MEDICAID PATHWAY REPORT

TO THE GREEN MOUNTAIN CARE BOARD

DECEMBER 8, 2016

VERMONT
HEALTH CARE REFORM

Agenda:

- The big goal
- Medicaid Pathway: How did this come about?
- What happened?
- Where are we now?
- Decision points for next admin
- GMCB questions

VERMONT
HEALTH CARE REFORM

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

Global Commitment Medicaid Waiver

Vermont's contract for how Medicaid will be administered

Allows Medicaid to participate in APM and pursue delivery system reform

Delivery System Reform (DSR) investment to fund future innovation that will help Vermont integrate and succeed with the APM Agreement

Creating an Integrated Health System

- Strategic choice by Administration and GMCB to move away from fee-for-service payment system.
  - Payment reform is moving away from fee-for-service nationally.
    - Medicare is making this transition through the Medicare Access and CHIP Reauthorization Act (MACRA), which starts in 2017. MACRA requires clinicians who bill Medicare to participate in either the Merit-Based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (Vermont's APM falls into this group).
    - Hundreds[1] of Large Employers and commercial insurance carriers are also shifting through their own programs.
    - Medicaid agency innovation is the top innovation effort nationwide (according to NAMD).

- *Key Question: How do you implement that payment reform?*

1. https://hcp-lan.org/about-us/committed-partners/

Why Pay Differently Than Fee-for-Service?

- Health care cost growth is not sustainable.

- Health care needs have evolved since the fee-for-service system was established more than fifty years ago.
    - More people are living today with multiple chronic conditions.
    - CDC reports that treating chronic conditions accounts for 86% of our health care costs.

- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health.
    - Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

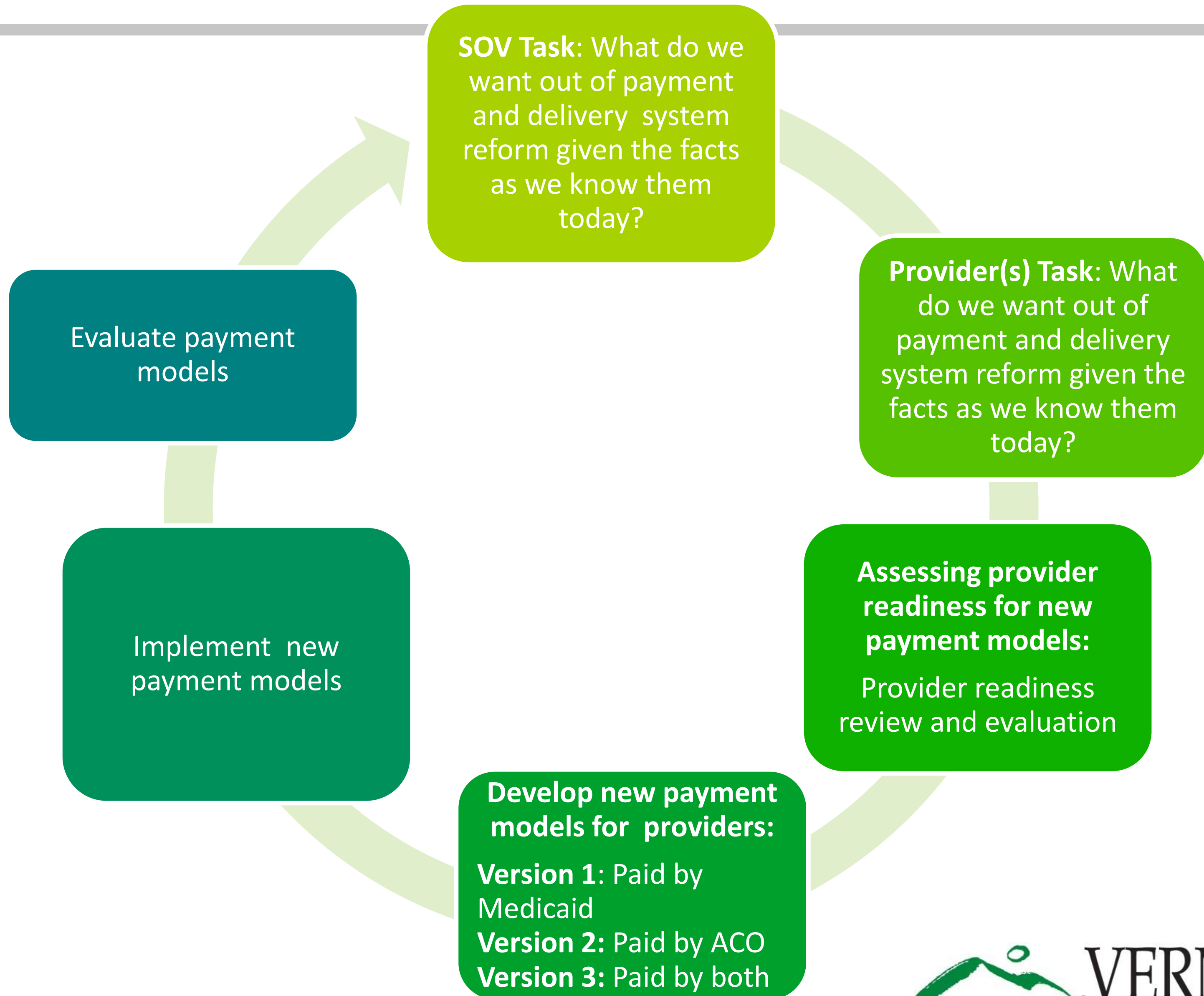
VERMONT
HEALTH CARE REFORM

MEDICAID PATHWAY: HOW DID THIS COME ABOUT?

