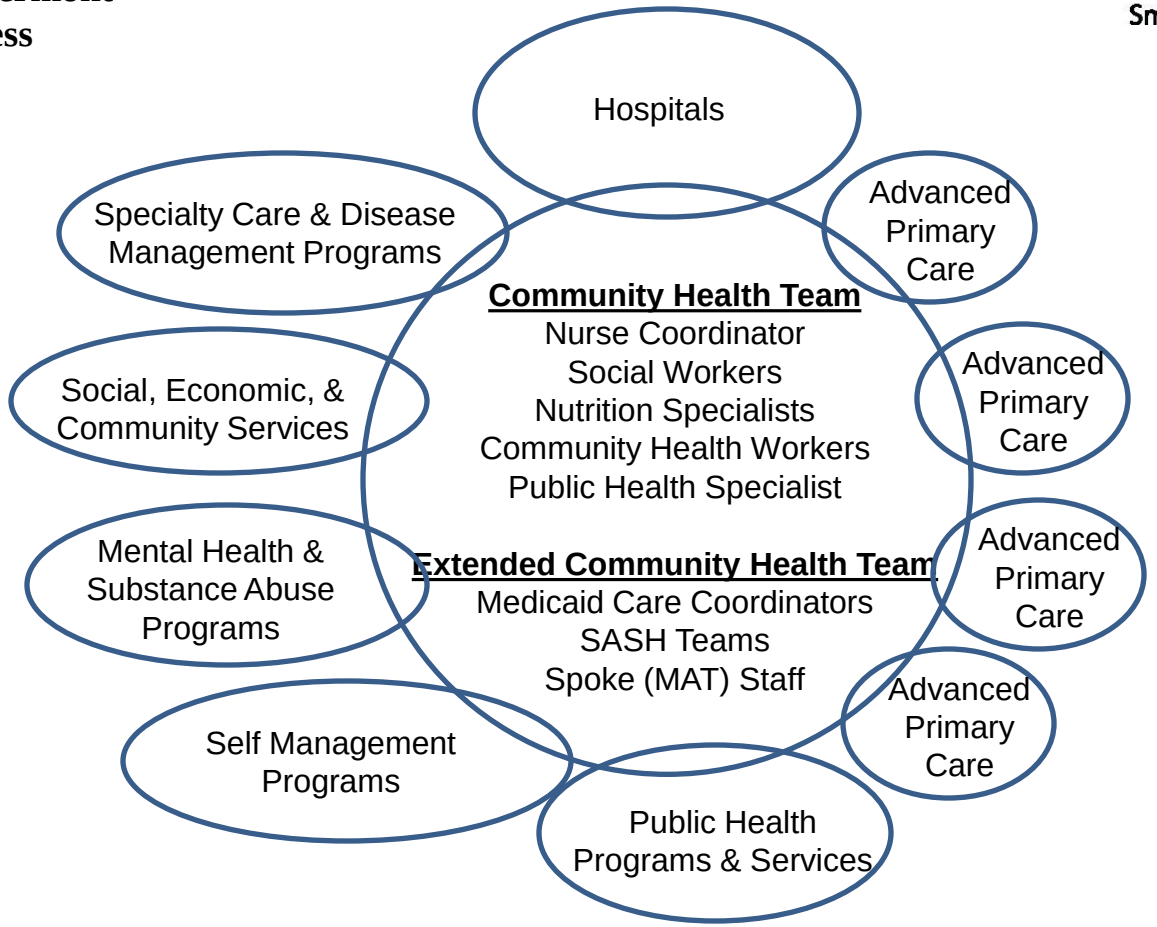
Blueprint Program Update

Healthcare Reform Oversight Committee

October 28, 2014

Background & Context



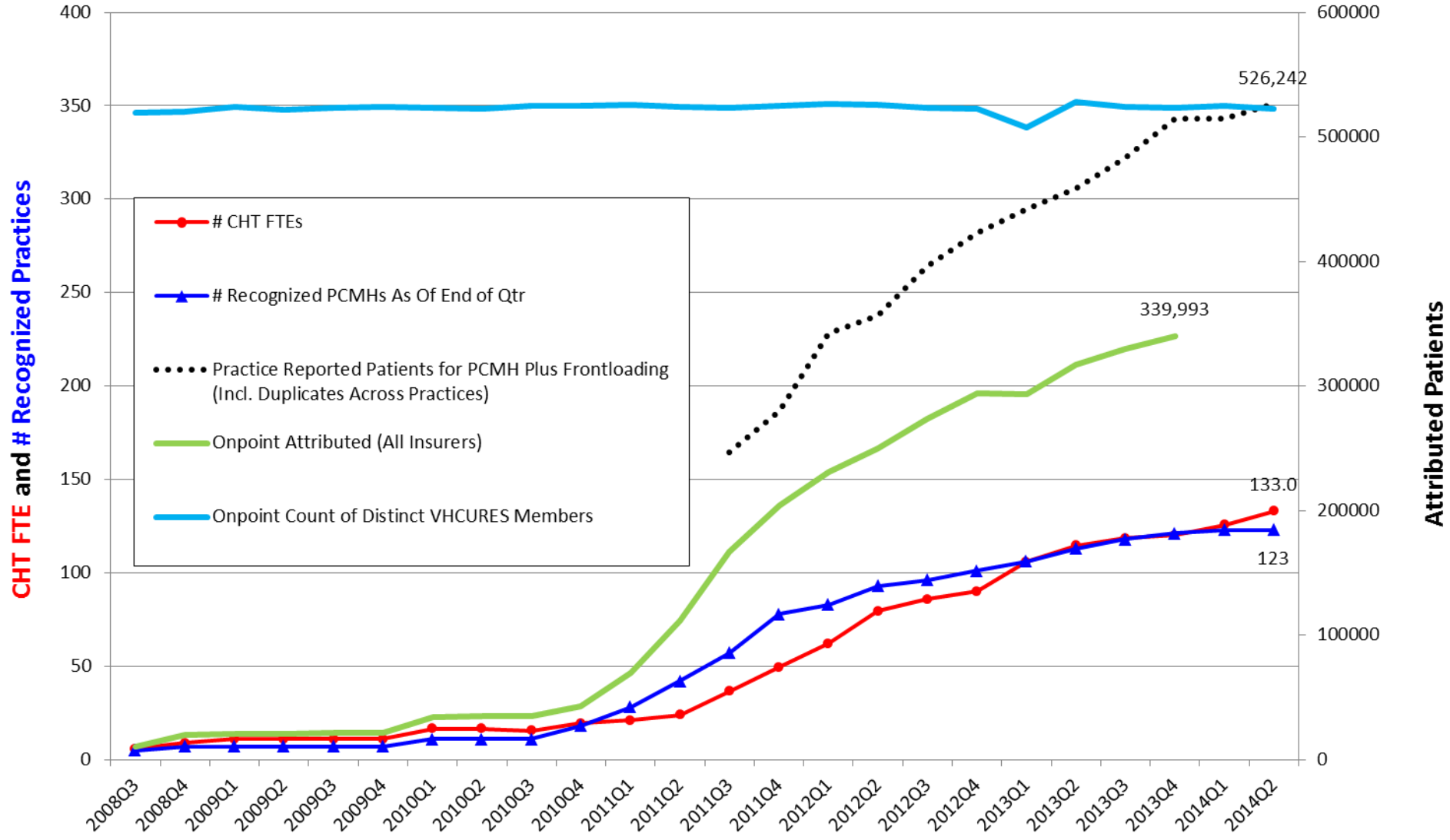
All-Insurer Payment Reforms

Local leadership, Practice Facilitators, Workgroups

