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Department of Vermont
Health Access

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Women's Health Initiative: MEAB

March 27, 2017

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Smart choices. Powerful tools.

The Big Goal:

Integrated health system able to achieve the Triple Aim

- ✓ Improve patient experience of care
- ✓ Improve the health of populations
- ✓ Reduce per capita cost growth

VT All-Payer Model Agreement

Vermont's contract with CMS to enable ACO Based Reform

CMS provides payment flexibility and local control in exchange for meeting quality, financial, and scale targets and alignment across payers

Sets forth planning milestones for future integration

VT Medicaid Next Generation ACO Pilot Program

The Medicaid component of the All-Payer Model

Program provisions are designed to align with Medicare Next Generation program as much as possible.

Platform for future ACO-based innovation

Healthier Women, Children, and Families

- In Vermont, 50% of all pregnancies are unintended
- Unintended pregnancies = increased risk, including:
  - Poor health outcomes for mothers and babies
  - Long-term negative consequences for health and well-being of children, including adverse childhood experiences (ACEs)
- Counseling and health interventions for women who intend to become pregnant can help lower risks, for example smoking cessation counseling and treatment for alcohol and substance abuse/use
- Healthy Vermonters 2020 goal for pregnancy intention is 65%

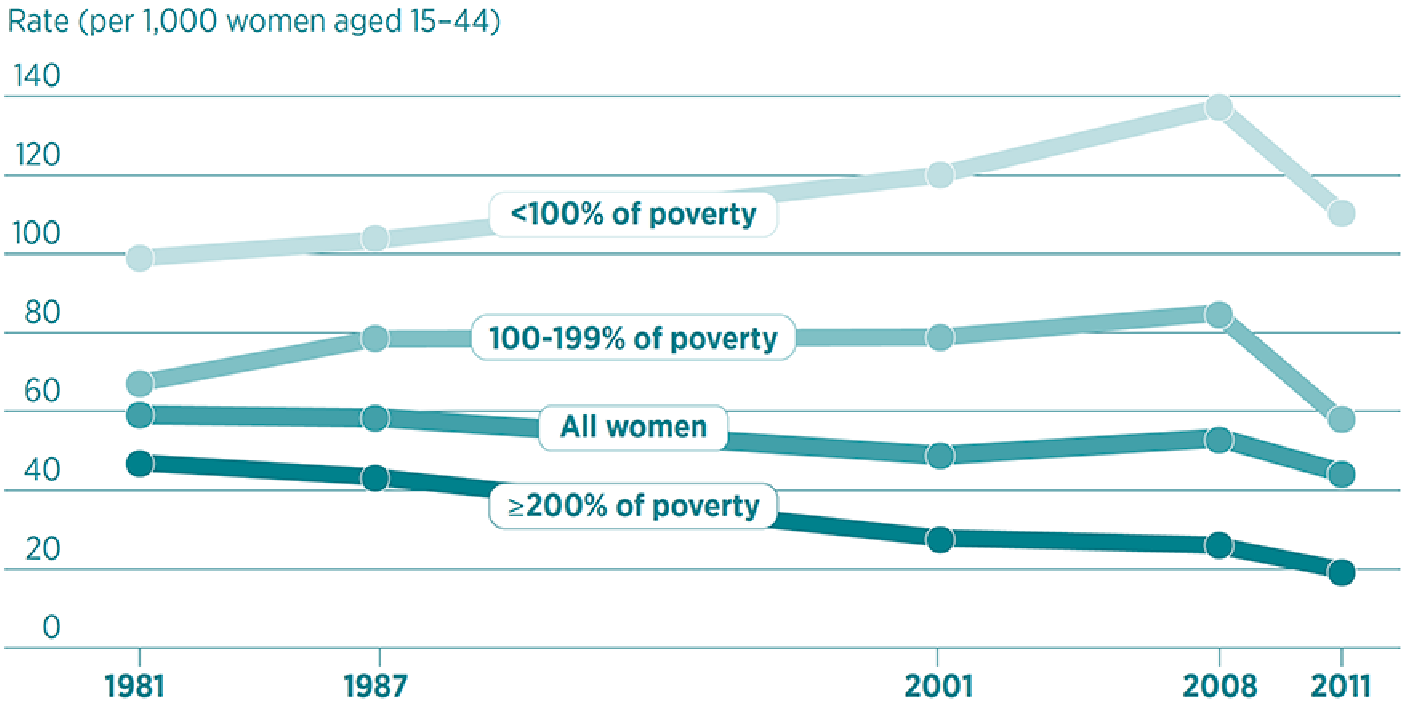
Women's Health Initiative Program Overview

