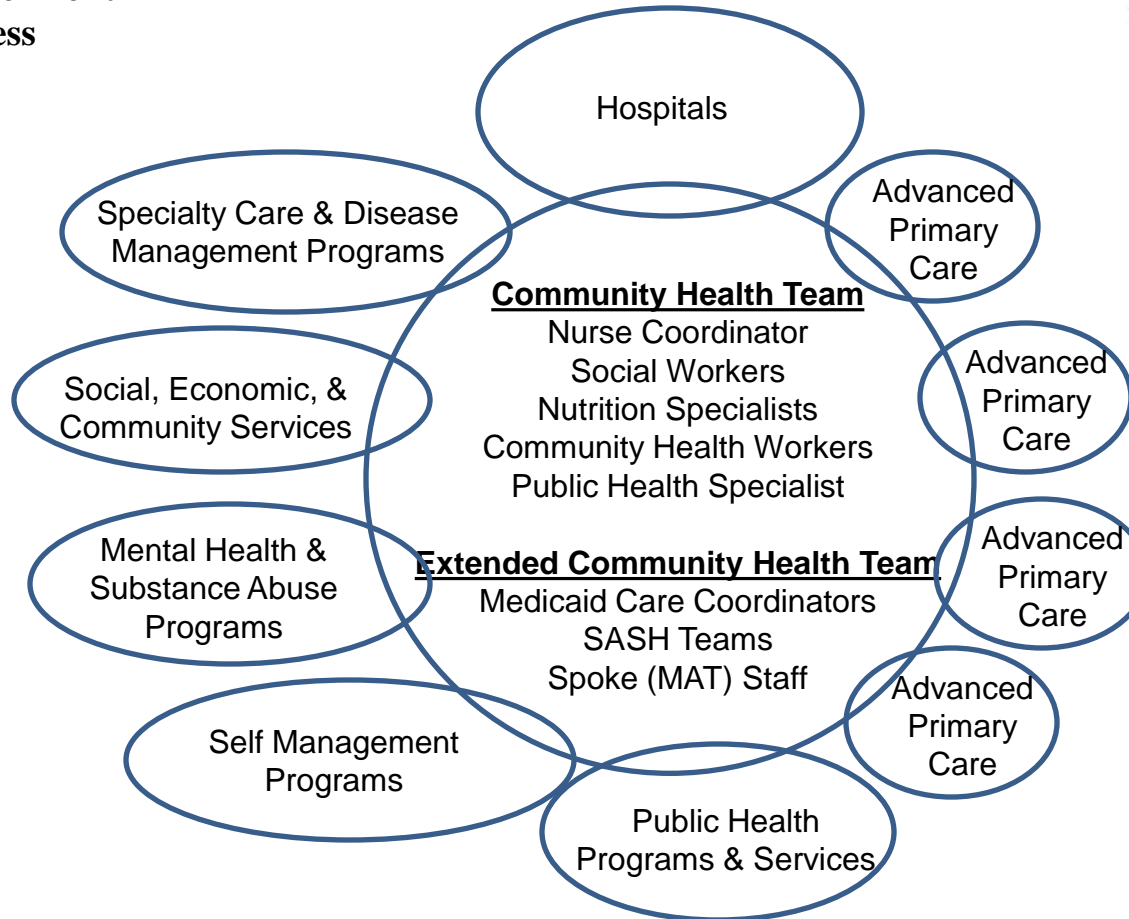


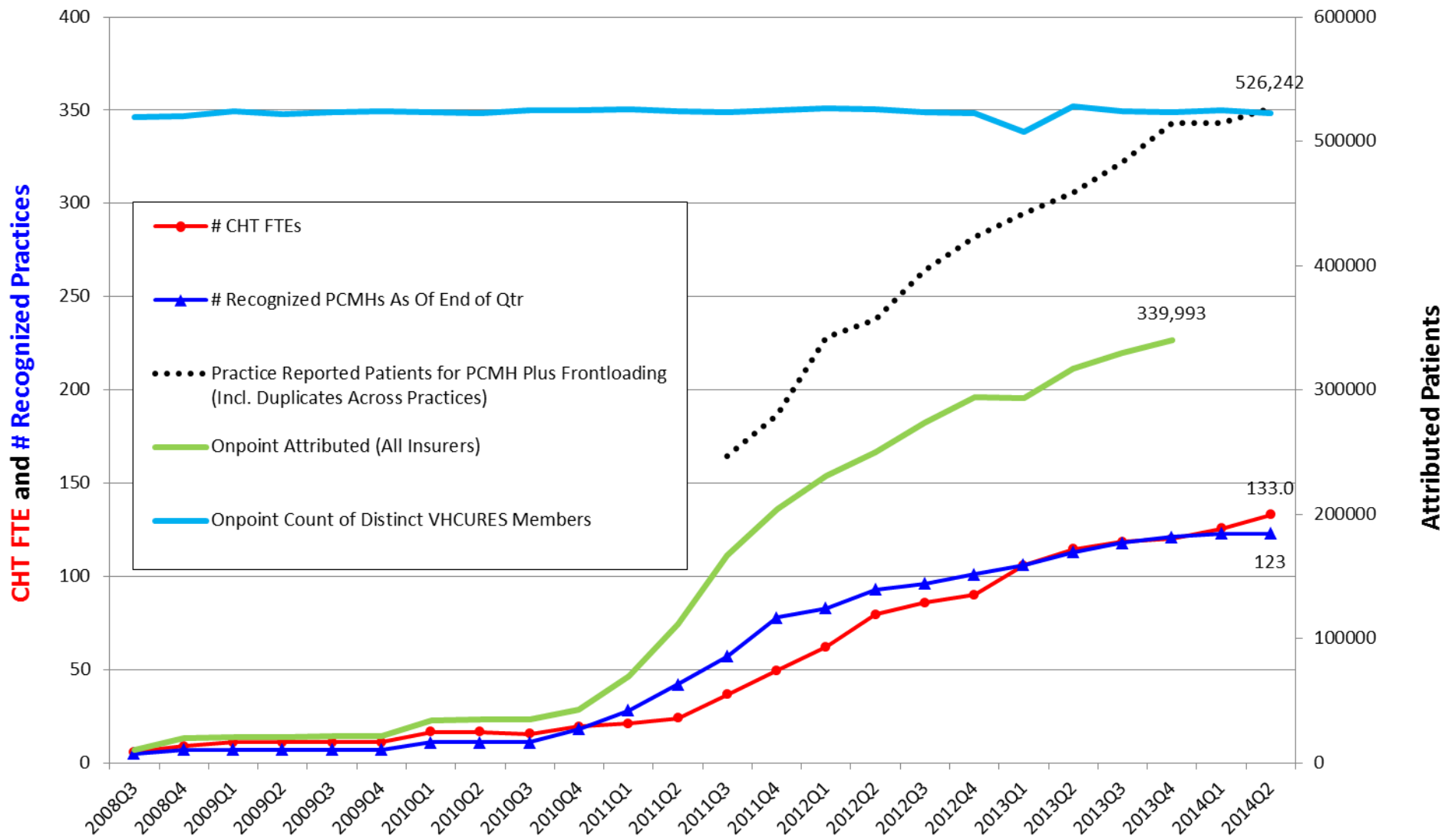
Blueprint Program Update

Healthcare Reform Oversight Committee

