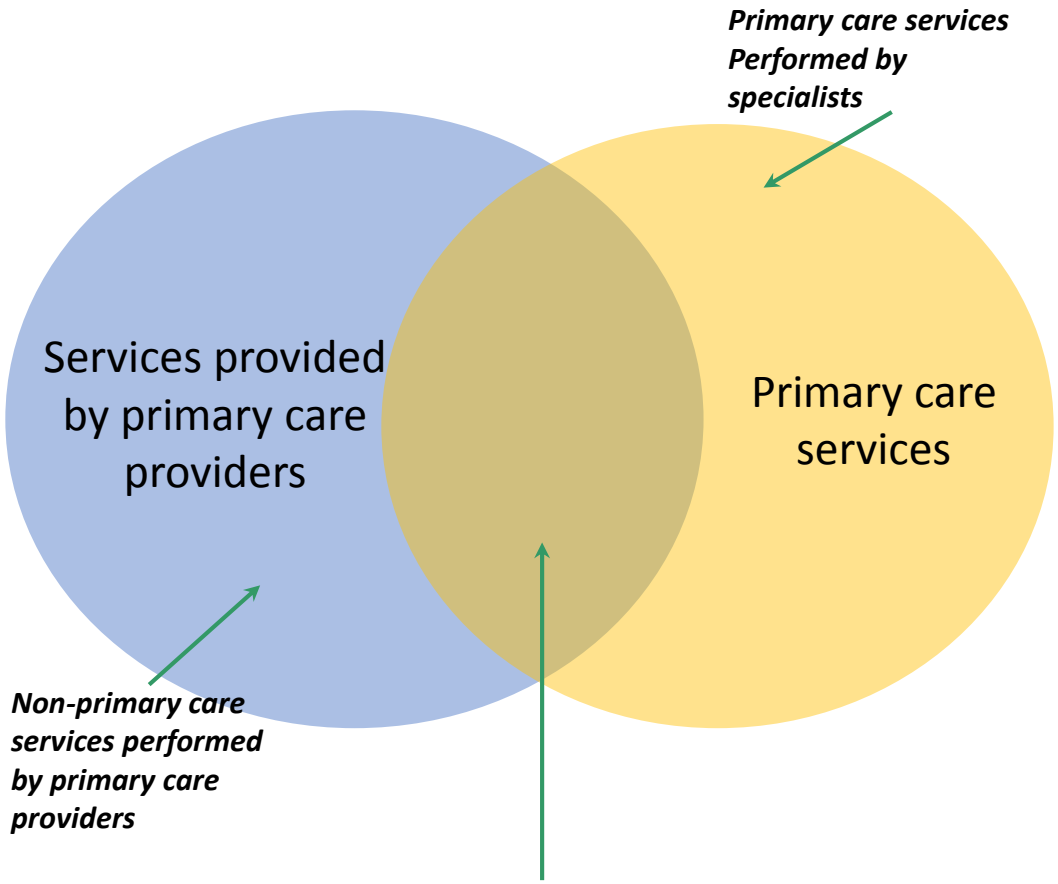
May 2018: Measure vetted with OneCare for inclusion in the 2019 ACO Budget Guidance.

October 2018: OneCare submitted their first run of the measure with their budget guidance (currently being validated by our analytics team and analytics vendor).

January 2019: Measure was used for the 2017 Total Cost of Care (TCOC) baseline and will continue to be used for this purpose by the analytics vendor for the APM TCOC reporting.

Components of Primary Care Spending

Claims-Based Payments



The sum of spending for selected CPT codes and non claims-based payments to primary care providers becomes the "numerator" in the spending calculation.

Non Claims-Based Payments

- Capitation payments
- Risk-based payments (AIPBP)
- Primary care medical home or patient centered medical home recognition
- Achievement of quality/cost-savings goals
- Develop capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Support providers adopt health information technology, such as electronic health records
- Additional staff such as practice coaches, patient educators, patient navigators or nurse care managers

Primary Care Definition

The GMCB used the following in the development of our primary care spend measure:

- AOA - Universal Primary Care
- SIM - GMCB Stakeholder Group
- DVHA
- Rhode Island
- Oregon
- Milbank Memorial Fund report
- OneCare Vermont – annual budget submission

Provider Taxonomies Included

Family Practice
Internal Medicine with no subspecialty
Internal Medicine with subspecialty of Geriatrics
Pediatrics with no subspecialty
General practice
Nurse Practitioner
Physician Assistant
Naturopath
Osteopath
Ob/GYN

Claims-Based Spending: CPT Code Categories Included

Office Visits

Encounter Payments (FQHC)

Preventive Visits

Vaccine Administration (not actual vaccine costs)

