**Vermont Medicaid Primary Care Reimbursement Primer**

**March 1, 2019**

The following primer summarizes the Vermont Medicaid primary care network and focuses on investments in primary care payments between SFY 2012 and SFY 2018.

***Primary Care Provider Enrollment and Payment Summary***

In calendar year (CY) 2018, DVHA's network of primary care providers including 888 enrolled providers; 114 independent physician practices; 14 federally qualified health centers (FQHCs) with 69 practice locations, and 8 rural health centers (RHCs) with 22 practice locations. Table 1 summarizes the count of primary care providers enrolled in Vermont Medicaid in CY 2016 and CY 2018. These counts indicate a stable and moderately growing primary care network over the last three years.

**Table 1. Counts of Primary Care Providers Enrolled in Vermont Medicaid Network CY16 - CY18**

| | **2016** | **2018** |
|---|---|---|
| Primary Care Providers | 829 | 888 |
| Primary Care Practices | 116 | 114 |
| FQHC Practice Sites | 60 | 69 |
| RHC Practice Sites | 22 | 22 |

In this timeframe, the Department of Vermont Health Access (DVHA) provided a cumulative average annual increase of 9% in primary care payments support each year, translating into an 87% increase in per member per month (PMPM) payments for primary care system services among the population of beneficiaries with full Medicaid benefits and Medicaid as a primary payer. The increase is attributable both to growth in DVHA's fee for service (FFS) rates which underpin the delivery system as well as payments made in value-based, alternative payment models (APMs). Table 2 summarizes total change in PMPM payments between 2012 and 2018.

**Table 2. Primary Care Estimated PMPM Payments (2012 and 2018)**

| **Type** | **Payment Stream** | **Description Financing Stream** | **PMPM 2012** | **PMPM 2018** | **Cumulative Annual Growth Rate** | **% Δ** |
|---|---|---|---|---|---|---|
| Total | PCP Payments | FFS + APMs | $58.54 | $109.49 | 9% | 87% |

Participation in APMs is widespread and has grown substantially since their inception. Almost 94% of primary care providers are participating in Vermont's patient-centered medical home (PCMH) model known as the Blueprint for Health. A further 229 providers are also registered as "Spokes," which are health homes for opioid use disorder. Table 3 summarizes the number of enrolled PCMH and Spoke providers as of the last quarter of 2014, 2016 and 2018, showing steady growth over time.

**Table 3. Counts of Blueprint for Health Providers Enrolled in Vermont Medicaid Network CY16 - CY18**

| | 2014 | 2016 | 2018 |
|---|---|---|---|
| PCMH Providers | 660 | 786 | 830 |
| Spoke Providers | 133 | 180 | 229 |

An overview and brief description of the models and payments used by DVHA to support primary care are summarized in Table 4. An illustration of the key elements of primary care support is provided in Figure 4 on the last page of this summary.

**Table 4. Primary Care Estimated PMPM Payments (2012 and 2018)**

| Type | Payment Stream | Description Financing Stream | PMPM 2012 | PMPM 2018 | Cumulative Annual Growth Rate | % Δ |
|---|---|---|---|---|---|---|
| Total | PC Payments | All described below | $58.54 | $109.49 | 9% | 87% |
| FFS | Primary Care Physician (PCP) Payments | Made directly to physician and other health professionals based on a Physician Fee Schedule; there is an enhanced rate paid to primary care providers equal to Medicare's rates, with a six month lag. | $30.37 | $43.26 | 5% | 42% |
| FFS | Federally Qualified Health Center (FQHC) Payments | Made to centers based on a floor of a federally legislative formula, with alternative option. | $16.00 | $33.75 | 11% | 111% |
| FFS | Rural Health Center (RHC) Payments | Made to centers based on a floor of a federally legislative formula, with alternative option. | $4.47 | $7.85 | 8% | 76% |
| FFS | Primary Care Case Management Fee (PCCM) | Made to providers; precursor to PCMH model and being phased out and reinvested in other models as of 2019 | $5.78 | $3.13 | -8% | -46% |
| P4P/ PCMH | Primary Care Performance | Made to director to providers based on performance and meeting PCMH requirements. | $0.96 | $4.55 | 25% | 375% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Incentive Payments | | | | | |
| PCMH /HH | CHT Payments | Regionally distributed payments to hire and administer community health team (CHT) staff including Opioid Use Disorder (OUD) staff. | $0.97 | $12.24 | 44% | 1165 % |
| PCMH /HH | Women's Health Payments | Made directly to providers to support patient-centered medical home activities and connectivity to primary care CHT staffing among women's health providers. | | | | |
| ACO | ACO Payments: | Made to ACO to support providers engaging in the Advanced Community Care Coordination model. | N/A | $4.72 | N/A | N/A |

