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Combined Meeting of The Blueprint Executive Committee and Blueprint Expansion, Design and Evaluation Committee

January 20, 2016

Attendees: F. Asava; J. Batra; D. Epstein; P. Farnham; K. Fitzgerald; J. Franz; C. Fulton; M. Hazard; L. Hendry; P. Jackson; C. Jones; K. Lange; J. Le; T. Mable; L. McLaren; M. Mohlman; A. Ramsay; J. Samuelson

By phone: P. Biron; W. Cornwell; E. Emard; J. Fels; T. Hanbridge; K. Hein; P. Jones; J. Krulewitz; E. McKenna; S. Narkewicz; L. Ruggles; J. Wallace; M. Young

The meeting opened at 8:30 a.m.

I. Opening Remarks and Context: Craig Jones, MD.

- Today's agenda and PowerPoint slide deck were distributed prior to this meeting.
- The Annual Report has a lot of information and details that tell the story and set the stage for what we hope to talk about this morning about the future of the Blueprint. C. Jones encouraged committee members to look at the report once it has been submitted to the Legislature. C. Jones thanked the team on gathering the information and the members of the field team for their input on their health service areas.

II. Program Updates

- 2008-2014 Evaluation
  - Slide #6, *Total Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and Older*, is a new slide that now includes data for Post Year 3. C. Jones stated we are continuing to see different rates of growth. The data does include Medicaid special services and shows we may be at a plateau.
  - A. Ramsey questioned if there was a way to rank those. We need to answer the question of how do we care for people with diabetes or heart conditions. C. Jones responded it is a very extensive piece of work and we are taking it on. We can make simple statements, but cannot really determine what is driving it.

- Slide #7, *Total SMS Expenditures Per Capita 2008 – 2014 Medicaid Ages 1 and Older*, shows an interesting trend and will need to be examined further. C. Jones stated this signals how health care trends are changing one way or another.
- Slide #9, *Emergency Department Visits Per 1000 Members 2008- 2014 All Insurers Ages 1 and Older*, remains constant. A. Ramsey believes it is an access issue. A. Ramsey stated the question to ask practices are do they designate open slots for new patients. The common response will be no, they are not able to keep slots open. Those open slots are always going to be filled ahead of time for financial purposes, given the current fee-for-service payment model. Providers lose money if they keep slots open.
- L. McLaren questioned if the graph on Slide #9 could be broken out by Commercial, Medicare, and Medicaid. M. Mohlman responded yes, and C. Jones stated we do have a graph.
- C. Jones stated urgent care will be captured in the next set.
- C. Jones discussed Slide #10, *MAPCP Evaluation (Q14 Draft Report),* and mentioned the scale of magnitude that the CMS evaluation is seeing is very similar to the trend that we are seeing in Vermont. The Medicare Advantage model is not included in the demonstration.

- Community-Oriented Population Health

  - C. Jones stated Community Health teams and SASH are the bridge to linking primary care and interventions. There are real powerful opportunities in social support. We are working to strengthen that with the ACOs and social support services.
  - C. Jones mentioned the Blueprint's Annual Conference theme is around this, "Integrating Medical and Social Services", and encouraged committee members to attend. The Blueprint Annual Conference will take place on Tuesday, April 12, at the Sheraton Hotel in Burlington, VT. One of the speakers is Elizabeth Bradley, PhD, MBA, and C. Jones recommended the committee members read her book titled The *American Health Care Paradox: Why Spending More Is Getting Us Less*.
  - K. Hein mentioned a SIM grant with a deadline of Feb. 5. The grant is based on Accountable Health Communities. C. Jones took this opportunity to also mention another initiative through CMS. CMS has released a new grant for Accountable Health Communities looking for bridge organizations that help create the linkage between medical and social supports in communities.

- Payment Modifications

  - C. Jones reminded the committee members that payment modifications started on Jan. 1, 2016. The base medical home payment has gone up and is based on achieving NCQA recognition. A lot of work went into this new model, and C. Jones thanked Mary Kate Mohlman and the ACOs who worked on it.
  - A. Ramsey questioned how the payments are allocated or paid out. C. Jones responded they are paid out in quarterly payments and depend on the insurers at which point they pay.