Care Management

Chronic Care Management

Ob/GYN

Nursing Facility

Home Services

Domiciliary/Rest Home/Custodial Care

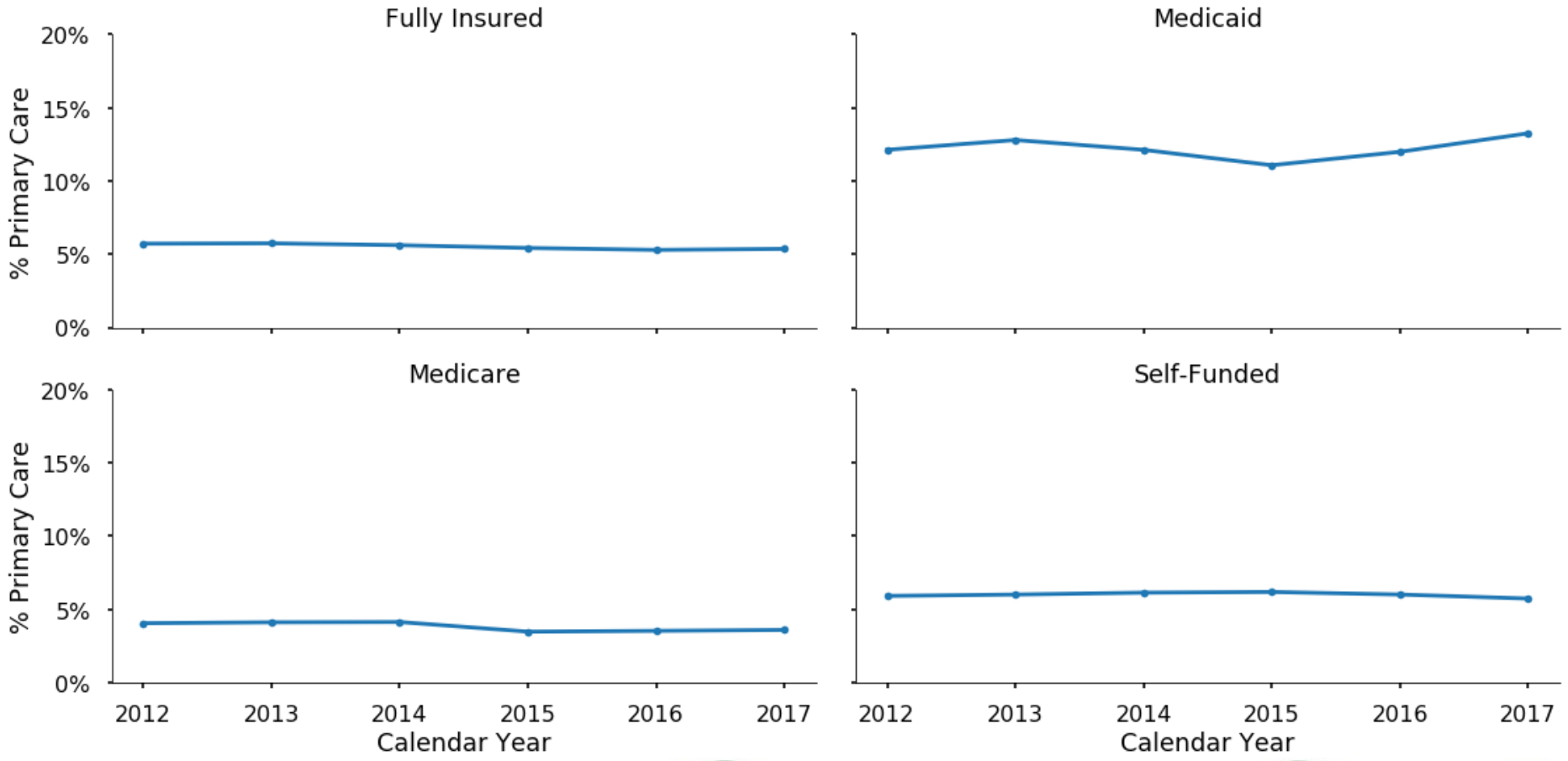
Prolonged Services

Non-Claims Spending: Challenges

- Many payment reform initiatives pay based on the episode, which means intentionally taking the provider and procedures performed out of the equation (e.g. bundled payments for maternity, DRG-based payments).

- Without a measure of total healthcare-related investments, it's difficult to put primary care spending like the Blueprint for Health in context.

Claims-Based Primary Care Spending
All-Payer Model Total Cost of Care (TCOC)



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Claims-Based Primary Care Spending All-Payer Model Total Cost of Care (TCOC)

Primary Care All-Payer Total Cost of Care Expenditures

	2012	2013	2014	2015	2016	2017
Medicaid	$38,599,922	$44,613,922	$47,280,169	$46,762,835	$50,665,697	$47,997,355
	12%	*13%*	*12%*	*11%*	*12%*	*13%*
Fully Insured	$38,295,640	$40,892,783	$38,879,910	$38,313,526	$34,595,080	$36,332,483
	6%	*6%*	*6%*	*5%*	*5%*	*5%*
Self-Funded	$24,535,380	$29,009,575	$33,772,187	$35,416,282	$20,103,138	$19,081,697
	6%	*6%*	*6%*	*6%*	*6%*	*6%*
Medicare	$38,178,978	$40,708,675	$43,731,698	$39,754,248	$42,906,562	$45,788,197
	4%	*4%*	*4%*	*3%*	*4%*	*4%*
TOTAL	**$139,609,919**	**$155,224,955**	**$163,663,963**	**$160,246,891**	**$148,270,479**	**$149,199,733**
	6%	***6%***	***6%***	***6%***	***6%***	***6%***

Considerations

- Estimating the total spending per person associated with residential populations may provide a more comprehensive and appropriate lens for evaluating health care system spending, especially for value-based payment mechanisms.

- In addition to per person spending, utilization may be monitored as one potential factor, which would speak to the proportion of primary care services delivered.

Questions?