Local, Regional, Statewide Learning Forums

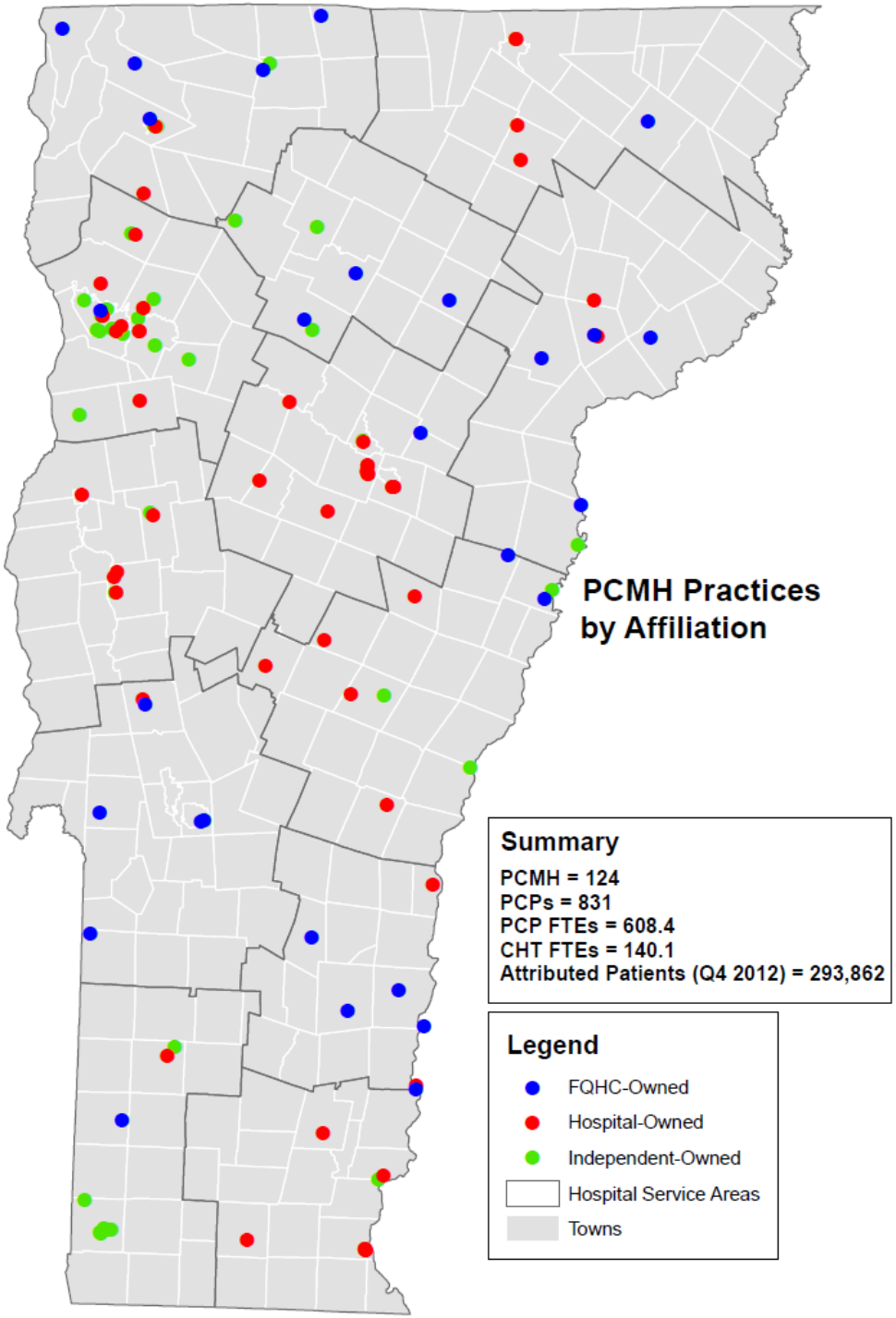
Health IT Infrastructure

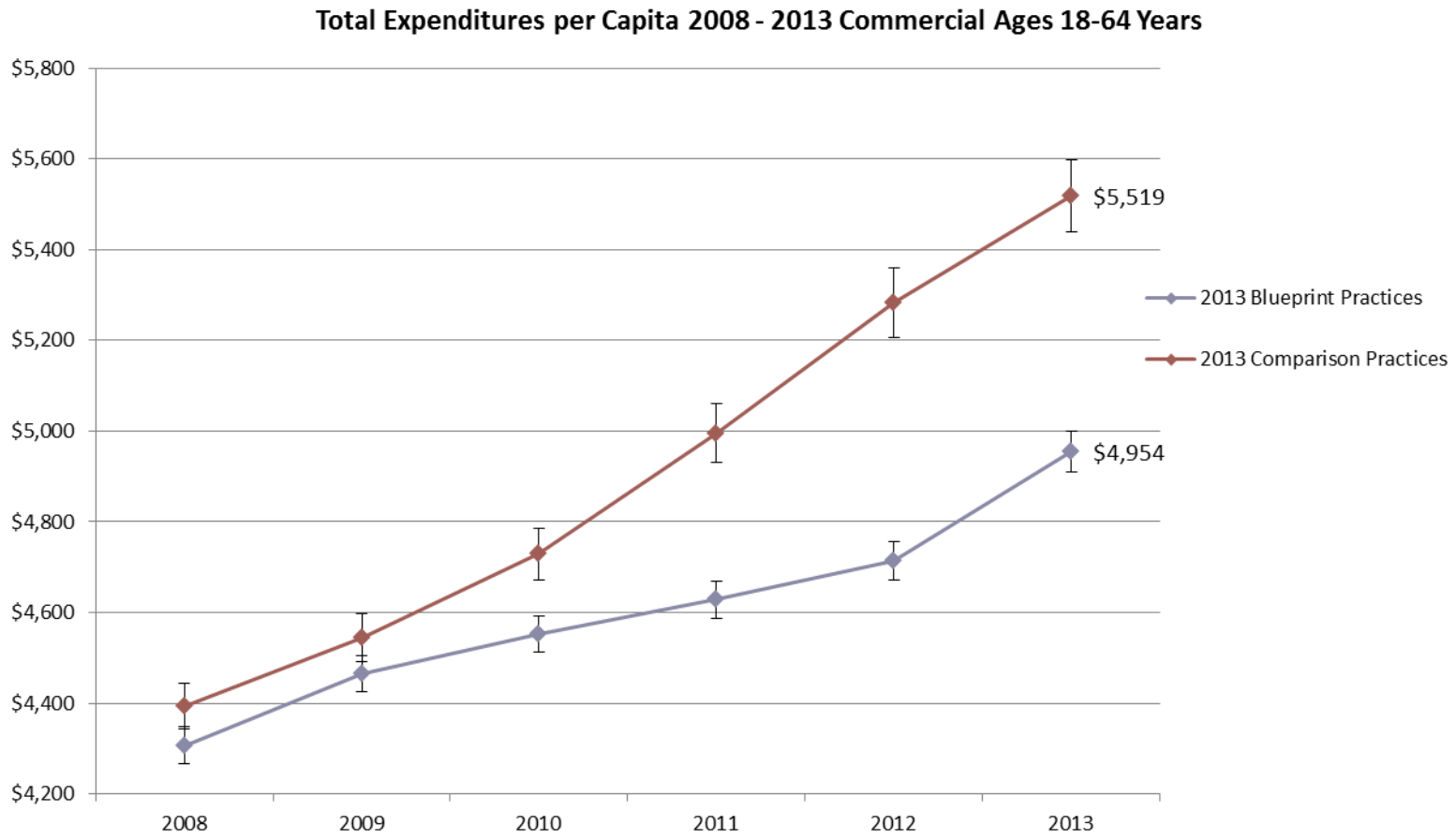
Evaluation & Comparative Reporting

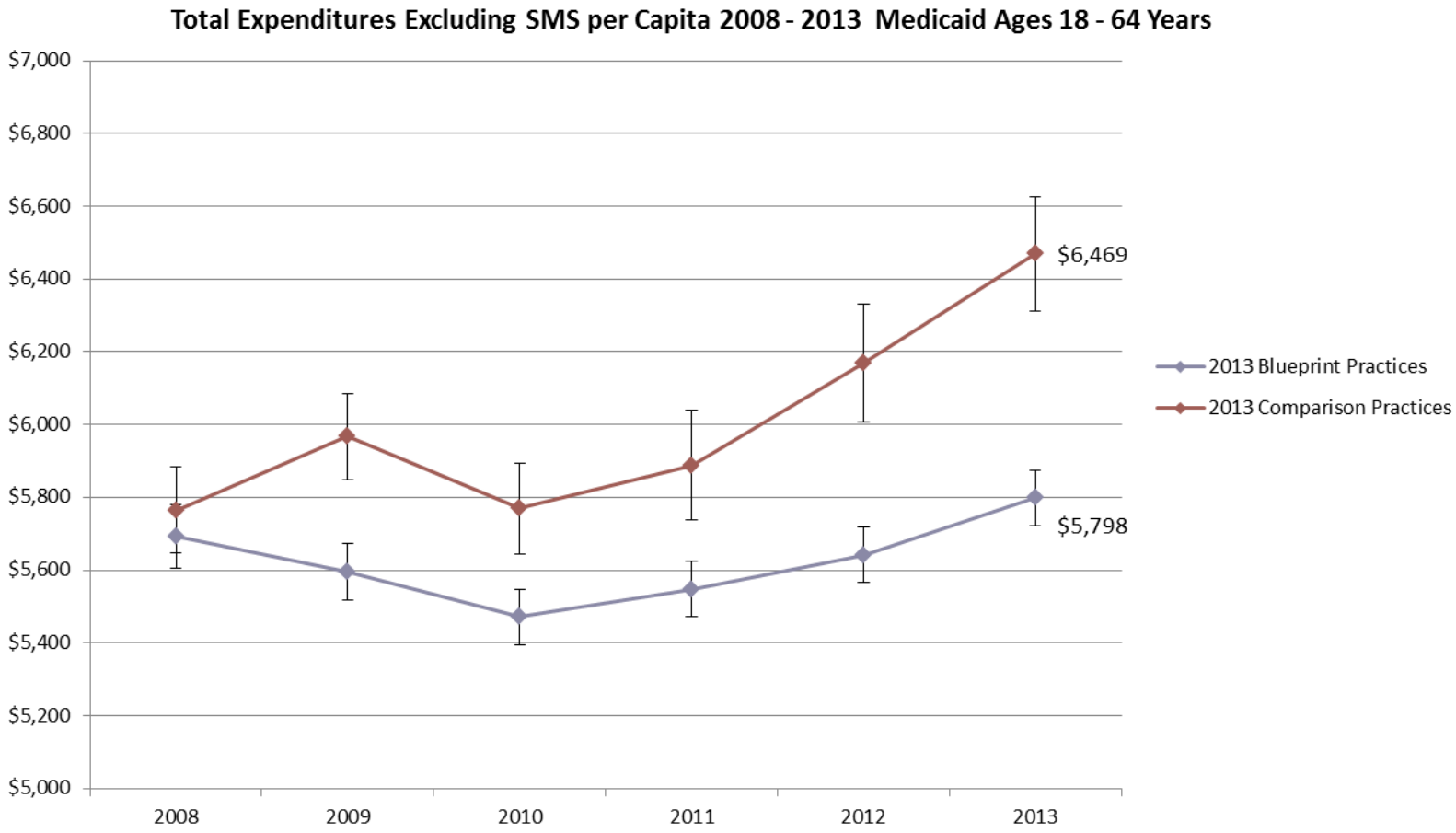

CHT FTE and # Recognized Practices
Attributed Patients
400
350
300
250
200
150
100
50
0
600000
500000
400000
300000
200000
100000
0
CHT FTEs
Recognized PCMHs As Of End of Qtr
Practice Reported Patients for PCMH Plus Frontloading (Incl. Duplicates Across Practices)
Onpoint Attributed (All Insurers)
Onpoint Count of Distinct VHCURES Members
526,242
339,993
133.0
123
2008Q3
2008Q4
2009Q1
2009Q2
2009Q3
2009Q4
2010Q1
2010Q2
2010Q3
2010Q4
2011Q1
2011Q2
2011Q3
2011Q4
2012Q1
2012Q2
2012Q3
2012Q4
2013Q1
2013Q2
2013Q3
2013Q4
2014Q1
2014Q2