October 28, 2014

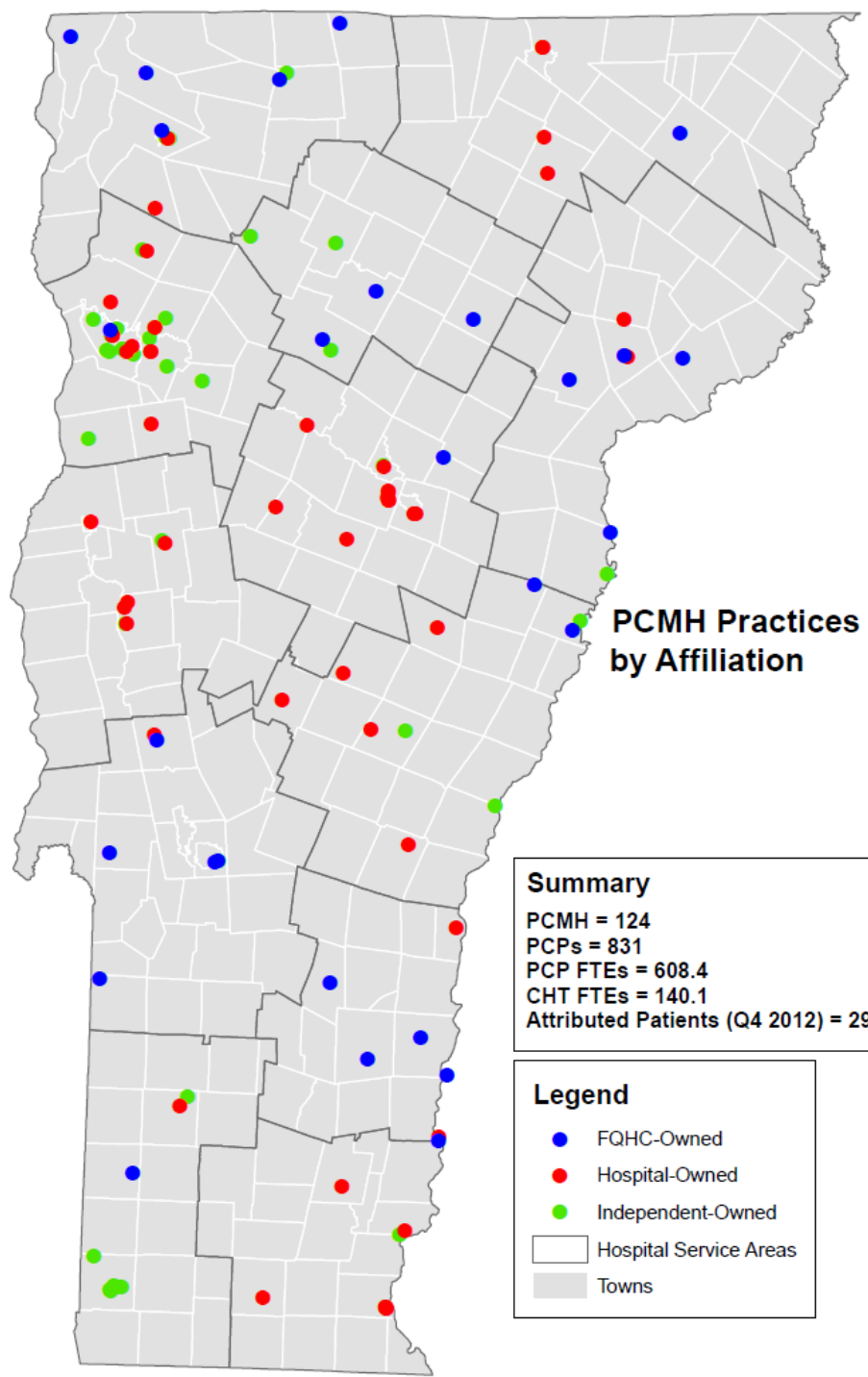
Background & Context



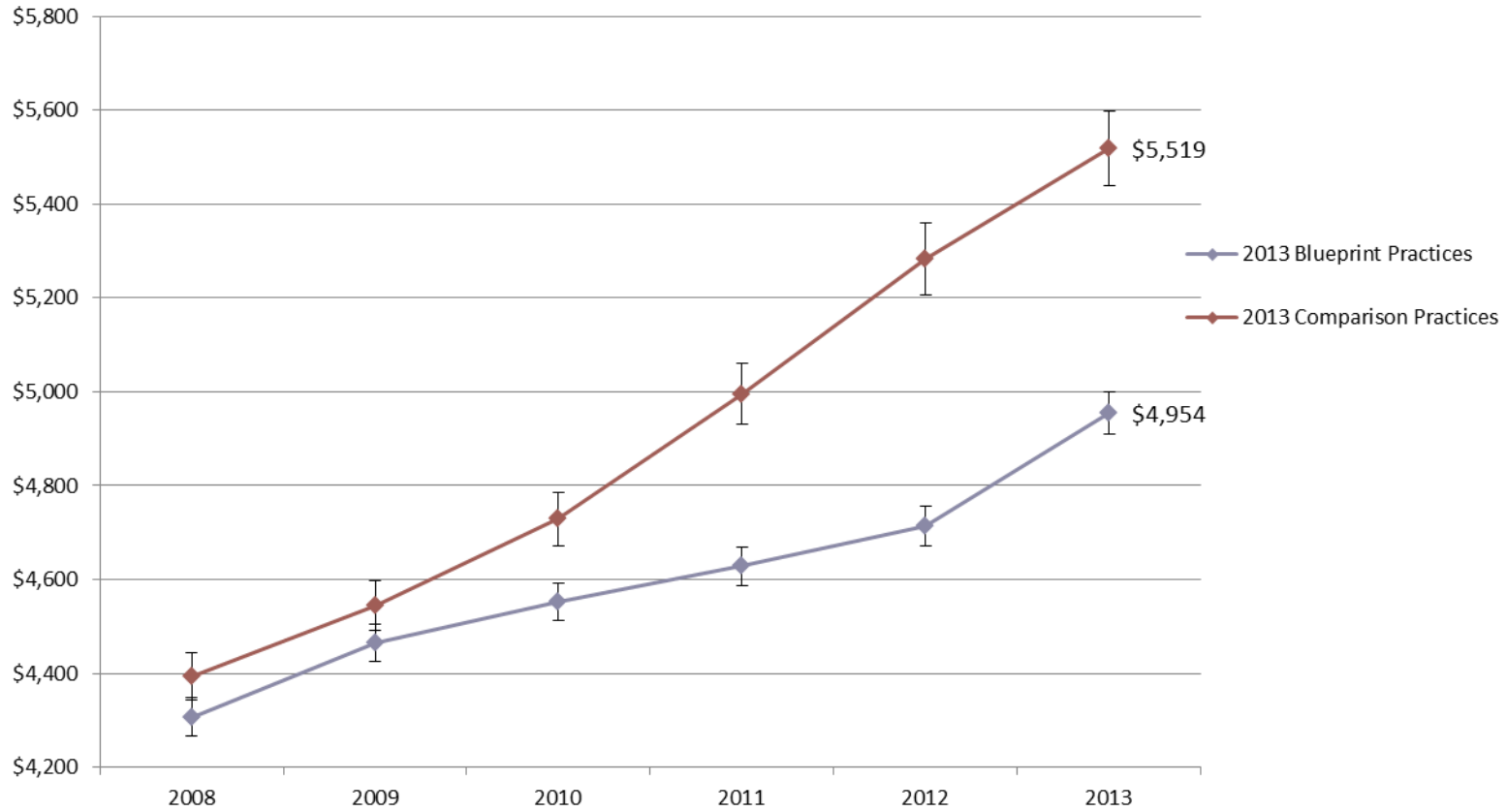


Health Services Network