- Many women receive majority of their health care at OB-GYN and women's health clinics
- In these settings, this initiative will allow for:
  - Enhanced health and psychosocial screening
  - Comprehensive family planning counseling
  - Timely access to long-acting reversible contraception (LARC)
- By offering:
  - New staff (supplemental CHT social workers)
  - Practice support (learning collaboratives & practice facilitators)
  - Payments (for practices participating in the initiative)

Disparities in Unintended Pregnancy in US

UNINTENDED PREGNANCY RATES

Between 1981 and 2011, unintended pregnancy has become increasingly concentrated among poor and low-income women.



www.guttmacher.org

Community Participation

- Form a coalition of diverse organizations including medical practices
- Identify and include organizations working with youth and women at risk
- Incorporate family planning counseling and screening for primary care into existing services of community organizations where relevant
- Community organizations act as navigators for their clients
- Create referral pathways between community organizations and health care providers that ensures immediate follow-up
- Update knowledge of providers and community on LARC
- Leverage social networks for community education

Practices and Communities Started on January 1

- The initiative is dependent on participation of both women's health practices and community organizations
- 14 practices started January 1, 2017 including hospital owned, independent, FQHC, and Planned Parenthood of Northern New England. Practices who are interested will join quarterly in 2017.
- January 1, 2017 represent 9 Health Service Areas (geographic regions)
  - Barre
  - Bennington
  - Burlington
  - Middlebury
  - Morrisville
  - Newport
  - Rutland
  - St. Albans
  - St. Johnsbury

Eligibility

- Practices:
  - Gynecology, maternal fetal medicine, obstetric, reproductive health, or family planning medical practice, specializing in providing women's preventive services as defined by the American Congress of Obstetricians and Gynecologists.
  - Mixed specialty medical practice with board certified obstetric or gynecology providers whose primary scope of services is women's preventive services as defined by the American Congress of Obstetricians and Gynecologists.
- Providers:
  - Physicians (MD, DO)
  - Advance Practice Registered Nurses (NP, CNM, APRN)
  - Physician Assistants

Practices - Screening and Referrals

- Psychosocial screening

  Within the first 3 months:
  - Depression
  - Current intimate partner violence and adverse childhood experience
  - Substance abuse

  Within the first 18 months
  - Access to primary care/patient centered medical home (PCMH)
  - Food insecurity
  - Housing stability
- Onsite availability of the full spectrum of LARC within 1 month
- Efficacy-based, comprehensive family planning counseling within the first 3 months
- Same-day insertion within 6 months
- Agreements with community based organizations to see patients within 1 week at which time they will provide same-day availability for full spectrum of birth control options within first year at least 3 agreements
- Agreement with PCMHs to accept patients who are identified without a primary care provider within first year at least 3 agreements

Payment

- Through the payments mental health clinicians through the Blueprint Community Health Teams will be available in Women's Health Practices for follow-up, brief intervention and referral.
- Long Acting Reversible Contraception will be available on-site.
- Three forms of payment:
  - WHI Practice Per Person Per Month - an ongoing payment to support enhanced care and screening
  - WHI CHT Payment – supports 1 FTE mental health clinician per every 1200 attributed beneficiary for brief intervention and referral
  - WHI Capacity Payment – on-time initial funding to help practices cover the costs of initially implementing the program including stocking LARC

Payment

- Payments to women's health providers (PCMH not eligible)
- Payment tied to implementing screening and referrals
- Medicaid payments only to start, but other insurers/payers invited to join
- Use a 24-month lookback period for the claims-based attribution
- De-duplicated by WHI practices with patients attributed to the practice that has provided the majority of services during the 24 month look back, with attribution going toward the most recent provider if there is the same number of visits to two or more providers

Practice PMPM & CHT Payments

Practices

- Year 1 - $1.25 PMPM payment for the population of Medicaid-enrolled reproductive-age women (age 15 to 44)
- Year 2 – Up to $1.50
  $1 base and $0.50 performance component)

CHT

- CHT mental health clinicians will be available in practices for brief intervention and follow-up
- $5.42 PMPM

Capacity Payments

Provide an initial one-time capacity payment scaled based on attribution

- Graduated rates based on whether a practice is 340B eligible
- Includes a floor based minimum expectation of LARCs stocked
- Creates a ceiling of 8 of each device for larger practices