III. Planning for the Future (Discussion)

- C. Jones started the conversation about positioning and roles and responsibilities of the Blueprint central office staff in 2017 and solicited input from the committee members. This conversation will continue over the next few months. C. Jones presented Slide #19, *Current State of Play*, and mentioned there is a lot of uncertainty, but a lot of progress. We will need to start organizing the possibilities.
- Common feedback/input from the committee members include:

    - Blueprint is neutral and does not represent anyone. Committee members would like to keep it that way.
    - Blueprint could continue almost as is and play the bridge role with the ACO(s).
    - Blueprint adds the perspective of population health and community services, where ACO data is more focused on targeted high-risk, high-cost populations and medical interventions.
    - Blueprint is a big supplement in making the ACO(s) successful.
    - Blueprint needs to maintain some independence from the ACOs.
    - Blueprint is the innovative think tank entity and also mplements the good ideas.
    - Where can the Blueprint have the most influence of centricity of model? (Moving from a hospital-centric to a primary-care-centric focus.)

With no further time, the meeting adjourned at 10:00 am.

Executive Committee
Planning & Evaluation Committee

January 20, 2016

Agenda

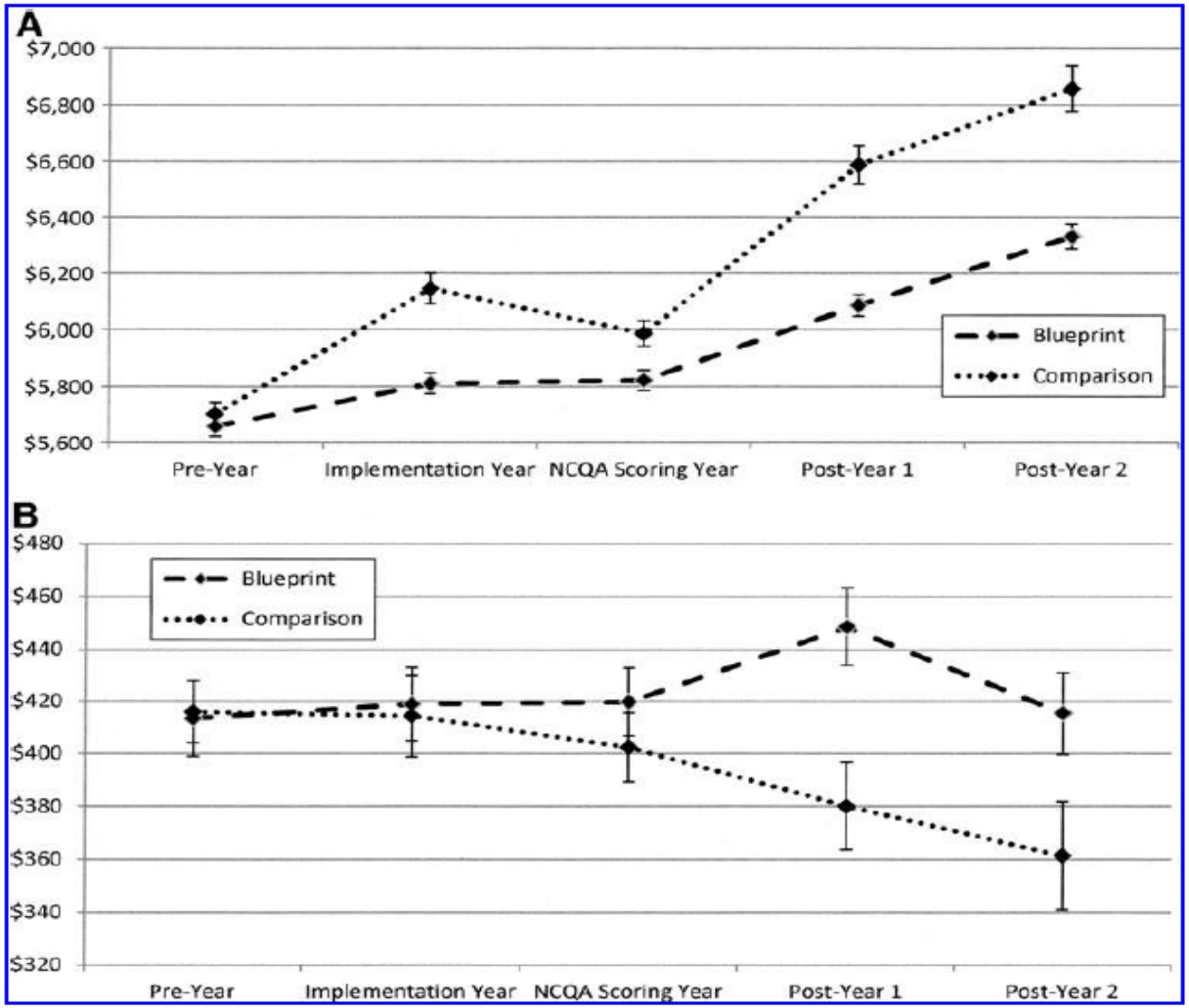
- Program Updates
  - 2008 – 2014 Evaluation
  - Community Oriented Population Health
  - Payment Modifications
- Discussion – Planning for the Future