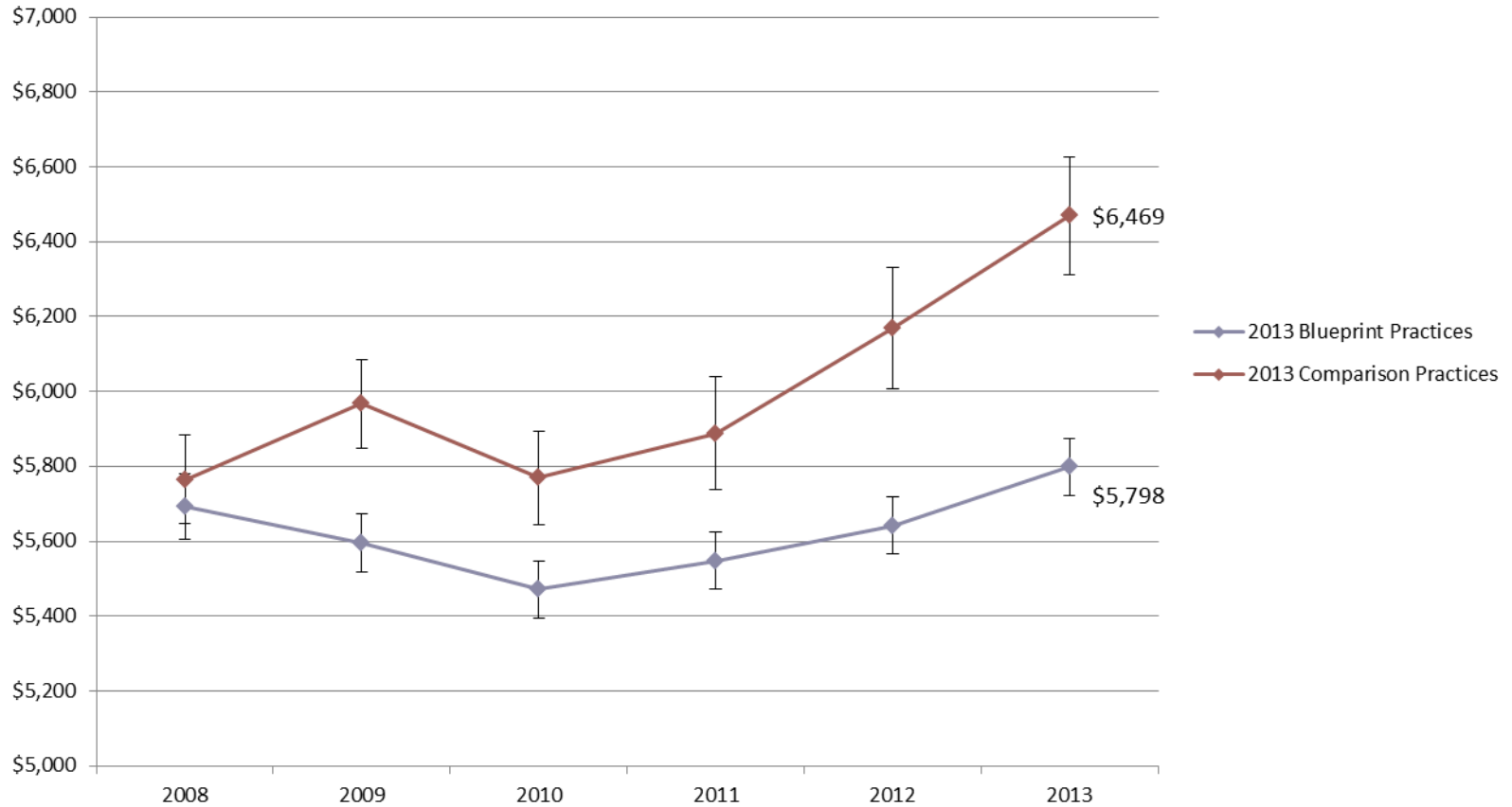
Key Components	July, 2014
PCMHs (active PCMHs)	123
PCPs (unique providers)	644
Patients (Onpoint attribution) (12/2013)	347,489
CHT Staff (core)	218 staff (133 FTEs)
SASH Staff (extenders)	60 FTEs (48 panels)
Spoke Staff (extenders)	47 staff (30 FTEs)



