Blueprint Performance Payment Calculation Methodology

Quality Performance-Based Payments:

The quality performance-based payment will be based on hospital service area (HSA) outcomes for the following measures:

- Adolescent Well-Care Visits
- Developmental Screening in the First Three Years of Life
- Controlling High Blood Pressure
- Diabetes, Poor Control – HbA1c >9%

A total of three points for HSA outcomes will be available for each measure summing up to 12 points across all four measures. Points for each measure will be awarded for an HSA achieving an average result at or above thresholds in the current measurement period and for improvement from the previous measurement period to the current measurement period. Measurement periods occur every six months and include results from attributed patients in the 12 month look-back.

There are two thresholds: the minimum threshold, which is the statewide average or rate, and the high achiever, which is the 90th percentile of Vermont HSA results or 90th percentile for national results, whichever is available and higher. An HSA will get one point for being at or above the state average and will get 3 points for qualifying for as a high achiever. If the HSA is not in the High Achiever level, it is eligible for improvement points. Improvement point eligibility is also dependent on the sample size of the quality measure being greater than or equal to 30 in both the current performance period and the previous performance period. Improvement points are described in Table 1.

Table 1. Improvement Scores

If not High Achiever , the following change scores apply	Points
Worsening of percent or index score	0 points
Maintaining (or not achieving minimum improvement)	1 point
Improving at or above the minimum improvement	2 points

The minimum improvement is 5 percentage points, meaning that if one HSA's average increases from 50% to 55% and another from 5% to 10%, both HSAs have an increase of 5 percentage points. Of note, an improvement for Adolescent Well-Care Visits, Developmental Screening, and Controlling High Blood Pressure is an increase by 5 percentage points. An improvement for Diabetes, Poor Control is a decrease of 5 percentage points.

The score for each measure is calculated by adding the threshold score to the improvement score, unless the HSA is in the high achiever level. In that case, the HSA gets the maximum score of 3. The points for each measure are summed for a Quality Measure Score. The combined score is associated with one of three payment levels up to the full $0.25 available for the Quality Performance-Based Payments. Table 2 shows the payment levels for which scores are eligible.

Table 2. Quality Score and Payment Eligibility

Score	Payment
0-2 points	$0.00
3-5 points	$0.07
6-8 points	$0.13
≥9 points	$0.25

Utilization Performance-Based Payments

The utilization performance-based payment is based on practice-level Resource Use Index (RUI) score. This measure is based on software developed by HealthPartners as part of their Total Cost of Care (TCOC) measurement system, which has been endorsed by the National Quality Forum (NQF). This methodology applies nationally accepted weighting methods such as Medicare Severity Diagnosis Related Groups (MS-DRGs) for inpatient services, Current Procedural Terminology codes (CPTs) and associated Ambulatory Payment Classifications (APCs) for outpatient facility services, and CPTs and associated Resource-Based Relative Value Scale (RBRVS) relative weights for professional services) to measure the relative intensity of services.

Each patient-centered medical home (PCMH) in the Blueprint program receives an RUI score relative to the state average, which is indexed at 1. The lower the RUI score the better a practice ranks for their attributed adult members and pediatric members. Both the practice RUI scores for the adult populations and pediatric populations were divided into quartiles. Q1 is the mid-way score between the first quartile, the one with the highest scores and the second quartile. Q2 is the median score demarking the second and third quartiles. Q3 is the mid-way score between the third quartile and the fourth, the quartile is the lowest scores. The three quartiles with the lowest scores are eligible for three payment levels, as shown in Table 3. Utilization payment eligibility is also dependent on the sample size of the RUI measure being greater than or equal to 30 in the current performance period.

Table 3. RUI Score Quartiles and Eligible Payment Levels for CY2016 Data, Effective January 1, 2018

Quartile	Adult Quartile Range	Ped. Quartile Range	Payment Eligibility
Q4	≤ 0.934	≤ 0.899	$0.25
Q3	0.935 - 0.986	0.900 - 0.989	$0.13
Q2	0.987 - 1.045	0.990 - 1.077	$0.07
Q1	≥1.046	≥1.078	$0.00

If a practice has both an adult and pediatric RUI score, then the payment a practice receives will be based the score of the population that makes up more than 75% of the practice's total population. If the majority population makes up less than 75% of the practice population, then the higher score of the two populations will be used.