Health Services Network

Key Components	June, 2015
PCMHs (active PCMHs)	127
PCPs (unique providers)	698
Patients (Onpoint attribution) (Avg. 2014)	334,898
CHT Staff (core)	212 (132 FTEs)
SASH Staff (extenders)	~60 FTEs (54 panels)
Spoke Staff (extenders)	67 (42 FTEs)

2008 – 2014 Program Evaluation

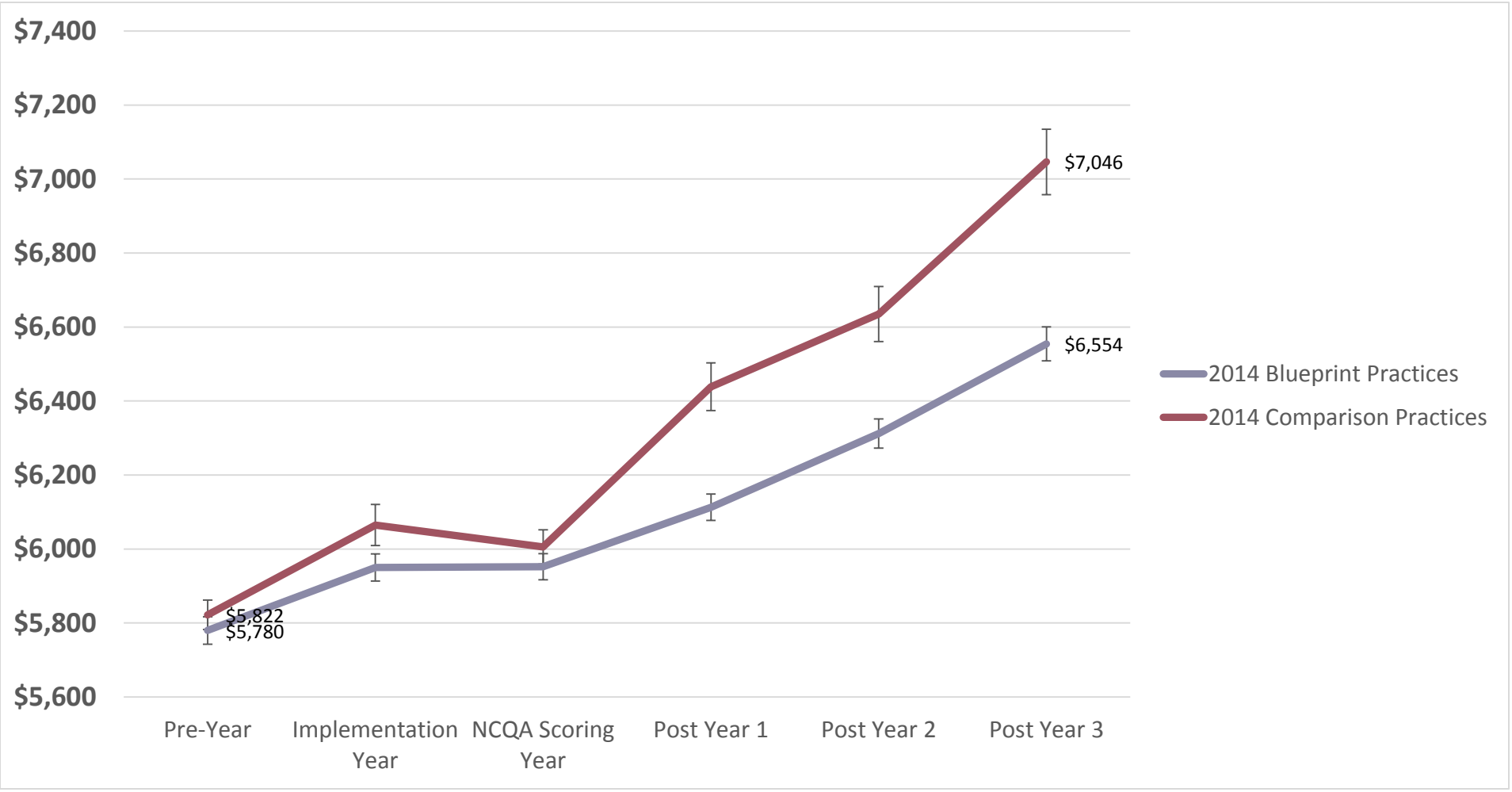
Figure 2. Expenditures Per Person



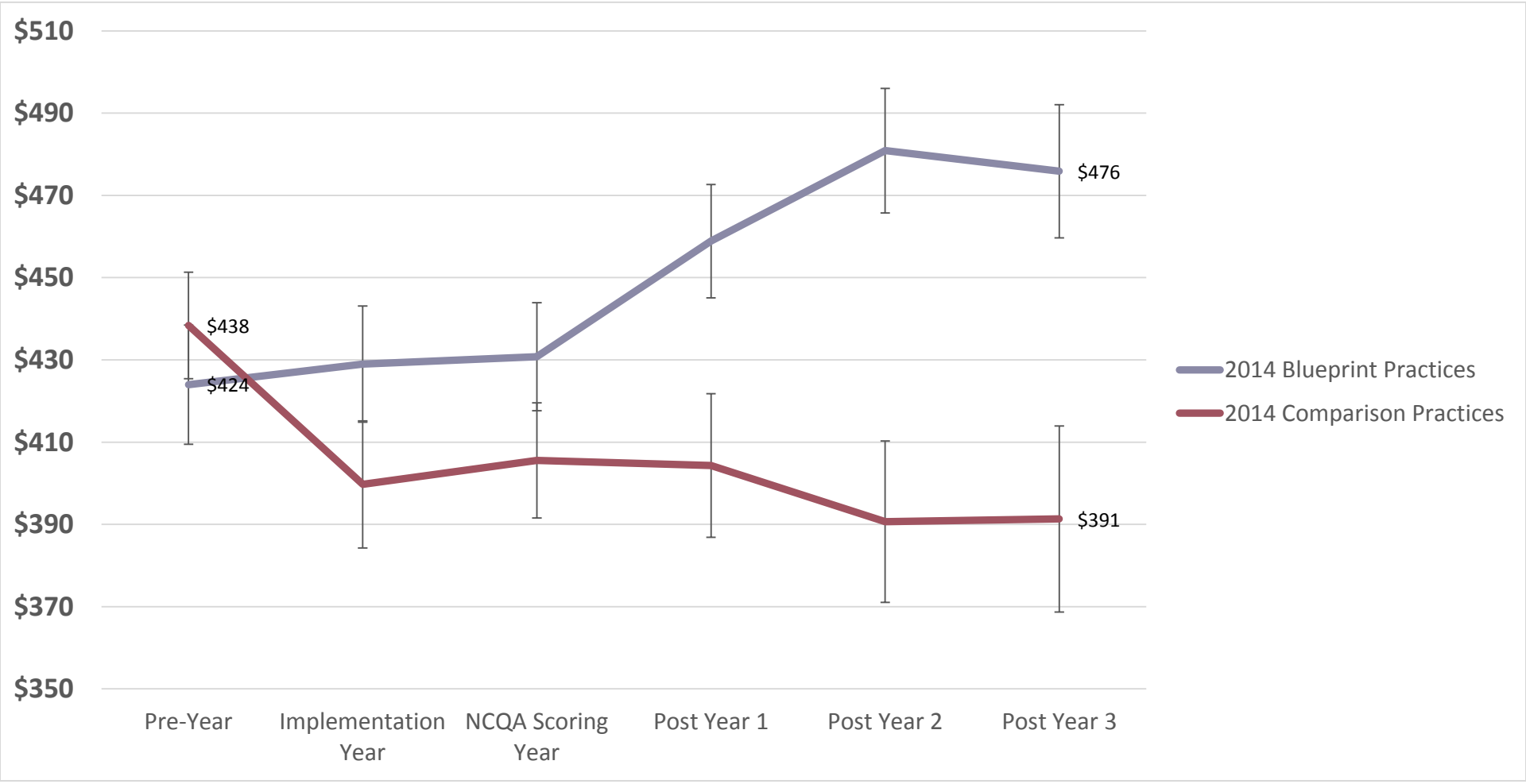
Expenditures on healthcare for the whole population