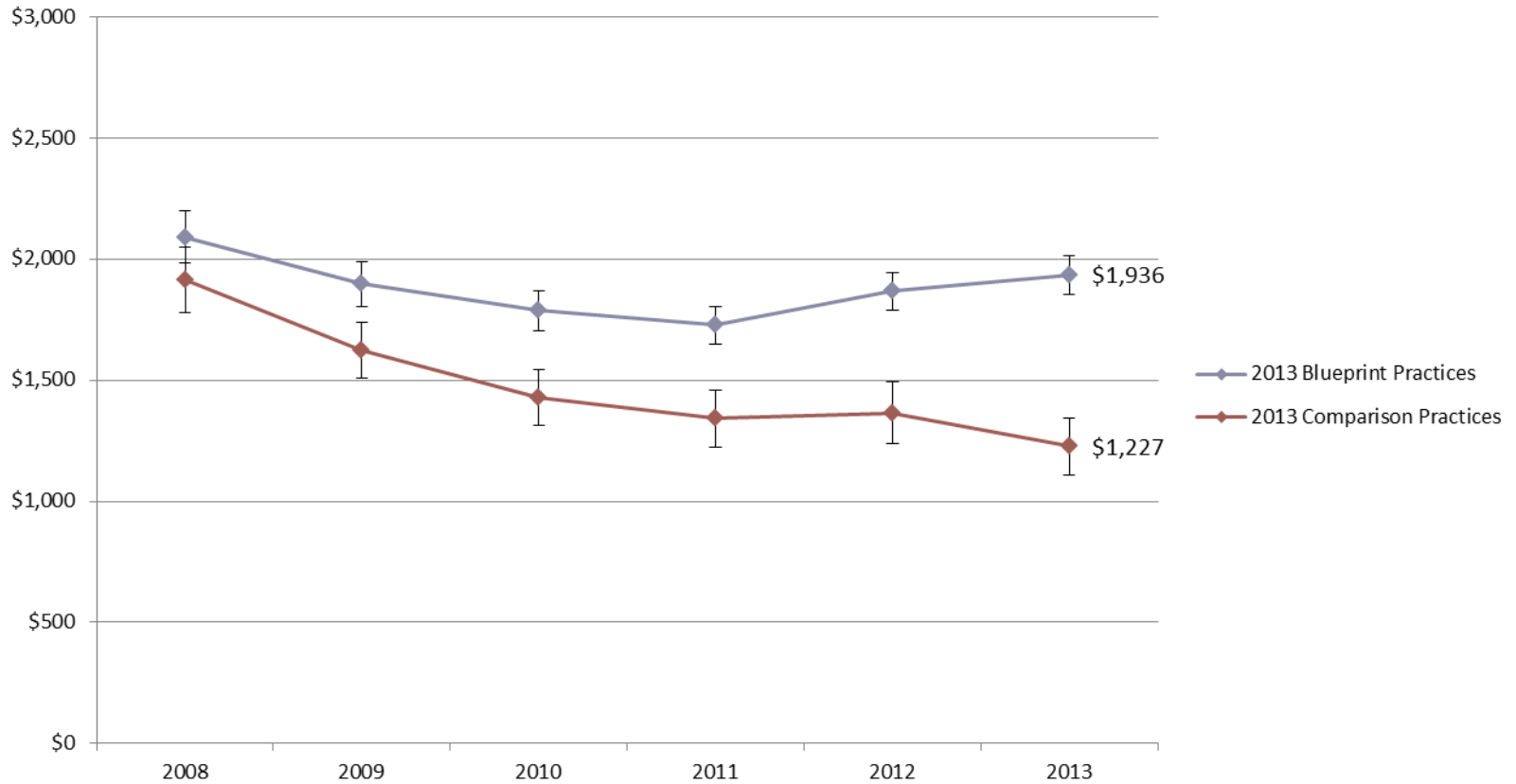
Total Expenditures per Capita 2008 - 2013 Commercial Ages 18-64 Years



Total Expenditures Excluding SMS per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years



SMS Total Expenditures per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years