FFS=Fee for Service; P4P=Pay for Performance; PCMH=Patient centered medical home; HH=Health Home; ACO=Accountable Care Organization.

The denominator for calculations in Table 4 is the total estimated member months for fully enrolled Medicaid beneficiaries in each year. Dual eligible beneficiaries, those with limited benefit packages, and claims paid by other payers are excluded from these calculations.

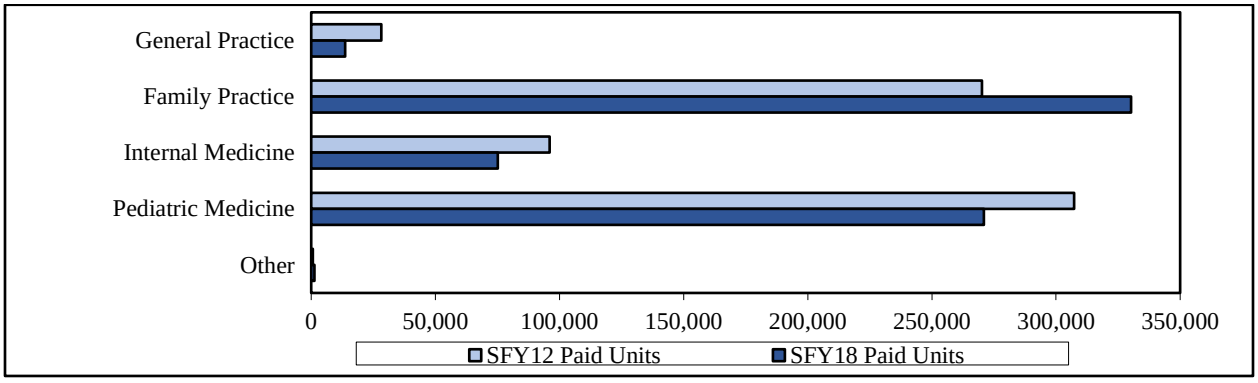
The primary care case management fee (PCCM) is being phased out and reinvested into other primary care payments.[1] The negative trend across years for this payment stream is therefore offset by increases in other areas.

### *Fee for Service Payments to Primary Care Physicians*

The volume of primary care services is largely unchanged over the SFY 2012 – SFY 2018 time period. PMPM payments, however, rose at an annual cumulative growth rate of 5%. See Figure 1 for a breakdown of unit volume and payments in SFY 2012 compared to SFY 2018 by primary physician specialty.

[1] http://dvha.vermont.gov/global-commitment-to-health/final-gcr-18-079-reduction-of-pccm.pdf
http://dvha.vermont.gov/global-commitment-to-health/2proposed-gcr-18-078-elimination-of-pccm.pdf
http://dvha.vermont.gov/global-commitment-to-health/proposed-gcr-18-090-pcmh-base-rate-increase.pdf

