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

September 16, 2015

Attendees: S. Aranoff; J. Batra; B. Bick; P. Cobb; S. Constantino; T. Dolan; P. Farnham; K. Fitzgerald; J. Franz; A. French; V. Harder; J. Hester; B. Hill; C. Huang; C. Jones; J. Le; S. Maier; M. Mohlman; J. Peterson; J. Samuelson; M. Sheehey; B. Tanzman; T. Tremblay; S. Weppler; B. Wheeler

By phone: P. Biron; E. Emard; J. Fels; C. Foulton; J. Krulewitz; P. Launer; E. McKenna; S. Narkewicz; M. Shattuck; T. Voci; J. Wallace; M. Young

The meeting opened at 8:31 a.m.

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

- Today's agenda and PowerPoint slide deck were distributed prior to this meeting.
- Additional meeting materials were distributed in today's meeting and will be electronically distributed as well.
- The purpose of today's meeting is to catch up with everyone on the process and what's been going on in the past couple of months.

II. Published Results

- C. Jones informed the group of our first peer-reviewed paper, *Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care*, was published in the Journal Population Health Management.
- C. Jones reviewed slide #4 that includes Figure 2 from the report. The charts represents actual expenditures that have been paid for in the claims and includes VT residents ages 1 year and older. The chart reflects pre-year, implementation year, NCQA scoring year, post-year 1 and post-year 2 for 2008 – 2013. The impact of the ACOs will not be shown in this.
    - The results are favorable.

- The relative reduction is across the three insurers types. Reductions offsets what was paid to both the medical homes and community health teams. The results show an increase in Medicaid special services such as dental, transportation, and other services not typically covered by other payers. The interpretation of this finding is that medical homes and community health teams are better connecting their patients to social and prevention services relative to the comparison group.
- Slide #15 gives an example of claims and clinical data linkage. C. Jones mentioned we are expanding our ability to link claims and clinical data. A new feature of the practice and Health Service Area profiles is a table showing percentages of patients linked clinical data on specific measures (e.g. blood pressure and BMI), and the percentages meeting criteria for chronic conditions (e.g. hypertension and obesity). There is no reason why other data, such as home, food, social, etc., can't be integrated.
- Linked clinical data are getting to the actionable results. Treatment data can also be added. V. Harder stated this will be powerful for practices to see and what to treat.
- C. Jones challenged the group to think creatively of where there are rosters (e.g. non-claims data) that can be flagged and linked.

- Before discussion moved onto the updates of Blueprint/ACO collaboration, J. Wallace requested an update about the Gobeille vs. Liberty Mutual case, whether claims data needed to be submitted for self-insured. C. Jones did not have a lot of information and heard the case will be heard before the Supreme Court this fall. If we lose the data on self-insured, we will be losing a lot. M. Mohlman reported the brief has been submitted and may be on the Green Mountain Care Board website. T. Tremblay mentioned the State attorneys have been looking at the work Blueprint has been doing and imagines that some of our work will be used in the hearing.

III. Community Collaboratives

- Over the past nine months, the leaders of the three ACOs have been working with the Blueprint in forming decision making groups who will help guide the community level health structure. All the communities are in different stages in the state and are beginning to use priorities and projects.
- J. Samuelson acknowledged the ACO partners, Miriam Sheehey (OneCare Vermont), Patty Launer (CHAC), and Susan Ridzon (Health First). We have been working collaboratively to merge our resources and support.
- Twelve of the communities are actively participating in the Care Coordination learning collaborative that SIM is currently holding. This shows how different types of organizations and communities are working together.
- S. Aranoff hopes the community collaborative meetings will be open to all. J. Samuelson mentioned the need to balance transparency with the communities' needs to develop trust among the members and leadership groups within the community.
- M. Sheehey gave nods to a couple of teams around their efforts that include: Bennington, Burlington and Newport.

- C. Jones stated this is actual decision making, showing both ACOs and CHT supporting a real initiative. This is the operation on the ground of the Community Health Structure. C. Jones applauds all.
- J. Hester mentioned this is critical. He also noted that CMMI is finalizing an initiative supporting ACO/Population Health and will work like what is being discussed. It should be out by the end of this year. C. Jones asked if there will be any challenges for eligibility, such as Next Gen ACO. J. Hester responded he doesn't believe so.

IV. Payment Modifications

- As of July 1, 2015, all eligible practices have received the $3 base payment for medical homes payment from Medicaid. Other insurers will join Medicaid on January 1, 2016. The performance component, which we have been working with the ACOs on, will be based on service area outcomes and will go into effect January 1, 2016.
- P. Cobb asked if the performance payments will be adjusted. C. Jones responded, yes, it will be twice a year, every 6 months.
- C. Jones went over slide #8, *Changes to the Payment & Eligibility Requirements*. In recognition to NCQA undergoing a change in their process for scoring, independent practices can defer to the end of 2016 until the NCQA process is underway. Most of the practices chose to rescore and have not dropped out yet. We're also piloting the new NCQA scoring process. Performance payment will be based on recognition and not score.
- Quality performance payment: M. Mohlman discussed the four ACO core measures that are tied to the performance payment and they include:

    1. Core-2: Adolescent well-care visit
    2. Core-8: Developmental Screening in the first three years of life
    3. Core-12: Rate of hospitalization for ACS conditions (PQI Chronic Composite)
    4. Core-17: Diabetes mellitus: hemoglobin A1c poor control (>9%)

- M. Mohlman stated the decision was to go with a point system and to use our State data. The HSA data have been adjusted to be comparable to the State. If an HSA is at or above the State average, the HSA will get one point for that measure. If an HSA is at or above the High Achiever (90^{th} percentile), the HSA will get three points. If you are not in the High Achiever bracket, the HSA is eligible for improvement points: 1 point for maintaining, 2 points for achieving at least a minimum improvement. Total of 3 possible points for each measure; total of 12 possible points for all four measures. HSA scores will make practices eligible for one of three payment levels, up to $0.25 for the quality performance payment. Utilization performance payment will be based on the Total Resource Use Index reported in the Blueprint HSA profiles.
- B. Bick questioned whether a more finely graduated performance payment system was desired, so that it would not be possible for a practice to get worse on a performance measure and still get the maximum payment. In contrast, other commenters supported the proposed approach, pointing out that it would be important to allow HSAs to focus on a subset of performance measures.

With no further time, the meeting adjourned at 10:17 am.