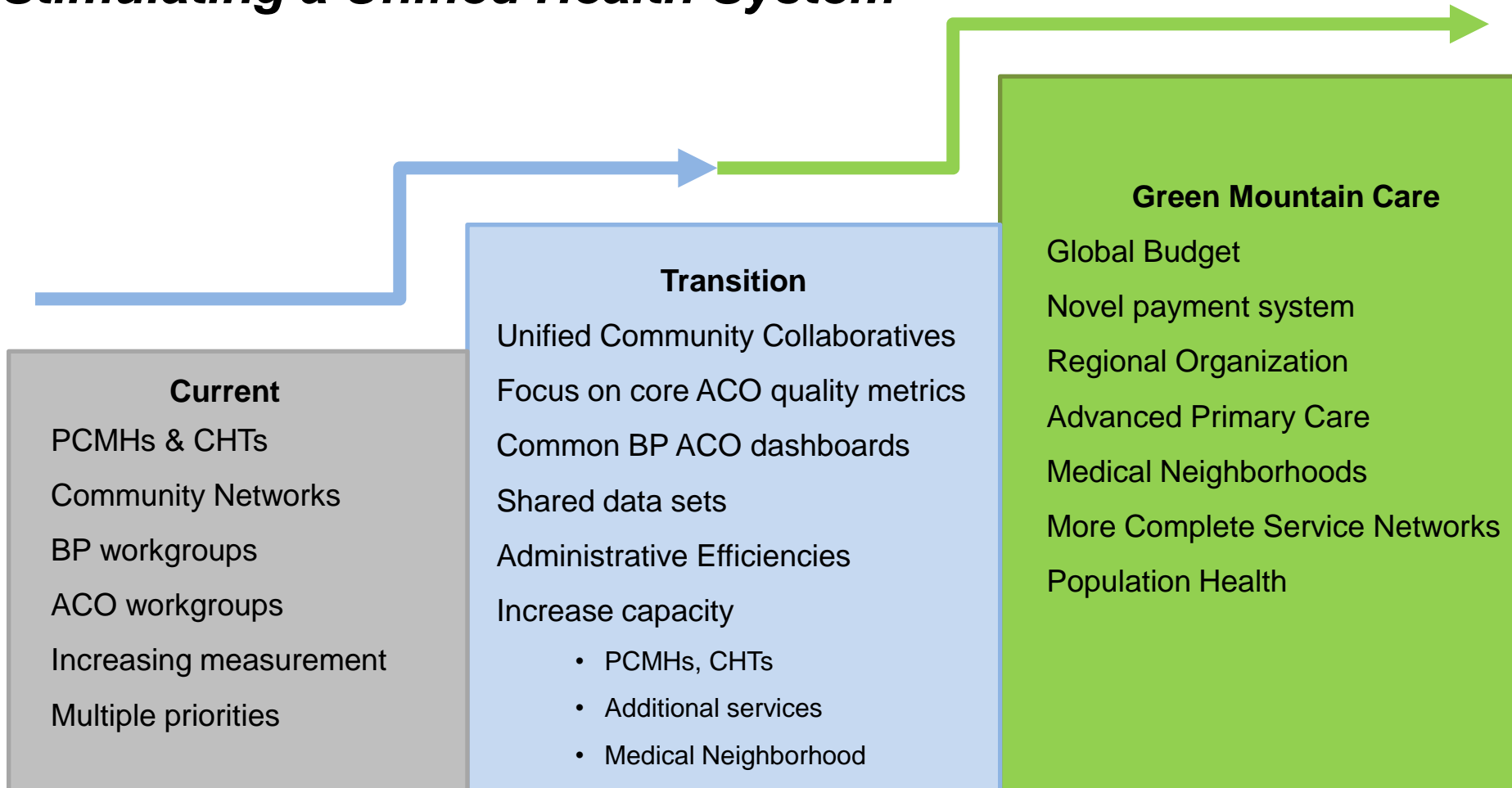


Current State of Play

- 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 and 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



Practice Profile: ABC P
Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Welcome to the 2014 Blueprint Practice Profile from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services. Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

Demographics & Health Status

	Practice	H.S.A.	St.
Average Members	4,081	84,070	2
Average Age	50.6	50.1	
% Female	55.6	55.5	
% Medicaid	14.5	13.0	
% Medicare	23.7	22.2	
% Maternity	2.1	2.1	
% with Selected Chronic Conditions	50.1	38.8	
Health Status (CRG)			
% Healthy	39.0	43.9	
% Acute or Minor Chronic	18.8	20.5	
% Moderate Chronic	27.9	24.5	
% Significant Chronic	15.4	12.3	
% Cancer or Catastrophic	1.4	1.3	

Table 1: This table provides comparative information on the demographics & health status of your practice, all Blueprint practices in your Health Service Area (HSA) as a whole. Included measures reflect the types of information used to adjust rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial enrollment during the year. In addition, special attention has been given to Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's practice, percentage of membership in Medicare, Medicare eligibility or end-of-stage renal disease status, and the member's receipt of special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of members through the claims data as having one or more of seven selected chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, co disease, hypertension, diabetes, and depression.