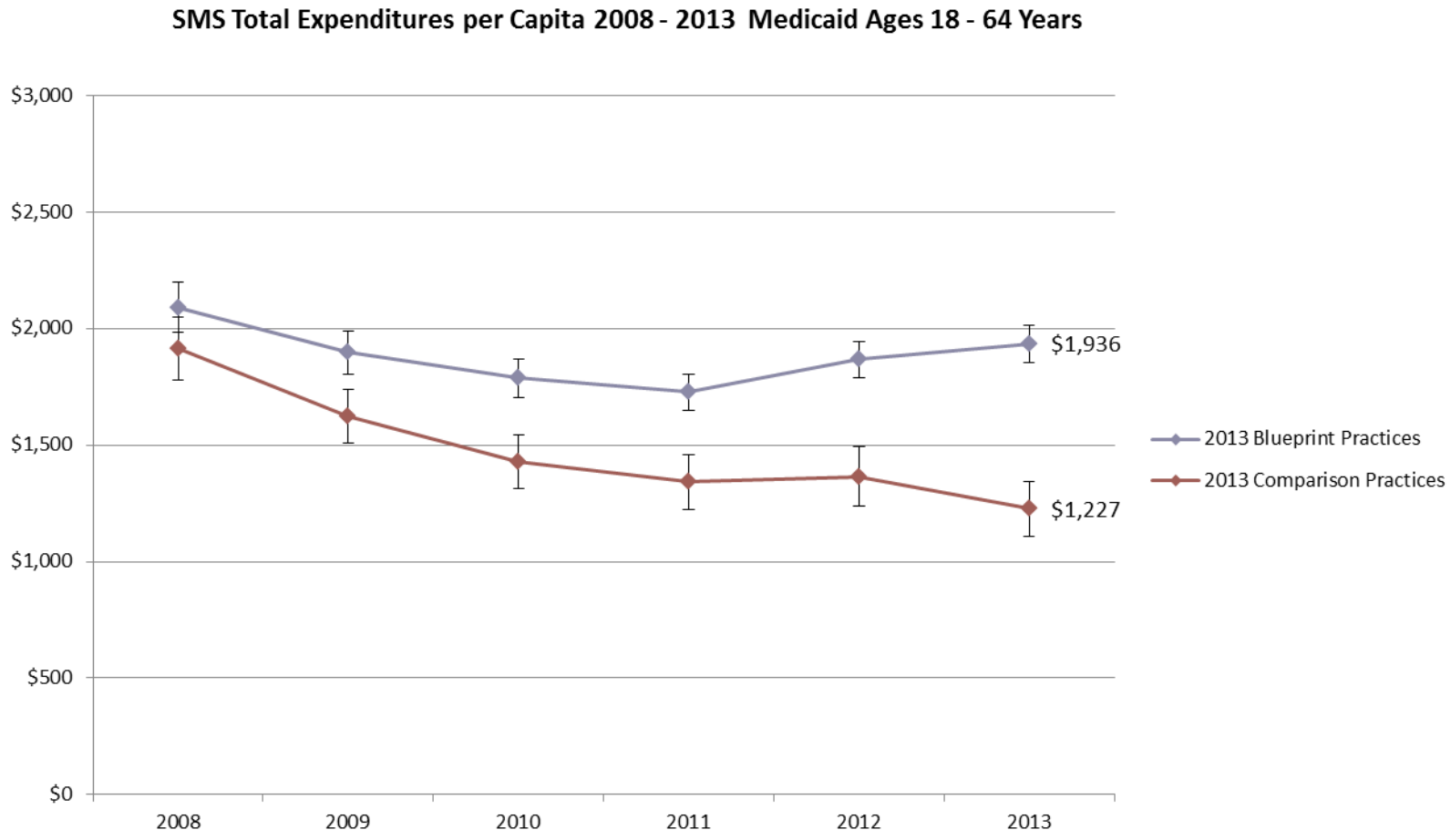
Health Services Network

Key Components	July, 2014
PCMHs (active PCMHs)	123
PCPs (unique providers)	644
Patients (Onpoint attribution) (12/2013)	347,489
CHT Staff (core)	218 staff (133 FTEs)
SASH Staff (extenders)	60 FTEs (48 panels)
Spoke Staff (extenders)	47 staff (30 FTEs)


PCMH Practices by Affiliation
Summary
PCMH = 124
PCPs = 831
PCP FTEs = 608.4
CHT FTEs = 140.1
Attributed Patients (Q4 2012) = 293,862
Legend
FQHC-Owned
Hospital-Owned
Independent-Owned
Hospital Service Areas
Towns


Total Expenditures per Capita 2008 - 2013 Commercial Ages 18-64 Years
$5,800
$5,600
$5,400
$5,200
$5,000
$4,800
$4,600
$4,400
$4,200
2008
2009
2010
2011
2012
2013
$5,519
$4,954
2013 Blueprint Practices
2013 Comparison Practices


Total Expenditures Excluding SMS per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years
$7,000
$6,800
$6,600
$6,400
$6,200
$6,000
$5,800
$5,600
$5,400
$5,200
$5,000
2008
2009
2010
2011
2012
2013
$6,469
$5,798
2013 Blueprint Practices
2013 Comparison Practices

