

Vermont Blueprint for Health
Integrated Health Services Program

MEMORANDUM OF UNDERSTANDING

For the two year period July 1, 2011 – June 30, 2013

“Stakeholders” in this Memorandum of Understanding (“MOU”) refers to the Vermont Blueprint for Health (“Blueprint”), the Department of Vermont Health Access (“DVHA”), Blue Cross Blue Shield of Vermont (“BCBSVT”), MVP Health Care (“MVP”), and CIGNA Health Insurance (“CIGNA”).

“Payers” in this MOU refers to DVHA, BCBSVT, MVP, and CIGNA.

“Blueprint-participating practices” refers to Advanced Primary Care Practices that have been recognized as patient-centered medical homes by the National Committee for Quality Assurance.

We, the undersigned parties to this MOU, in accordance with the following sections of Act 128 of 2010, affirm our commitment to our joint efforts in support of the integrated health services program adopted by the Blueprint Director and our support for the statewide expansion as advised by the Blueprint Expansion Design and Evaluation Committee:

Sec. 1. FINDINGS

...(13) ...Vermont’s health care reform efforts to date have included the Blueprint for Health, a vision, plan, and statewide partnership that strives to strengthen the primary care health care delivery and payment systems and create new community resources to keep Vermonters healthy. Expanding the Blueprint for Health statewide may result in a significant system wide savings in the future.

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

(1) ...All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time...

(3) Primary care must be preserved and enhanced so that Vermonters have care available to them; preferably, within their own communities.

Sec. 13. ...CHRONIC CARE INREASTRUCTURE AND PREVENTION MEASURES

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

...(c)(5) ...implementation of the Blueprint in Communities across the state should be accompanied by payment to providers sufficient to support care management activities consistent with the Blueprint, recognizing that interim or temporary payment measures may be necessary during early and transitional phases of implementation....

(d) The Blueprint for Health shall include the following initiatives: (1) Technical assistance...to implement: (A) a patient-centered medical home; (B) community health teams; and (C) a model for uniform payment for health services by health insurers, Medicaid, and Medicare if available, and other entities that encourage the use of the medical home and the community health teams.

§706. HEALTH INSURER PARTICIPATION

...(b) No later than January 1, 2011, health insurers shall participate in the Blueprint for Health as a condition of doing business in this state as provided for in this section and in 8 V.S.A. §4088h.

(c)(1) The Blueprint payment reform methodologies shall include per-person per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating the community health teams. Per-person per-month payments to practices shall be based on the official National Committee for Quality Assurance's Physician Practice Connections – Patient Centered Medical Homes (NCQA PPC-PCMH) score and shall be in addition to their normal fee-for-service or other payments.

Sec. 19. BLUEPRINT FOR HEALTH: EXPANSION

The commissioner of Vermont health access shall expand the Blueprint for Health, as described in chapter 13 of Title 18 to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013, to primary care practices statewide whose owners wish to participate.

I. Support for the integrated health services model includes the following elements, in accordance with AHS Bulletin 10-19 (Blueprint for Health Rules) and the Blueprint for Health Implementation Manual:

1. Providing financial support in monthly payments for Community Health Teams (“CHTs”). Table 1 outlines projected CHT patients, staffing and payments. All Payers will share in the cost of the CHTs; BCBSVT, CIGNA, and DVHA will each pay 22.22% of total CHT costs as outlined in Table 1 and MVP will pay 11.12% of total CHT costs as outlined in Table 1 for each Health Service Area (“HSA”). In addition, Medicare will pay 22.22% of total CHT costs as outlined in Table 1 for each HSA. There will be at least one CHT in each HSA to provide support services for the population of patients receiving their care in Blueprint Advanced Primary Care Practices. As the Blueprint expands to all willing primary care providers and the number of patients increases, the size of the CHT(s) in each HSA will be scaled up or down based on the number of patients in the Blueprint-participating practices that the CHT supports. The number of patients will consist of the number of unique Vermont patients in Blueprint-participating practices with one or more Evaluation & Management coded visits to the practices during the previous 24 months regardless of insurance coverage. Total payments for all Payers will occur at a rate of \$35,000.00 per year (\$8750.00 per quarter and \$2916.67 per month) per 2,000 patients attributed to Blueprint-participating practices in each HSA.