**Figure 1. Primary Care Physician (PCP) Units and Payments in State Fiscal Years 2012 and 2018**

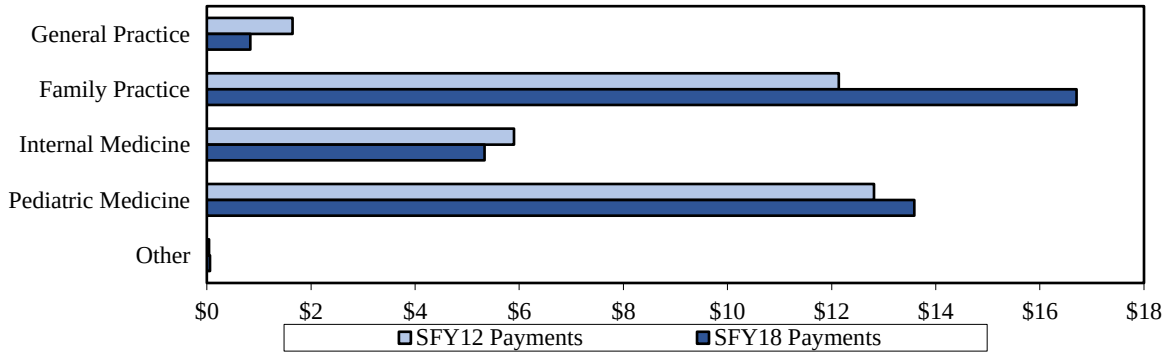



| | SFY12 Paid Units | SFY18 Paid Units |
|---|---|---|
| General Practice | 28,196 | 13,659 |
| Family Practice | 270,137 | 330,219 |
| Internal Medicine | 96,069 | 75,096 |
| Pediatric Medicine | 307,243 | 270,955 |
| Other | 638 | 1,321 |

**Total Paid Units:**

In SFY12: 702,283

In SFY18: 691,250




| | SFY12 Payments | SFY18 Payments |
|---|---|---|
| | (in millions) | |
| General Practice | $1.65 | $0.83 |
| Family Practice | $12.14 | $16.70 |
| Internal Medicine | $5.90 | $5.33 |
| Pediatric Medicine | $12.82 | $13.59 |
| Other | $0.04 | $0.06 |

