

Blueprint Payment Implementation In-Person Work Group Meeting

June 24, 2013

Gifford Medical Center, Randolph

Minutes

Attendees: Candace Collins (St. Albans HSA), Elise McKenna (Morrisville HSA), Wendy Cornwell (Brattleboro HSA), Mark Young (Barre HSA), Kaylie Chaffee (Springfield HSA), Loral Ruggles (St. Johnsbury HSA), LaRae Francis (Randolph HSA), Scott Frey (BCBSVT), Pam Biron (BCBSVT), Pat Jones (GMCB), Nick Lovejoy (DVHA), Lisa Dulsky Watkins (DVHA), Connie Schutz (DVHA), Barbara Liberty (Middlebury HSA), Robyn Skiff (Burlington HSA), Lou McLaren (MVP), David Brace (CHSLV)
Attendees via phone: Kevin Ciechon (CIGNA), Roberta Gilmore (FAHC), Jenney Samuelson (DVHA)

CMS and CHT updates

- * 3 year demo, ends July 2014, however CMS hints at positive outcome.
- * Blueprint will continue with or without Medicare funding
- * SASH has the most to lose
- * As of June 2013, 113 practices recognized staffed by 588 providers (not FTEs) serving 458,437 unique patients, 105.9 CHT FTE positions
- * Some primary care practices have opted not to be involved

Attribution algorithm

- * CMS will be adding two new care transition codes 99495 and 99496 to their attribution algorithm. These codes are for non-face-to-face encounters, broadening the definition of interaction with patients
- * This may not affect total attribution numbers as they are linked to an E&M coded visit occurring within 7-14 days
- * Commercial insurers to bring codes back to their colleagues to see if they want to include these codes in their algorithm.

Insurer no cost contract

- * Changing the expiring MOU to a no-cost contract, currently routing at the Agency of Human Services/Agency of Administration with anticipated execution date of July 1, 2013
- * Continues to view CHT as a shared utility
- * Changed the percentages of CHT funding paid by some of the payers to reflect market share changes as follows:
 - Cigna 18.22%
 - BCBSVT 24.22%
 - Medicare 22.22%

Medicaid 24.22%

MVP 11.12%

Other payment reform activities

GMCB

- * SIM Grant = funding to test payment reform models, 5 or 6 states got these grants.
- * Shared savings
 - * 2 ACOs here in Vermont, OneCare (FAHC and Dartmouth) and Accountable Care of the Green

Mountains

- * Looking to get a commercial (BCBSVT and MVP) and Medicaid ACO using exchange
 - * Begin Jan '14
 - * Blueprint is a major driving force for the creation and effective implementation of ACOs
- * Bundled payments
 - * CHF and COPD
- * Pay for performance
 - * Blueprint through PPSM payments.
 - * Most mature aspect of reform in terms of payment and delivery system in state.
- * Evaluation of payment reform relies on solid Health Information Exchange.
- * How do all the ACOs align with single payer?
 - * GMCB is trying to align measures and evaluation among ACOs. The exchange will be a singular means for evaluation.
- * GMCB is creating a process for submitting applications for projects

CHIPRA grant

- * Accelerated implementation of Blueprint in pediatric practices with salary support for practice facilitation, with several dozen peds practices either recognized by blueprint or in queue.

Hub and Spoke

- * "Perfect storm" of increasing rates of dependency, poor outcomes, high expenditures, difficult population to manage clinically
 - * Creating a "health home" with DVHA and ADAP,
 - * Hubs = specialized addictions treatment centers (methadone and buprenorphine)
 - * Deal with complex/ co-occurring conditions
 - * Access to health and human services
 - * Make use of NCQA specialty standards
 - * Spokes = counseling and support services in the primary care sites
 - * Community based
 - * Physicians can prescribe buprenorphine in the spokes or hubs
 - * Use learning collaboratives
 - * Phase 1 is "west coast" rolled out Jan '13
 - * Big outreach already in phase 1

- * Enhancing the size and scope of the CHT

Question was posed about commercial payer support for Hub and Spoke activity

- * Lou: Commercial insurers already pay into similar programs and per existing opioid treatment centers

- * Laural: everyone is going to get this service, just not everyone will be paid for. Question is why are we now creating these more siloed programs, when Blueprint started out with broad access

- * Lou: MVP paying significantly now, but states that she has not seen how many MVP beneficiaries the CHT in the HSAs have been touched. She suggested that some of this funding could be redirected towards other services. Commercial insurers are limited in what they can create a premium around. Social services like finding a job cannot be included in a premium.

- * BCBSVT has begun looking at coding guidelines for Hub billing.

***send out requests for total unique patients along with requests for changes to rosters. Include a deadline. Send all changes along with VCHIP score, (1st day of the second month of the quarter)

Action items:

1. Lisa to email 2014 standards with comment opportunity link out to group - done
2. Lisa to send out AAFP worksheet to group – done
3. Future update planning - send out requests for total unique patients along with requests for changes to rosters. Include a deadline. Send all changes along with VCHIP score, (1st day of the second month of the quarter)