TABLE 1: Projected CHT Patients, Staffing and Payments, July 2011 - June 2013

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total 24 Months
	Jul-11	Oct-11	Jan-12	Apr-12	Jul-12	Oct-12	Jan-13	Apr-13	July 2011 - June 2013
Patients	250,081	316,662	360,044	409,422	458,801	508,179	540,418	572,657	N.A.
Core CHT \$	\$1,094,104	\$1,385,396	\$1,575,193	\$1,791,221	\$2,007,254	\$2,223,283	\$2,364,329	\$2,505,374	\$14,946,155
DVHA	\$243,110	\$307,835	\$350,008	\$398,009	\$446,012	\$494,014	\$525,354	\$556,694	\$3,321,036
Medicare	\$243,110	\$307,835	\$350,008	\$398,009	\$446,012	\$494,014	\$525,354	\$556,694	\$3,321,036
BCBSVT	\$243,110	\$307,835	\$350,008	\$398,009	\$446,012	\$494,014	\$525,354	\$556,694	\$3,321,036
CIGNA	\$243,110	\$307,835	\$350,008	\$398,009	\$446,012	\$494,014	\$525,354	\$556,694	\$3,321,036
MVP	\$121,664	\$154,056	\$175,161	\$199,184	\$223,207	\$247,229	\$262,913	\$278,598	\$1,662,012

Payments will be made monthly or quarterly, as determined by the Payer in conjunction with the Blueprint Director, upon receipt of an invoice sent by the CHT administrative entity to each payer on the first of the month (if an invoice is required by the Payer). Invoices will be prospective, reflecting CHT payments for the current month or quarter. Changes in the amount of financial support due to scaling up or down of CHT capacity will be made quarterly; will be reflected in the January, April, July and October invoices (if applicable) and payments; and will not be retroactive. The Blueprint will provide reports to Payers and CHT administrative entities reflecting changes in patient numbers and CHT scaling prior to the first day of each quarter. The information for these reports will be based on data provided by CHT administrative entities to the Blueprint.

Payments related to the initiation of a new CHT will begin on the first day of the month after (or on which) Payers receive information from the Blueprint indicating that practices have received their scores from VCHIP and/or achieved NCQA recognition and the CHT begins clinical operations. The amount of the payments will be based on the number of patients in Blueprint-participating practices. For payers making quarterly CHT payments, payment amounts will be pro-rated if a CHT begins clinical operations after the start of the quarter. Changes in payments related to scaling up or down of CHT capacity will begin on the first day of the quarter after (or on which) the number of patients in Blueprint-participating practices changes.

CHTs under the same administrative entity within an HSA that are geographically dispersed throughout the HSA or otherwise segmented will be treated as a single CHT for payment purposes, regardless of the CHT's capacity and the number of patients in Blueprint-participating practices. If there is more than one administrative entity in the HSA, the CHTs for each administrative entity will be treated as individual CHTs for payment purposes. In the event that there is more than one administrative entity, each practice in the HSA will be assigned to one CHT and one administrative entity; a practice will not be split between administrative entities and CHTs.

See Appendix A for a description of CHT scaling based on the number of patients in an HSA.

2. Providing financial support for enhanced provider payment to the participating practices. The per person per month ("PPPM") payment is designed to support the operations of a patient centered

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medical home and is based on each Blueprint-participating practice's National Committee for Quality Assurance Physician Practice Connections-Patient Centered Medical Home ("NCQA PPC-PCMH") score, as shown below in Table 2 (for practices scored according to 2008 NCQA Standards) and Table 3 (for practices scored according to 2011 NCQA Standards). Each Payer will provide the enhanced PPPM payment for all of their Vermont covered lives in a practice; covered lives are determined by a patient attribution methodology agreed to by the Blueprint Director, with input from the Expansion Design and Evaluation Work Group. Upon request of the practices or their parent organizations, or at the Payer's initiative, the proposed list of attributed patients will be provided for review and reconciliation if necessary. To calculate the total amount of the PPPM payment all Payers will conduct an attribution process to determine their number of unique covered lives that are active patients in each participating practice. The active patient population includes all eligible patients, as determined by the Payer in conjunction with the Payment Implementation Work Group and the Blueprint Director, with a visit to the practice (e.g. – an Evaluation & Management coded visit, any CPT coded visit, or a blend of the two) during a defined look back period. The look back period can range from 12 to 24 months as determined by each Payer. The attribution methodology must include patients of all ages (pediatric patients as well as patients over the age of 18). The total amount of the payment that each Payer makes to each Blueprint-participating practice each month is calculated as the number of unique patients that are attributed to the practice multiplied by the PPPM amount based on the practice's most recent applicable NCQA PPC-PCMH score (Tables 2 & 3).