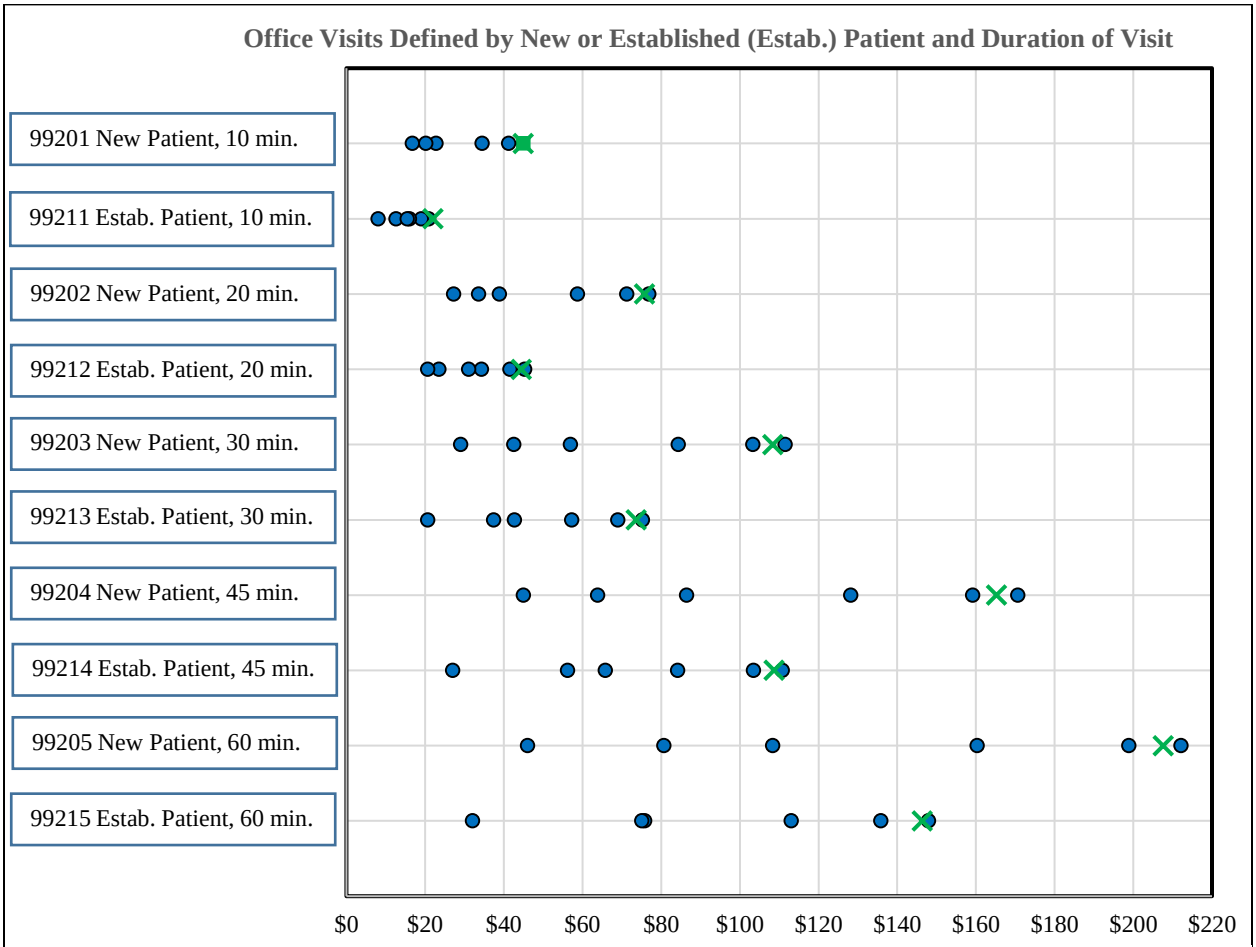
**Total Payments:**

In SFY12: $32,545,367

In SFY18: $36,518,719

In 2013 and 2014 the federal government provided an enhanced match to Medicaid in order to pay primary care providers up to Medicare fee for service rates; this program sunset at the end of 2014. Vermont (VT) was unable to maintain the rate initially, but incrementally increased the rates to be equivalent to Medicare's rates again by August 2017. Connecticut (CT) and Maine (ME) continued to reimburse providers at rates equivalent to Medicare throughout. Other northeastern states decreased primary care rates as the federal program ended. At this time, Massachusetts (MA), New Hampshire (NH), New York (NY) and Rhode Island (RI) all have rates ranging from 77% - 33% of Vermont's (and Medicare's) rates for primary care services. A comparison of New England Medicaid rates for the most common evaluation and management (E&M) primary care services are summarized in Figure 2. As of February 2019, Vermont, Connecticut, and Maine are paying the Medicare rate but there are marginal differences due to the benchmark Medicare uses and geographic practice cost indexes (GPCI).

**Figure 2. Comparison of Rates Paid by New England Medicaid States for the Most Common Evaluation and Management (E&M) Services**