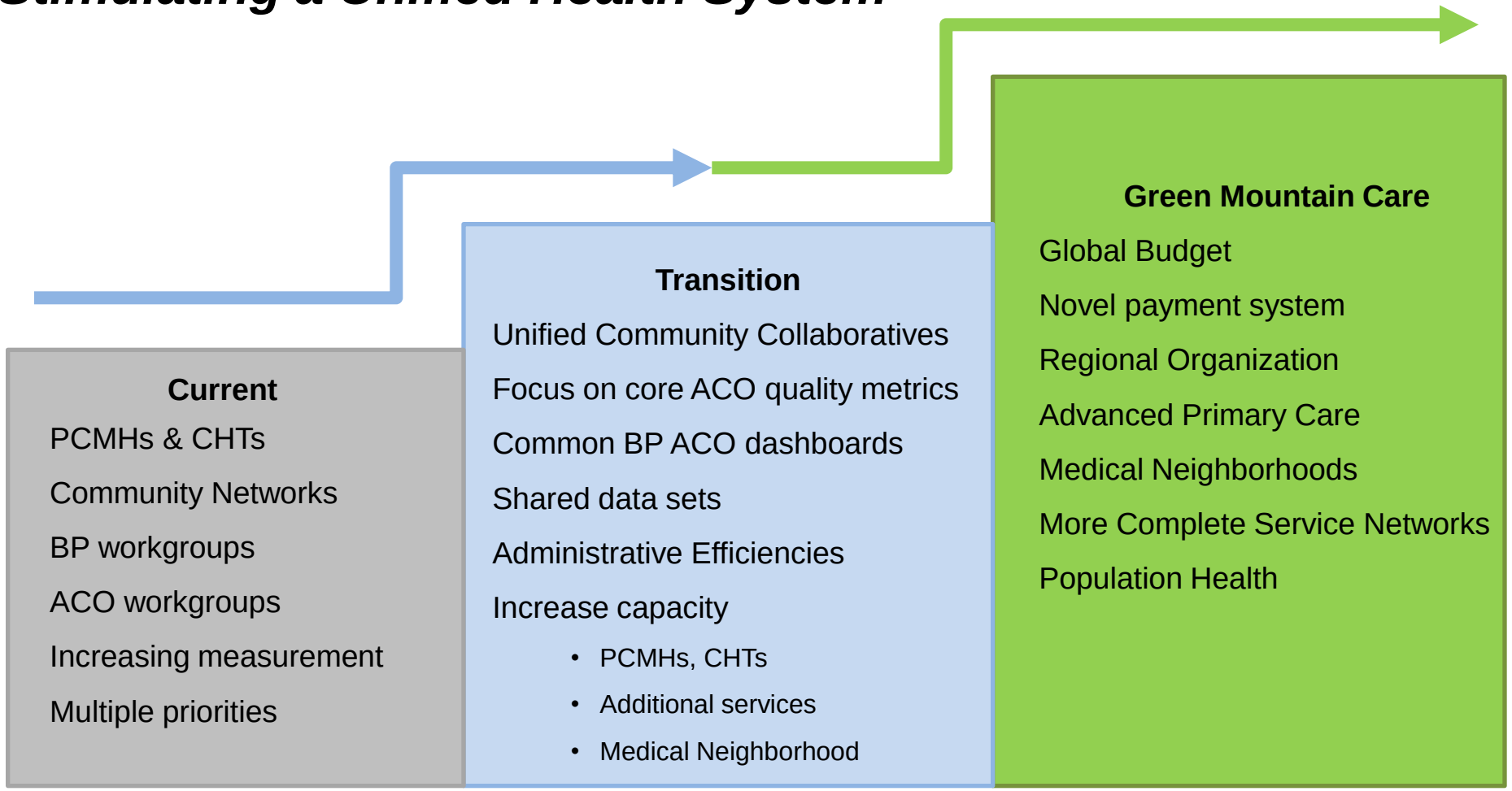

SMS Total Expenditures per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
2008
2009
2010
2011
2012
2013
$1,936
$1,227
2013 Blueprint Practices
2013 Comparison Practices

Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Essential delivery system foundation for Green Mountain Care
- Favorable trends over 6 years (utilization, expenditures, quality)
- Reduced expenditures that offset investment (PCMH & CHT payments)

Stimulating a Unified Learning Health System

Transition to Green Mountain Care
Stimulating a Unified Health System



Strategy for the Transition to Green Mountain Care

1. Unified Community Health System Collaboratives
2. Unified Performance Reporting & Data Utility
3. Administrative simplification and efficiencies
4. Build the medical neighborhood
5. Implement new service models (e.g. ACE, ECHO)
6. Payment Modifications

Strategy for the Transition to Green Mountain Care

Unified Community Health System Collaborative

- Unified local quality collaboratives (blend BP & ACO groups)
- Focus on core ACO measures (add ACO measure dashboard)
- Review examples that are up and running
- Quarterly larger groups & leadership, Monthly workgroups
- Co-chairs including clinical leadership from ACOs
- Local groups adopt charter an select leadership