The Health Status measure aggregates ICD-10 Clinical Risk Groups (CRGs) into the year for the purpose of generating adjusted rates. Aggregated risk class include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., dystrophy, cystic fibrosis).



Practice Profile: ABC Primary Care
Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Total Expenditures per Capita

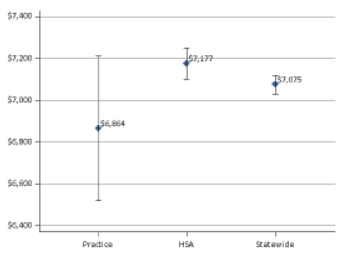


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

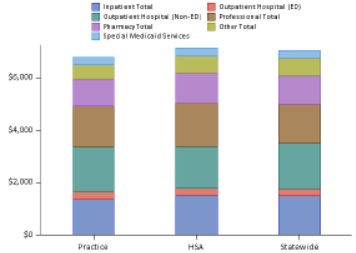


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

Total Expenditures Excluding SMS

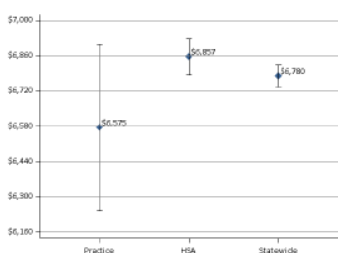


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medical Services, capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

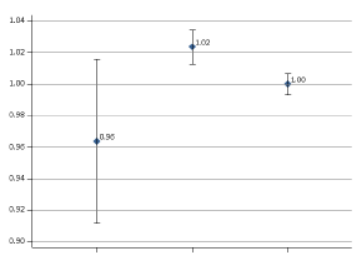
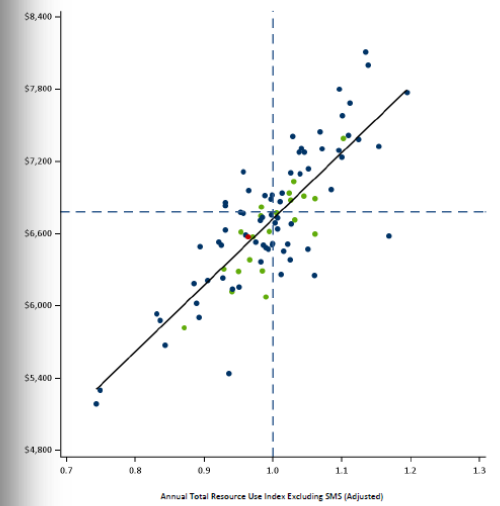


Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per resource varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects on aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medical Services. The practice and HSA are indexed to the statewide average (1.00).



Practice Profile: ABC Primary Care
Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)



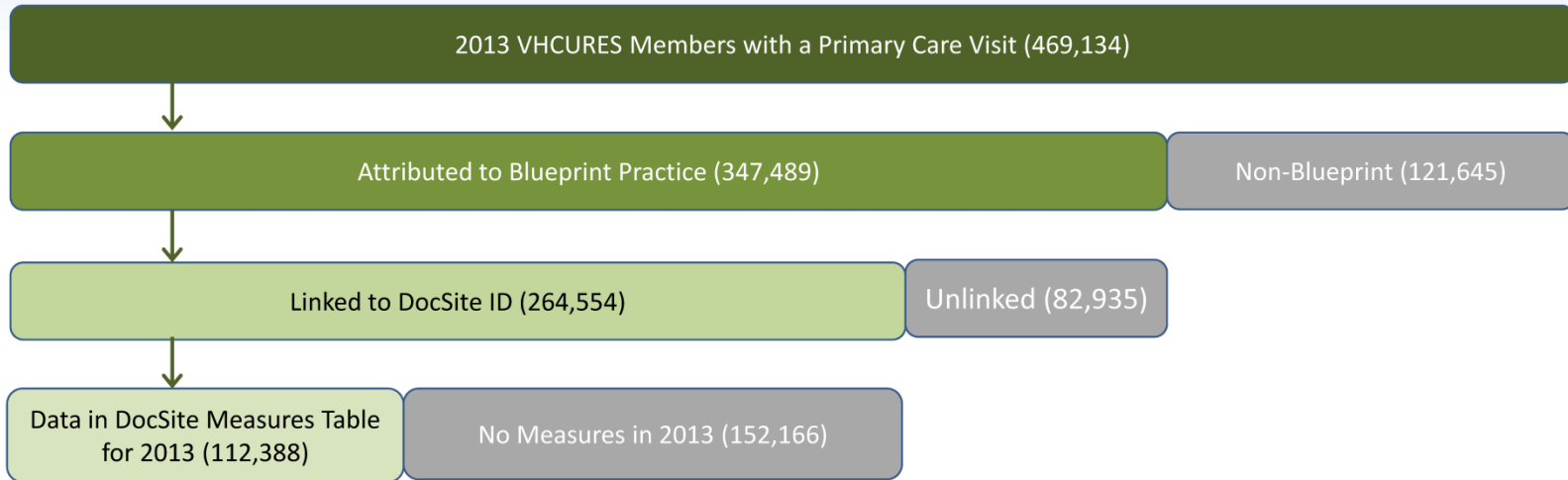
This graphic demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint practices (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI statewide (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand corner with lower expenditures and utilization are in the lower left-hand corner. An RUI value indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization. A trend line has been included in the graphic, which demonstrates that, in general, practices with a utilization had higher risk-adjusted expenditures.