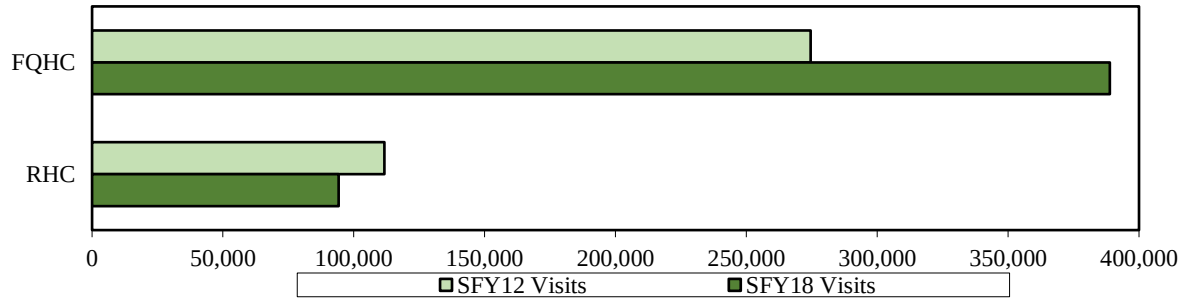



Circles represent the rate paid for the type of visit by each of the State Medicaid Agencies in New England. The data shown is from Vermont, Connecticut, Maine, Massachusetts, New York, New Hampshire and Rhode Island. The Vermont rate is shown with the X on each row.

### *Fee for Service Payments to FQHCs and RHCs*

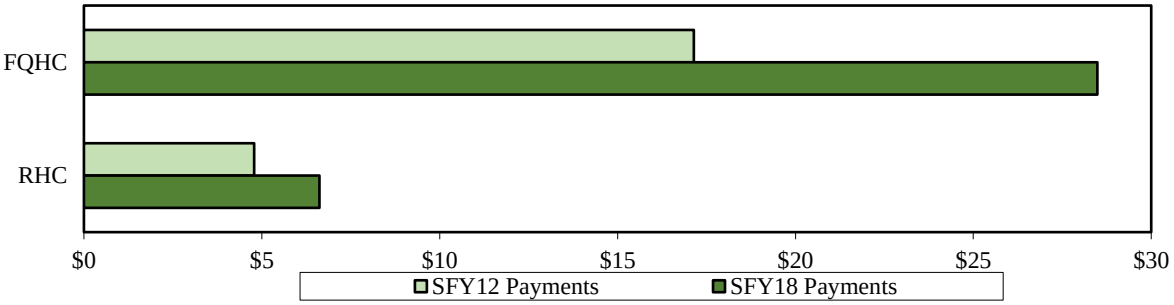
Primary care volume at FQHCs increased substantially in this time period; RHC volume was stable during the same period. Given the federally prescribed methodology for paying FQHCs and RHCs, DVHA is obligated to increase payments, at minimum, by the Medicare Economic Index (MEI) and to reflect changes in the scope of services provided by individual facilities over time. Notably starting on 1/1/2018, an additional $2.4 million dollars were allocated to enhance existing FQHC and RHC rates resulting in the PMPM increases observed in Table 4. See Figure 3 for a breakdown of unit volume and payments in SFY 2012 compared to SFY 2018 for FQHCs and RHCs.

**Figure 3. FQHC and RHC Visits and Payments in State Fiscal Years 2012 and 2018**




| | SFY12 Visits | SFY18 Visits |
|---|---|---|
| FQHC | 274,548 | 388,802 |
| RHC | 111,646 | 94,170 |

**Total Visits:**
In SFY12: 386,194
In SFY18: 482,972




| | SFY12 Payments | SFY18 Payments |
|---|---|---|
| | (in millions) | |
| FQHC | $17.14 | $28.49 |
| RHC | $4.79 | $6.62 |

**Total Payments:**
In SFY12: $21,929,780
In SFY18: $35,110,267

### *Alternative Payment Model: Blueprint for Health*

The Blueprint for Health[2] started in 2008 and has grown to include more providers and initiatives over time. Through the Blueprint model, providers agreeing to meet requirements of a PCMH as defined by The National Care Quality Alliance (NCQA) are eligible to receive a pay for performance (P4P) incentive payment as well as support of regionally organized community health teams. Hub and Spoke, a health home model for opioid addicted individuals, commenced a few years later and provides support in the form of specialized community health team staff. Most recently, the Women's Health Initiative was added to support participating providers implementing targeted PCMH activities. Spending associated with these activities is summarized in Table 5.

