

## Blueprint Expansion Design and Evaluation Committee Meeting Minutes of February, 8, 2011

**Present:** T. Bequette, P. Biron, Peter Cobb, K. Cooney, S. Fine, A. Garland, C. Jones, P. Jones, L. Leu, S. Maier, J. McDaniel, L. McLaren, R. Messier, S. Narkewicz, L. Ruggles, N. Sarkar, M. Scholten, J. Shaw, K. Simmons, R. Slusky, K. Smith, B. Tanzman, L. Watkins

### I. Expansion and MAPCP Updates:

- Dr. Watkins introduced Beth Tanzman, newly hired Blueprint Assistant Director. Beth will focus on Behavioral Health issues in the HSA's.
- Dr. Watkins attended the Multi-State Collaborative meeting and the CMS Demonstration meeting in Washington last week.
- Multi-State Collaborative has been focusing on common metrics and common methodologies.
- CMS Demonstration Update:
  - 8 States have been selected to participate in the CMS demonstration.
  - These 8 states are members of the Multi-State Collaborative group as well as 4 others.
  - The most important discussion of the meeting revolved around the evaluation of each states program.
  - Payment start date is not firm. Internal operations won't be ready until at least July, 2011 and an October date is more likely. CMS will consider making retroactive payments but that is still under discussion
  - We continue to attend Bi-weekly calls with CMS. CMS has requested to work with only one contact person from each state. They will not work with multiple project managers. CMS has also added a VT only monthly call.
  - CMS is trying to have an automated mechanism to determine number of patients. Medicare will not pay for those patients who do not live in Vermont
  - CMS will have a process for making PMPM payments. The line of payment to support the CHT's will probably go to each hospital service area.
  - We are currently working on the design of the SASH payments.
- The anticipated expansion timeline table of all hospital services areas can be located in the 2010 Blueprint Annual report. (Table 1 Page 14)

- Pediatric Practices Expansion: Three pediatric practices are preparing for scoring immediately. Anticipated completion date for scoring is March 1 for these three.
- Primary care does include OB/GYN, however OB/GYN practices do need to meet the NCQA standards, for example in St. Johnsbury the OB/GYN's could technically be NCQA recognized except for the fact that they do not treat asthma. Dr. Jones stated that he would explore how other states are handling the OB/GYN dilemma.
- BCBS currently does not recognize OB/GYN as primary care. This is not a straight forward issued and BCBS has offered to participate in further discussions to flush this out.
- The new NCQA medical home standards have been released. The new standards must be used for those practices that purchase the survey starting in March. Those sites being scored now can continue using the old standards. We will continue to follow the NCQA timeline standards and payments will be made whether or not a practice is using the old or new standards.
- Practice facilitators have completed their initial training. A new practice facilitator has now been hired for the Rutland region and will also be trained.
- On March 14, Dr. Tom Bodenheimer will be conducting a full day session on integrating multi-disciplinary teams in primary care practices with a focus on self-management support. We are asking Practice Facilitators, Project Managers, Practice Staff and anyone else who might benefit to take advantage of this wonderful opportunity. Dr. Bodenheimer has extraordinary experience in team based care at the practice level. Our practices really need to focus on same day care access.

## II. Community Health Team Payment Strategy:

- Our three pilot sites were required to have at least 20,000 patients for each HSA and an initial Community Health Team of 5 FTE's.
- Our goal is to make the CHT teams as strong as possible at start up.
- In principle the Community Health Teams should grow. As the Blueprint practices are expanded, additional CHT staff should be added to practices that serve less than 20,000 patients based upon an agreed upon pro-rata calculation.
- Payments for the CHTs should go to the administrative entity in each HSA.
- We will share contact information of the administrative entity for each HSA.
- It was agreed that Quarterly payment adjustments for the CHTs seemed reasonable.
- Reminder: We are looking at total population of VERMONT patients only. Medicare will not pay for patients who do not live in Vermont. There was a lengthy discussion about how to segregate / best identify Vermont patients vs. across the border patients. Do practices know in what state a patients insurance has been purchased? Would a reasonable definition be to include only those patients who have been seen in a practice within the last two years and who carry insurance issued by a Vermont employer? More detailed work is still needed to sort this out. We need to poll the practices about how they segregate by insurer. Dian Kahn at BISHCA will look into obtaining "border" information, both

incoming and outgoing. Andrew Garland feels that we should concentrate on getting the practices up and running and then refine the specific mechanics.

- Current MOU agreements with our Insurers need to be revisited. These need to be modified in accordance to ACT 128.
- The money that comes from our insurers covers the core community health teams only. They do not cover Home Health Care, or other related services. The premise is that having the CHT's in place should translate into better coordination and more referrals for Home Health and other organizations.
- The current ratio is 1 FTE per 4,000 patients or \$350,000 for 5 FTE's. The dollar amount can go up or down on a unit basis. We will calculate patient numbers to FTE's and send out a proposed CHT Payment Formula with number and dollar estimates for review.

### III. Evaluation Discussion – Early Trends (2010 Annual Report) and Data Sources:

- Early trends are described in the 2010 Blueprint Annual Report. We focused on early trends in utilization/expenditures as well as extensive focus on quality, and clinical process. The table on page 22 of the report lays out the different data sources needed to get to a multi level infrastructure. Dr. Jones thanked the pilot project managers for making the utilization data available to us, the Jeffords Institute for working with that data and VCHIP for their outstanding chart review work.
- The early utilization trends are pointing in a similar direction from all of our different sources.
- Please go to [http://hcr.vermont.gov/blueprint\\_for\\_health](http://hcr.vermont.gov/blueprint_for_health) for on-line access to the Annual Report. Early trends in hospital inpatient admissions & emergency department visits begin on Page 25. Initial trends indicate that those who used the CHTs had a greater rate of change from the general population.
- Reminder: The data only includes patients actually seen in a practice since the start of the pilot with a 4 year period look back. This is not a controlled comparison.
- An analytic workgroup will be meeting on a monthly basis to continue this work.

With no further business, the meeting adjourned at 10:35 a.m. The next scheduled meeting will be on:

April 12<sup>th</sup>  
8:30 – 10:30 a.m.  
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Williston