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail

Linking Claims & Clinical Data

Enhancing Blueprint Reporting: Clinical Outcomes



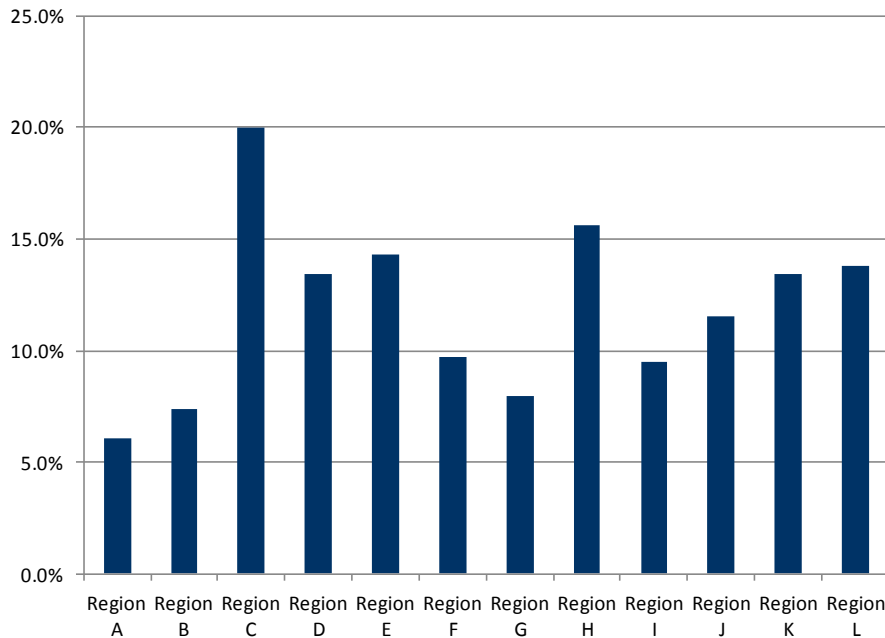
Examples of Patient Volume for Key Measures in 2013

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

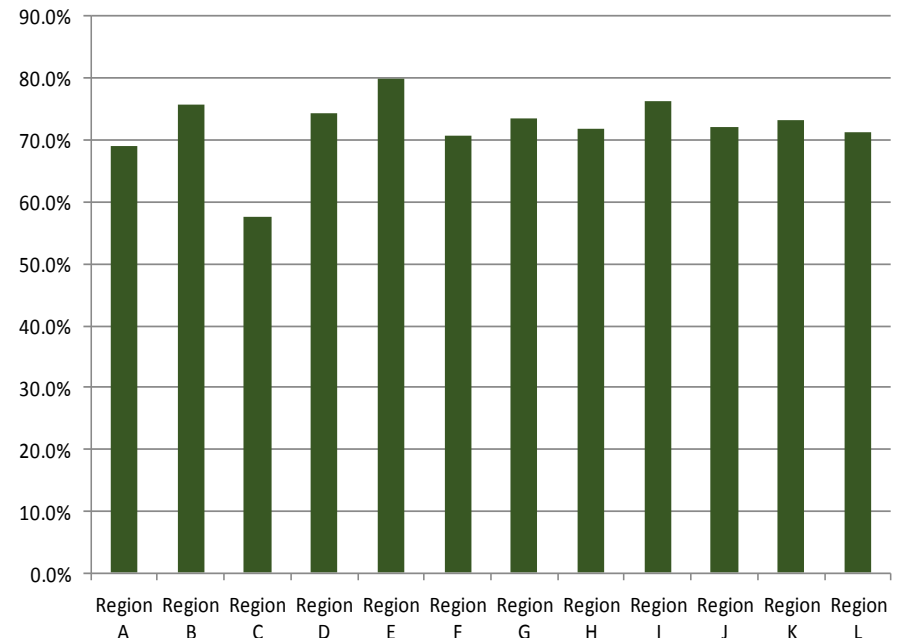
Linking Claims & Clinical Data

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