**Table 5. Blueprint for Health APM Activities (2012 – 2018)**

| Blueprint for Health APM | CY12 $ | CY13 $ | CY14 $ | CY15 $ | CY16 $ | CY17 $ | CY18 $ |
|---|---|---|---|---|---|---|---|
| Pay for Performance | $1,026,708 | $1,516,915 | $2,001,715 | $2,402,398 | $3,841,139 | $3,762,174 | $3,840,430 |
| Community Health Teams | $1,036,485 | $2,394,347 | $5,575,515 | $6,281,462 | $8,360,384 | $9,554,333 | $10,134,362 |
| Women's Health Initiative | N/A | N/A | N/A | N/A | N/A | $ 200,367 | $ 196,569 |
| **Total** | **$2,063,193** | **$3,911,262** | **$7,577,230** | **$8,683,861** | **$12,201,522** | **$13,516,874** | **$14,171,361** |

### *Alternative Payment Model: Accountable Care Organization (ACO)*

The Vermont Medicaid Next Generation (VMNG) ACO program is an advanced APM modeled after the Medicare Next Generation ACO program. It is considered an advanced APM because providers take accountability for the cost and quality of a defined population and achieve those performance targets by implementing provider-led, primary care-centered, innovative care strategies like population health management. The model is organized around Medicaid members' relationships with their primary care providers, and additional resources are available to participating providers through DVHA's contract with OneCare Vermont.

Although the ACO program does not specifically change how primary care services are reimbursed, funds have been included in the ACO contract to support both primary care providers and other providers across the care continuum to work together to coordinate care for attributed Medicaid members, as summarized in Table 6. These funds have been distributed to

[2] https://blueprintforhealth.vermont.gov/sites/bfh/files/Vermont-Blueprint-for-Health-Annual-Report-2017.pdf
http://blueprintforhealth.vermont.gov/sites/bfh/files/Methods-Document.pdf

providers by the ACO in the following types of Advanced Community Care Coordination payments:

- Level 1 - Community Capacity Payment: Annual payment of up to $25,000 to the organization holding the Blueprint for Health HSA contract in each community for project management support including community-specific workflows; workforce readiness and capacity development; and analysis of community care coordination metrics, gap analysis, and remediation planning.
- Level 2 - Team Based Complex Care Coordination Payment: A per-member-per-month (PMPM) payment of up to $15 to primary care and continuum of care organizations (i.e. area agency on aging, designated mental health and substance abuse agencies, and home health) for active participation in team-based care planning for patients identified in the top 16% (i.e. high and very high risk) based on prospective risk stratification. Primary activities include active participation on an interdisciplinary care team; contributing to person-centered shared care plans; and participating in care team meetings, care conferences and transitional care planning.
- Level 3 - Patient Activation & Lead Care Coordination Payment: A one-time annual payment of up to $150 to the organization of the patient's identified lead care coordinator plus an additional PMPM payment of up to $10 to that organization for ongoing facilitation and support. Primary activities in addition to the team-based care coordination payment include activating and engaging patients in care coordination, leading the development of the person-centered shared care plan and documentation in Care Navigator, coordination and communication among care team members, planning and facilitating care conferences, and tracking care plan goals and milestones.

In addition to the Advanced Community Care Coordination payments funded through the VMNG ACO contract, OneCare Vermont also offers a Population Health Management payment of $3.25 per member per month to independent primary care practices that are voluntarily participating in the Comprehensive Payment Reform pilot. These dollars are not Medicaid-specific, and therefore are not included in the calculations in Table 6. The number of independent primary care practices participating in this ACO pilot has increased from three in 2018 to nine in 2019.

**Table 6. APM Activities (2012 – 2018)**

| ACO APM | CY12 $ | CY13 $ | CY14 $ | CY15 $ | CY16 $ | CY17 $ | CY18 $ |
|---|---|---|---|---|---|---|---|
| ACO | N/A | N/A | N/A | N/A | N/A | $1,307,983 | $3,981,108 |
| **Total** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **$1,307,983** | **$3,981,108** |

**Figure 4. Illustration of DVHA Primary Care Payment and Delivery Models 2012 and 2018**