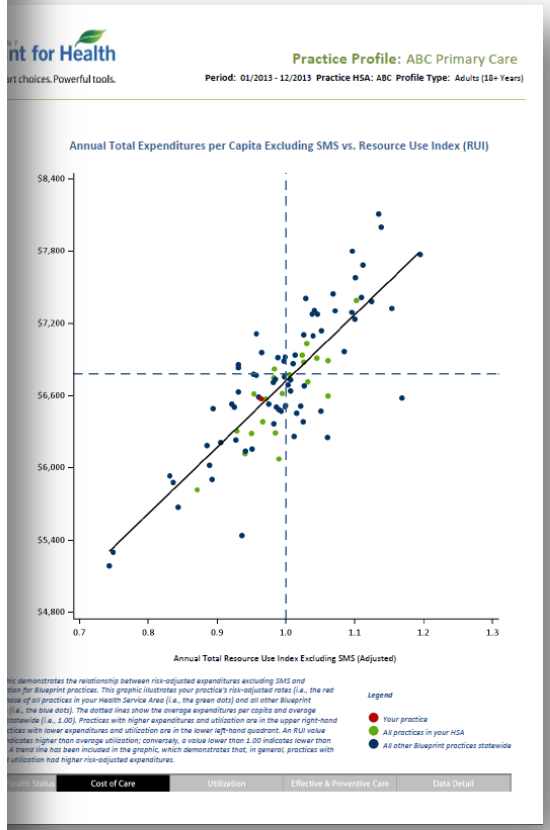
Strategy for the Transition to Green Mountain Care

Collaborative Performance Reporting

- Co-produce comparative profiles
- Include dashboard with results for ACO measures
- Possible thru a linkage of claims and clinical data
- Objective basis for planning & extension of best practices

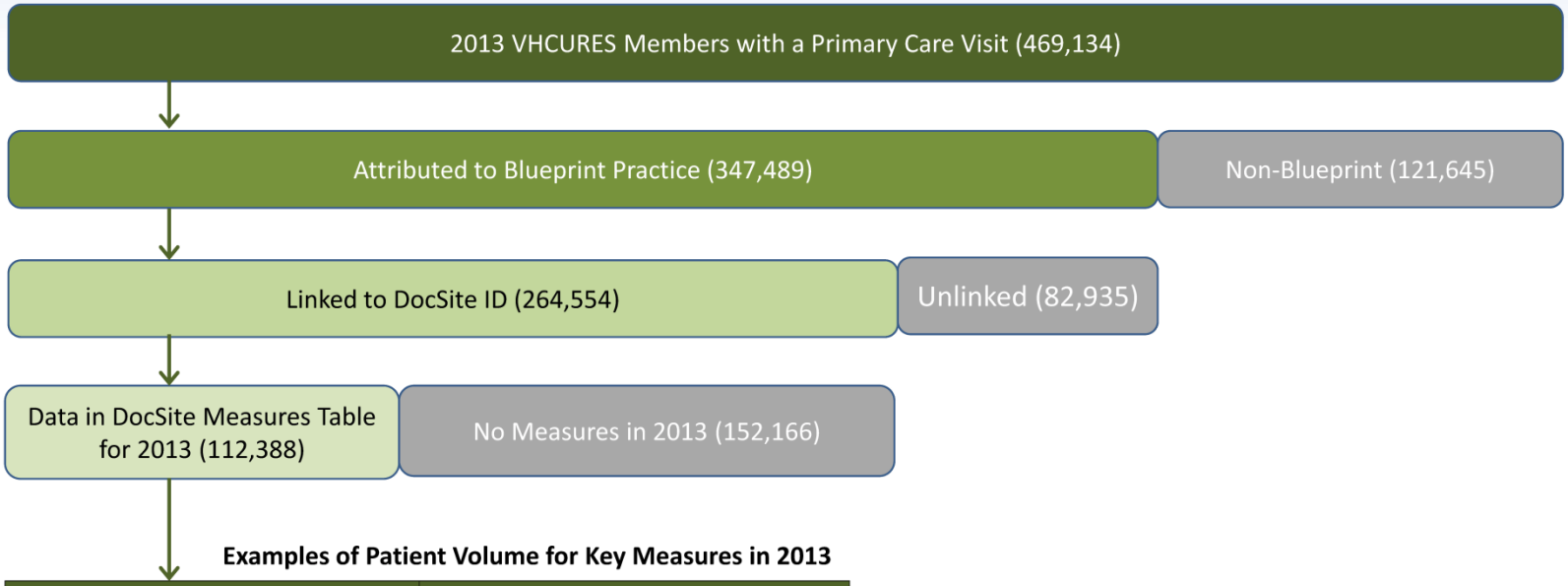
Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare



Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Clinical Outcomes



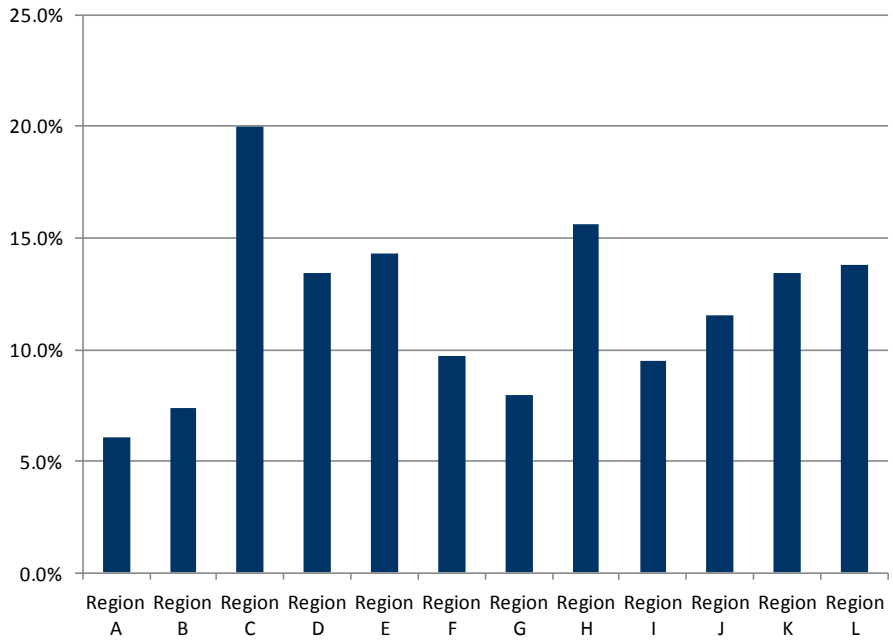
Examples of Patient Volume for Key Measures in 2013

Measure	Number of Patients with Data
Blood Pressure	93,230
Triglycerides	26,585
LDL-C	24,978
Tobacco Use	18,004
HbA1c	12,812

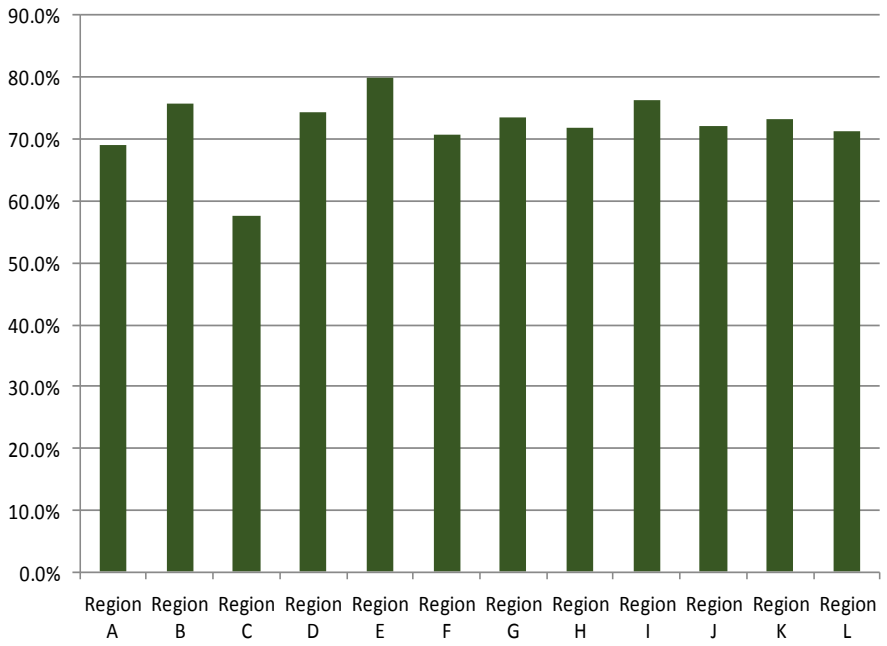
Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Outcomes Data

(ACO 27) % of Members with Diabetes, Glucose Not in Control (A1c >9%)



(ACO 28) % of Members with Hypertension, Blood Pressure in Control (<140/90 mm Hg)



Strategy for the Transition to Green Mountain Care

Data Utility

- Integration of diverse data sets for advanced measurement
- Produce analytic data sets to meet ACO measurement needs
- Share analytic data sets with ACOs
- Collaborative work with VITL and others to build data infrastructure

Strategy for the Transition to Green Mountain Care

Administrative Simplification, Efficiencies, & Cost Offsets

- Reduce insurer medical management programs (e.g. diabetes, hypertension)
- Insurer referrals to enhanced Community Health Teams
- BP participation meets insurer quality requirements for rule 9-03
- Approach NCQA regarding insurer requirements (quality, care management)
- Unified attribution process using VHCURES data

Strategy for the Transition to Green Mountain Care

Options for Payment – Stimulate Unified Community Collaboratives

- Adjust insurer portion of CHT costs to reflect market share
- Increase CHT payments
- Increase PCMH payments
- Increase CHT and PCMH payments
- Test new models (e.g. fully capitated PC payment, P4P, Health Home)

Goals for the Transition to Green Mountain Care

- Assure that Vermonters have unhindered access to the highest quality primary care and team based services
- Stimulate unified cohesive networks of medical and non-medical services in each community
- Demonstrate measurable improvement in the quality of preventive services that Vermonters receive (core measures, additional measures)
- Demonstrate measurable improvement in key outcomes in each community (health status, experience, utilization, costs)
- Formalize a community oriented and data guided health system, ready to operate under Green Mountain Care.

Questions & Discussion