Medicaid expenditures on special services

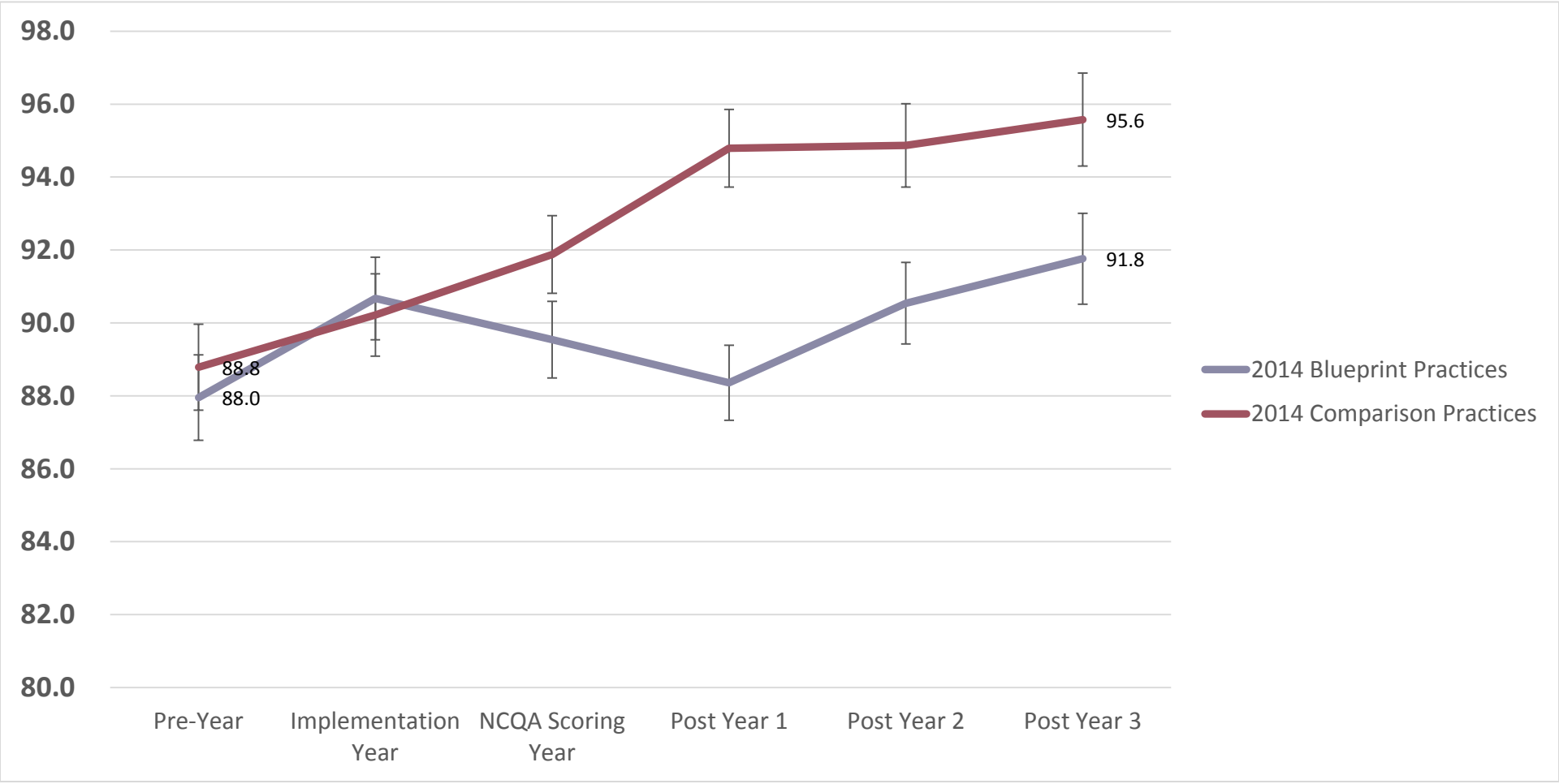
Total Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and older