Medicaid Pathway

- The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the total cost of care of Vermont's All-Payer Model.
- The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles to support a more integrated system of care for all Vermonters.
- The first services under review within the Medicaid Pathway are:
  - Cohort 1: Those provided by Designated and Specialized Service Agencies (mental health, substance use disorder treatment, and developmental disability services).
  - Cohort 2: Those provided by Long-Term Services and Supports Providers through the Choices for Care program (including Nursing Facility, Residential Care/Assisted Living, Home Health, AAA, Adult Day); primary focus on Home and Community Based Services.
  - *Hypothesis: We can do better in Medicaid.*

Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle



VERMONT
HEALTH CARE REFORM

Process to date:

- Convening Stakeholder Groups for each cohort.
- Convening State Staff for each cohort.
- Contractors developed a financial model upon which we can build a new payment structure.
  - Ongoing vetting of the data.
- Release of Information Gathering Document for Feedback.

VERMONT HEALTH CARE REFORM

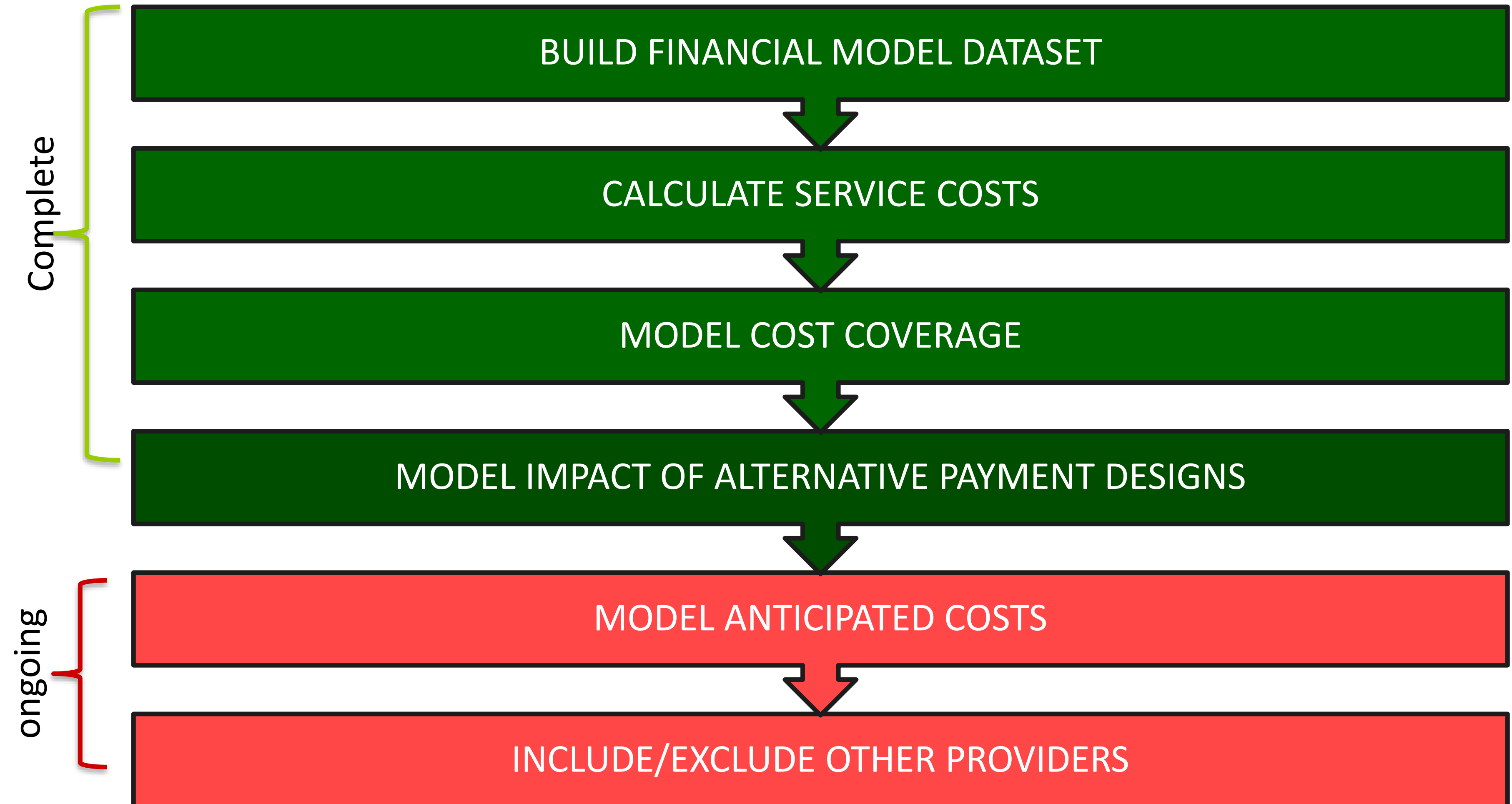
The activities have included:

- Discussion of the Vermont Model of Care and how these providers can/do meet the Model of Care.
- Identification of services that could be included in the first phase of reforms (this is iterative and ongoing).
- Discussion of the organization of the delivery system and governance requirements.
- Discussion of a quality framework.
- Identification of manuals, regulations, State operations issues to determine feasibility of reforms.
- Identification of provider-specific operations issues to determine feasibility of reforms.

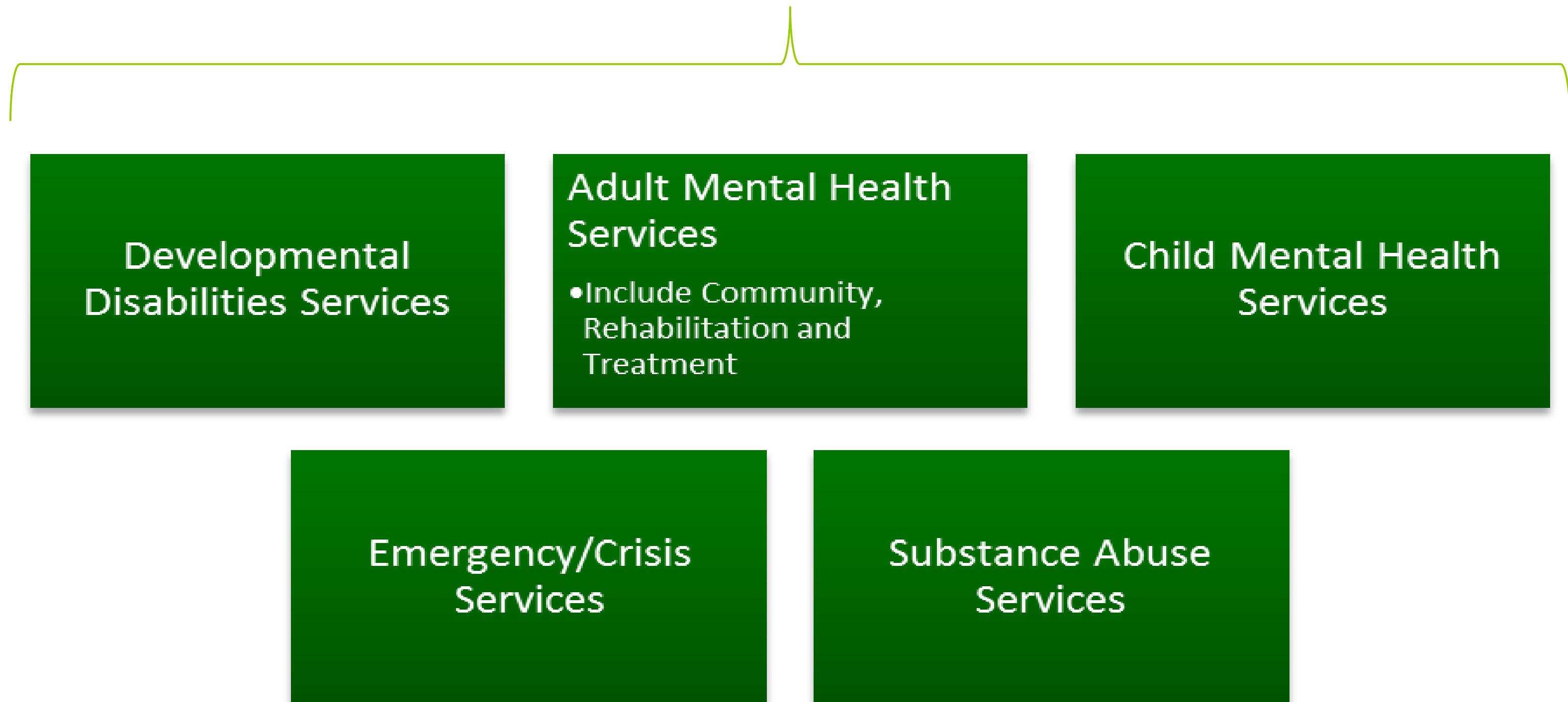
WHERE ARE WE NOW?

- Financial Model of baseline data is nearly complete and being vetted with the DAs.
- Early work on quality measure evaluation is complete and on hold pending model decisions.
- Preliminary analysis of departmental rules, manuals, and other operational needs.

Financial Modeling Tasks



What is the potential payment model structure for cohort 1?



DECISION POINTS FOR NEXT ADMINISTRATION

VERMONT
HEALTH CARE REFORM

High Level Decision Points:

- Final payment model designs that align with APM
- Scope of reform (what services are included)
- Implementation schedule

Questions?