340B Eligible Practices

PMP - $4.42
Floor – $927
Ceiling – $5,163

Non-340B Eligible Practices

PMP - $11.87
Floor – $3,387
Ceiling – $16,184

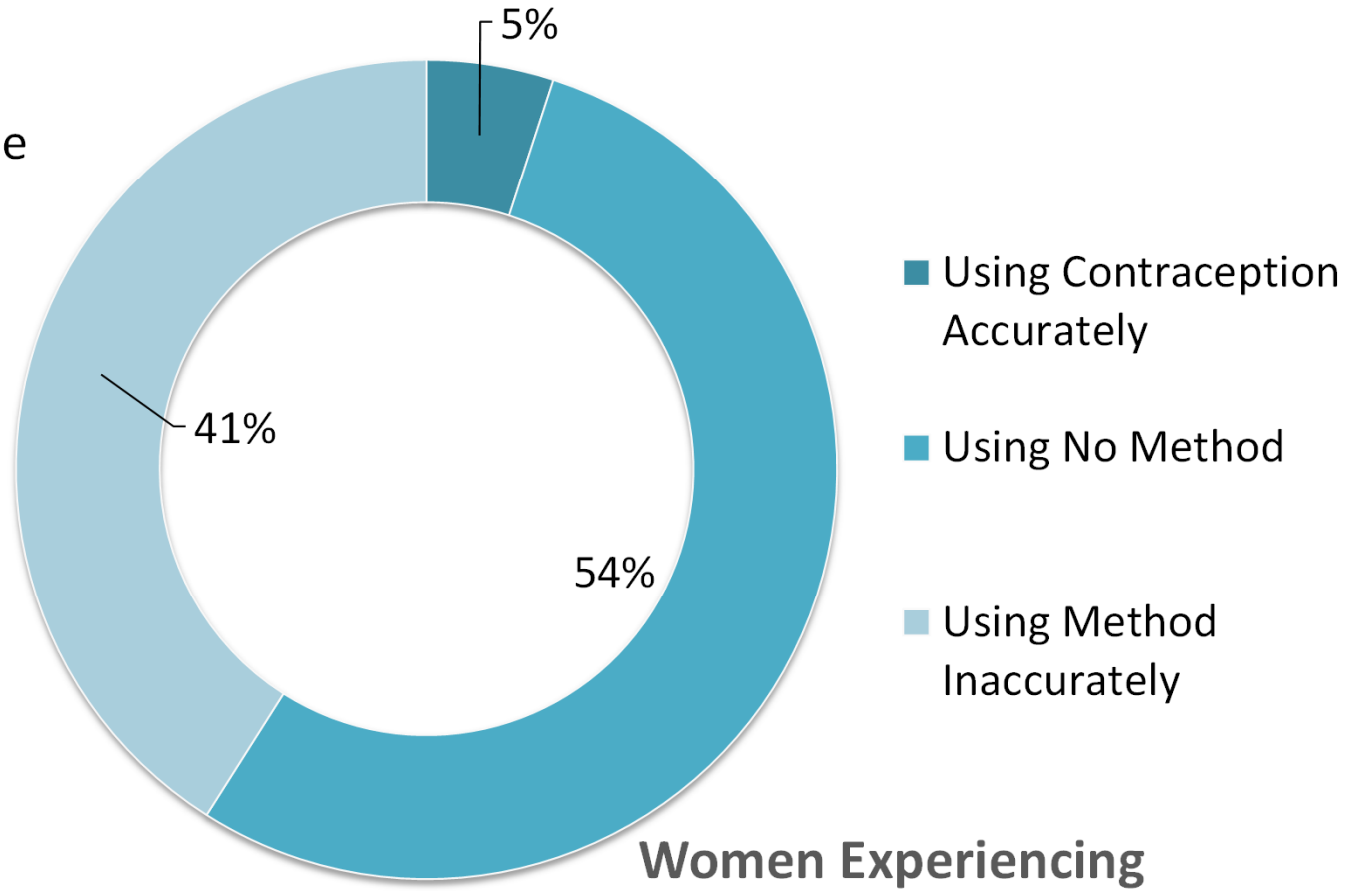
Innovation at AHS

- Goal to align innovation at AHS between AHS Central Office, Blueprint, and across the departments.

- Leveraging Blueprint to align Medicaid's reimbursements with innovation.
  - Women's Health Initiative
  - Act 120 mandate to create a value based payment for LARCs
    - PPNNE issue
    - Aligning efforts going forward
  - Can we make the connections?

Why LARC Matters

A significant portion of women experience intended pregnancy are using birth control



Women Experiencing Unintended Pregnancy

Questions