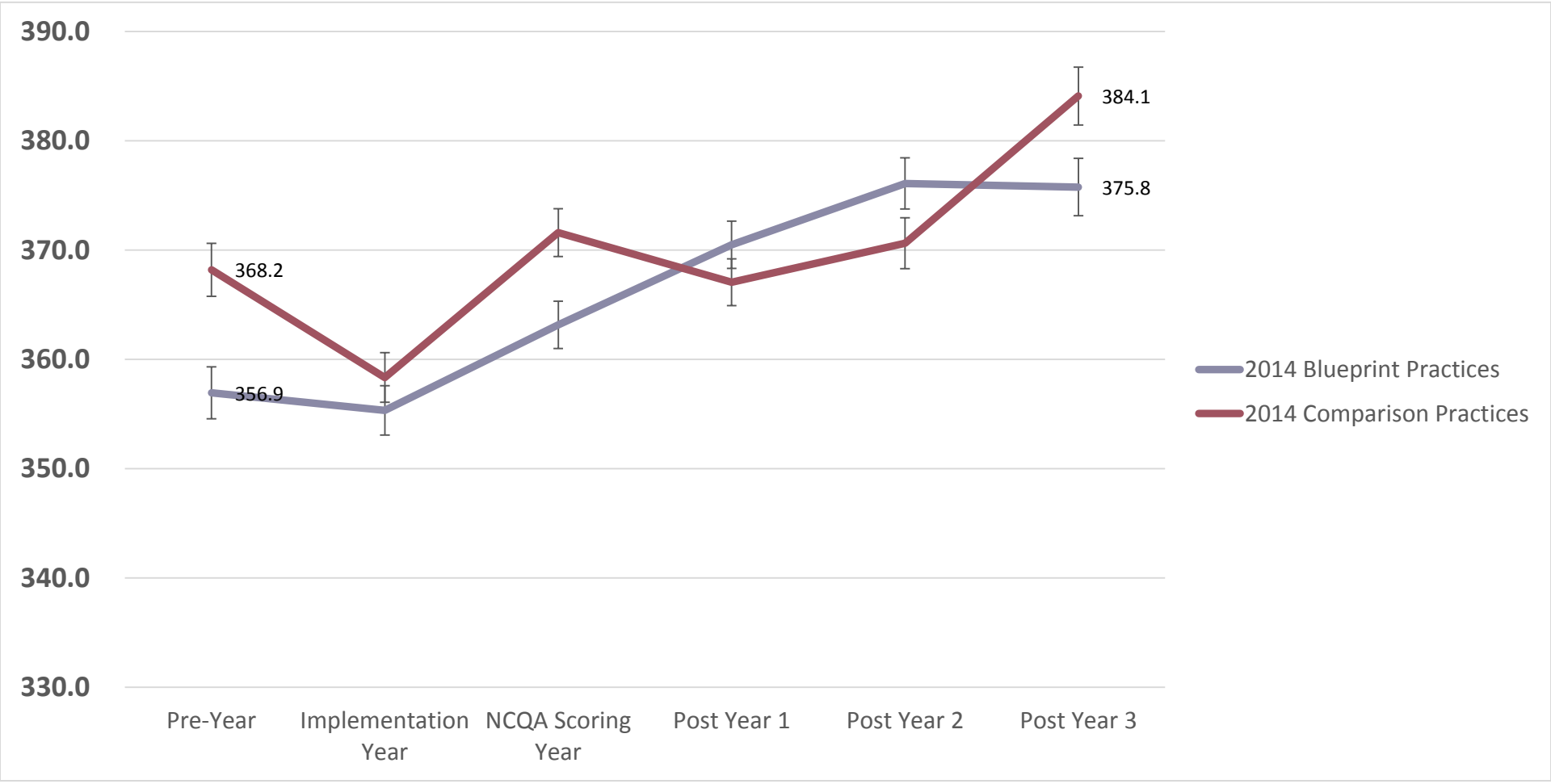
Total SMS Expenditures Per Capita 2008 – 2014 Medicaid Ages 1 and older



