

**Minutes: Vermont Blueprint for Health Payment Implementation Workgroup**

**July 12, 2011, 1:00 PM**

**Attendees:**

<b>Name</b>	<b>Organization</b>
Jenney Samuelson	DVHA - Blueprint
Pat Jones	Blueprint
Laura Hubbell	Central Vermont Medical Center
Crystal Thibodeau	Mt. Ascutney Hospital
Anthony Otis	Vermont Chiropractic Association
Katherine West	DVHA
Brenda Metivier	DVHA
Dana Noble	United Health Alliance
Sarah Narkewicz	Rutland Regional Medical Center
Julie Riffon	North Country Hospital
Maria Webb	Brattleboro Memorial Hospital
Jean Cotner	Porter Hospital
Laural Ruggles	Northeastern Vermont Regional Hospital
Tracey Paul	North Country Hospital
Elise McKenna	Community Health Services of Lamoille Valley
LaRae Francis	Gifford Hospital
Nancy Thibodeau	Springfield Health System
Beth Steckel	Fletcher Allen Health Care
Lou McLaren	MVP
Chrissie Racicot	HP
Carol Cowan	BCBSVT
Pam Biron	BCBSVT
Scott Frey	BCBSVT

## **Roster Template Revision**

The most recent version of the roster template was distributed. The NCQA number will no longer be needed, so it is not included in the template. The template will be posted on the Blueprint website so that project managers can have ready access to the most recent version.

## **Remaining CMS Information Needs**

CMS is testing files; Pat is communicating remaining issues to project managers.

## **Status of MOU**

The MOU is being sent to payers for signature; verbal agreement has been achieved. The MOU needs to be circulated sequentially; which will take some time. It will be effective on July 1, 2011.

## **CHT Payment Tables**

Pat sent the tables with CHT payments to payers and project managers for review. The payment levels are based on the terms of the MOU. No disparities or issues were reported. Lou McLaren reminded the group that CHT payments are prospective under the new MOU. As a result, invoices should be for the following months rather than the preceding months. Elise asked for clarification on which payers need invoices for CHT payments – currently it is CIGNA, MVP and Medicaid. Medicaid is moving toward having no invoice. Medicare and BCBSVT do not require invoices. Beth asked if the MOU would be provided to project managers. Pat indicated that she would circulate the document. Beth also asked if the payment methodology grid would be updated; Pat said that it would be updated once the MOU is signed. Jean recommended that the grid be posted on the website so that project managers can access the most recent version.

## **Question Regarding CHTs Working with ER Patients**

Elise had asked after the last meeting whether CHTs could follow up on patients seen in the ER who do not have a primary care provider (PCP), or who do not have a PCP in one of the Blueprint-participating practices. Elise described some scenarios to the group when it might be helpful for the CHT to become involved – e.g. – patients who present in the ER but who don't have a PCP to offer follow up care; patients who are not patients in Blueprint-participating practices using the ER for primary care. The payers expressed some discomfort with CHTs serving patients from non-participating practices. Pat suggested that the issue be discussed further at a future project managers' meeting.

## **HIPAA Question**

Sarah Narkewicz had asked if the payers have language in their contracts that members sign that allows for the sharing of health information with the Community Health Team. This could be covered in language related to care coordination and/or case management that has been provided

by outside vendors. It could also be covered in the agreements the payers have with the provider offices. Her hospital needs to know if it needs to change the HIPAA form that all patients sign to cover the sharing of health information with the CHT. Pat asked the payers to provide feedback via e-mail on this question after the meeting.

### **Questions Regarding Per Diem and Temporary Providers**

Project managers had previously asked whether there need to be roster updates for temporary hires (e.g. – to cover maternity leaves), and when roster updates should occur for new providers - when they are credentialed or when they are hired. There was also a discussion of whether to list per diem providers on the rosters; payers suggested that it depends on how they are contracted and whether they are marketed as participating providers. The group agreed that providers would become active upon credentialing rather than upon hiring. Project managers won't know when providers are credentialed and the timing will vary according to payer. The group agreed that it made the most sense for project managers to add providers to rosters when they are hired, with the understanding that payment won't occur until the provider is credentialed. Payers are in the best position to track when credentialing has occurred.

In terms of per diem or temporary providers, the insurers reported that if these providers aren't advertised as PCPs, they aren't listed as such. Dana provided an example of a practice that hired two physicians to provide urgent care when a physician left the practice; the two interim physicians will leave when a new physician is hired. Lou said that how billing occurs will impact the situation; if the temporary physicians aren't credentialed, they will not generate PPPM payments. She also indicated that MVP continues providers for 12 months after they have left a practice. Pat asked whether there was any harm in listing per diem providers; in the worst case scenario, they will be listed but not credentialed so there would be no payments made. BCBSVT said that there would be an administrative burden associated with that approach; the group then discussed having project managers determine whether a provider was seeking credentialing and if not, to exclude them from the roster. Beth reported that FAHC practices generally include only those per diem providers who are carrying a patient caseload.

The group then engaged in a discussion of whether the providers needed to be marketed as PCPs well as credentialed. Pat pointed out that insurers have products that do not require the selection of a PCP (e.g. - non-HMOs); as a result, attribution methodologies could result in providers who aren't marketed as PCPs having non-HMO patients attributed to them. The group agreed to think about this issue in greater detail for the next meeting. Beth offered to e-mail MVP a list of per diem providers.

### **Other business**

The next meeting is August 9 by phone, beginning at 1:00 PM. Beth suggested that a discussion about self-insured patients occur at the next meeting.