Payment for newly-scored practices will be effective on the first of the month after the date that the Blueprint transmits NCQA PPC-PCMH scores from the Vermont Child Health Improvement Program ("VCHIP") to the Payers, and will initially be based on VCHIP scores. Changes in payment due to the subsequent receipt of NCQA scores, as well as for practices that are being re-scored, will occur on the first of the month after NCQA scores are received by Payers from the Blueprint. The PPPM payment schedules shown below and the attribution and payment methodologies are the current models generated in collaboration with the Payment Implementation Work Group, and approved by consensus by the Blueprint Expansion Design and Evaluation Committee. Practices must be re-scored every three years and may request an interim scoring evaluation, pending availability of VCHIP, but not more frequently than once every six months. The actual payments to specific practices will be based on their most recent scores.

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Table 2: Enhanced Provider Payment based on 2008 NCQA Standards (\$ PPPM for each provider)

NCQA PPC-PCMH Score, in Points	Average PPPM Payment (in \$)
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	1.20
30	1.28
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Requires 5 of 10 must pass elements.

Requires 10 of 10 must pass elements.

Table 3: Enhanced Provider Payment based on 2011 NCQA Standards (\$ PPPM for each provider)

NCQA PPC-PCMH Score, in Points	Average PPPM Payment (in \$)
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	0.00
30	0.00
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Requires 6 of 6 must pass elements.

3. Providing claims data on an ongoing basis to the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) consistent with the format of the multi-payer claims data base called the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES).

4. Full participation in the Blueprint Integrated Health Services Program design, implementation, and evaluation activities in accordance with sections of Act 128 of 2010, AHS Bulletin 10-19 (Blueprint for Health Rules) and the Blueprint for Health Implementation Manual.

II. Period of Agreement and Modification

This MOU is effective July 1, 2011 and will remain current through June 30, 2013. The MOU may be renewed biennially. No changes, modifications, or amendments in the terms and conditions of this MOU shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of all Stakeholders.

III. Stakeholder Signatures

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS MOU:

Dated this 4th day of August, 2011

Print Name: Craig Jones

Title: Director of Blueprint

Signature: 
Authorized Agent of the Blueprint for Health

Dated this 4th day of August, 2011

Print Name: Lori Collins

Title: _____

Signature: 
Commissioner or Designee, Vermont Department of Health Access

Dated this 8th day of August, 2011

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Dated this _____ day of _____, 2011

Print Name: _____

Title: _____

Signature: _____

Authorized Agent of Blue Cross Blue Shield of Vermont

Dated this August 10, 2011 day of _____, 2011

Print Name: DONALD M. CURRY

Title: President, General Manager New England.

Signature: Donald M. Curry

Authorized Agent of CIGNA Health Insurance

Dated this _____ day of _____, 2011

Print Name: _____

Title: _____

Signature: _____

Authorized Agent of MVP Health Care

Print Name: D O N C . G E O R G E

Title: P R E S I D E N T & C E O

Signature: *D. C. George*
Authorized Agent of Blue Cross Blue Shield of Vermont

Dated this _____ day of _____, 2011

Print Name: _____

Title: _____

Signature: _____
Authorized Agent of CIGNA Health Insurance



Dated this 4th day of AUGUST , 2011

Print Name: W I L L I A M V . L I T T L E

Title: V P V E R M O N T

Signature: *William V. Little*
Authorized Agent of MVP Health Care

APPENDIX A

CHT Scaling Based on Number of Patients

Principle: Community Health Teams (CHTs) should grow as Blueprint practices are added. Funding from public and private insurers is provided to CHT administrative entities according to a pro-rata calculation that is based on the number of patients in Blueprint-participating practices. The pro-rata calculation is shown in the following table:

Number of Patients Attributed to	Total (All Public and Major Commercial)
12,000	\$210,000
14,000	\$245,000
16,000	\$280,000
18,000	\$315,000
20,000	\$350,000

A CHT administrative entity will be entitled to additional funding when the number of patients attributed to Blueprint-participating practices reaches the number associated with the increased funding level. For administrative entities with more than 20,000 patients, funding will be increased at the rate of \$35,000 for every 2,000 patients.