Inpatient Discharges Per 1000 Members 2008 – 2014 All Insurers Ages 1 and older



Emergency Department Visits Per 1000 Members 2008 – 2014 All Insurers Ages 1 and older



MAPCP Evaluation (Q14 draft report)

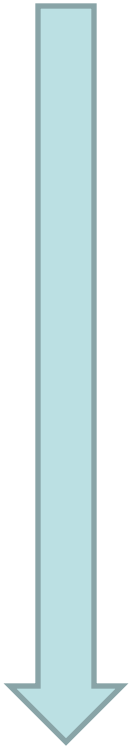
- Intervention Group – In-state
  - 110 NCQA-recognized PCMH practices in state
- Comparison Group – Out of State
  - Areas included:
    - 10 counties in NH
    - All FQHCs in Massachusetts
    - Additional FQHCs, RHCs or CAHs in Michigan and Maine
  - 33 comparison PCMH and 165 comparison non-PCMH
- Lower PPPM Expenditures (-$48.37, -$34.20)
- Cumulative Savings (-$110,027,050, -$77,807,696)

Community Oriented Population Health

Community Collaborative

- Integration of ACO and Blueprint workgroups & support network
- Leadership team including medical & community providers
- Focus on improving coordination, quality, core ACO measures
- Guide community health team operations
- Progress in all 14 service areas

Evolution of Community Collaboratives



Activities	Structure
Information sharing & learning within separate initiatives	BP workgroups, ACO workgroups
Information sharing & learning across organizations & programs	Integrated service area collaborative
Consensus based planning of coordination & quality initiatives. Initiatives supported by PMs, PFs, CHT leads, and ACO quality leads	Integrated service area collaborative, workgroups
Strategic initiatives to meet accountable health system and population health priorities. Initiatives supported by PMs, PFs, CHT leads, and ACO quality leads	Integrated service area collaborative, workgroups, leadership team

Payment Modifications

Payment Modifications

- Increase medical home payments (range from $3.00 to $3.50 pppm)
- All eligible practices receive $3.00 pppm base payment
- Practices earn up to $0.50 pppm based on 2 performance payments
  - 1 payment tied to service area performance on core measures
  - 1 payment tied to practice performance on utilization index
- Each insurers portion of CHT costs based on market share

Impact of New Medical Home Payment Model (Annualized)

Payer	Previous Annualized PCMH Costs (Pre- July 1, 2015)	Payer-Reported Attributed PCMH Patients*	Market Share of Attributed PCMH Patients	Increased Annualized PCMH Costs ($3.21 PPPM Avg.)	Increased Annualized Cost Difference	Percent Change From Previous Costs
BCBSVT	$2,721,019.40	107,819	36.30%	$4,153,187.88	$1,432,168.48	52.63%
Cigna	$34,305.60	1,404	0.47%	$54,082.08	$19,776.48	57.65%
Medicaid	$2,625,359.48	109,496	36.86%	$4,217,785.92	$1,592,426.44	60.66%
Medicare	$1,655,788.56	68,448	23.04%	$1,655,788.56	$0.00	0.00%
MVP	$273,290.04	9,866	3.32%	$380,038.32	$106,748.28	39.06%
Total	$7,309,763.08	297,033	100.00%	$10,460,882.76	$3,151,119.68	43.11%

*Estimates are based on insurer-reported PCMH-attributed patients in 2015-Q2.

Impact of Market Based CHT Payments (Annualized)

Payer	Share of CHT Costs (Pre-July 1, 2015)	Previous Annualized CHT Costs (Pre- July 1, 2015)	Payer-Reported Attributed CHT Patients*	Market Share of Attributed Patients	Market-Share Annualized CHT Costs	Market-Share Annualized Cost Difference	Percent Change From Previous Costs
BCBSVT	24.22%	$2,302,103.76	107,819	36.78%	$3,583,903.56	$1,281,799.80	55.68%
Cigna	13.66%	$1,298,378.92	1,404	0.48%	$46,668.96	-$1,251,709.96	-96.41%
Medicaid	24.22%	$2,302,103.76	109,496	37.35%	$3,639,647.04	$1,337,543.28	58.10%
Medicare	22.22%	$2,112,004.36	68,448	23.35%	$2,028,798.72	-$83,205.64	-3.94%
MVP	11.12%	$1,056,952.68	6,000	2.05%	$199,440.00	-$857,512.68	-81.13%
Total	95.44%	$9,071,543.48	293,167	100.00%	$9,498,458.28	$426,914.80	4.71%

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

Planning for the Future

Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Community Health Teams providing supportive services to population
- Team extenders supporting key populations (SASH, Hub & Spoke, VCCI)
- Maturing health information & data systems, comparative reporting
- Integration with ACOs & formal community collaborative structure
- Growing emphasis on coordination, accountability, & population health
- Planning underway for a single accountable health system

Planning for the Future

Program Assets

- 8 Team Members with skills and experience leading a complex statewide change process
- $4 million program budget
  - Systematized capitated payment process
  - Transformation network (PMs, PFs, CHT leaders)
  - Self-management network (HLWs, DPP, Tobacco, Pain)
  - Data systems (claims, clinical, provider, other sources)
  - Analytics, comparative measurement, modeling
  - Reporting (PCMH profiles, HSA profiles, Reports, Papers)
  - Learning health system activities

Planning for the Future

Priorities for Next Phase of Reforms

- The foundation continues to improve (primary care, community services)
- Next generation payment models (primary care, community services)
- Best use of the transformation network (PFs, PMs, CHT leaders)
- Self management programs strengthened (HLWs, DPP, Tobacco)
- The data utility continues to develop (quality, aggregation, linkage)
- The use of data continues to advance (learning, QI, predictive models)

Planning for the Future

Soliciting Input

- Focus of program
- Location of program
- Best use of Blueprint team & program assets
  - Maintain emphasis on primary care, community networks, ACOs
  - Shift to other health sectors
  - Health services science, health services transformation network, community organization, practice support, learning initiatives, data systems, analytics, reporting

Questions & Discussion