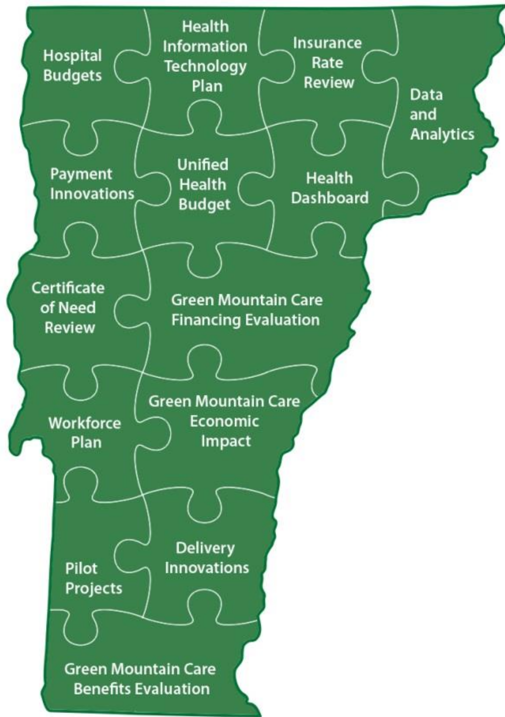


Advisory Committee Meeting

Wednesday, October 7, 2015

Susan Barrett, Executive Director, Green Mountain Care Board

VERMONT
GREEN MOUNTAIN CARE BOARD

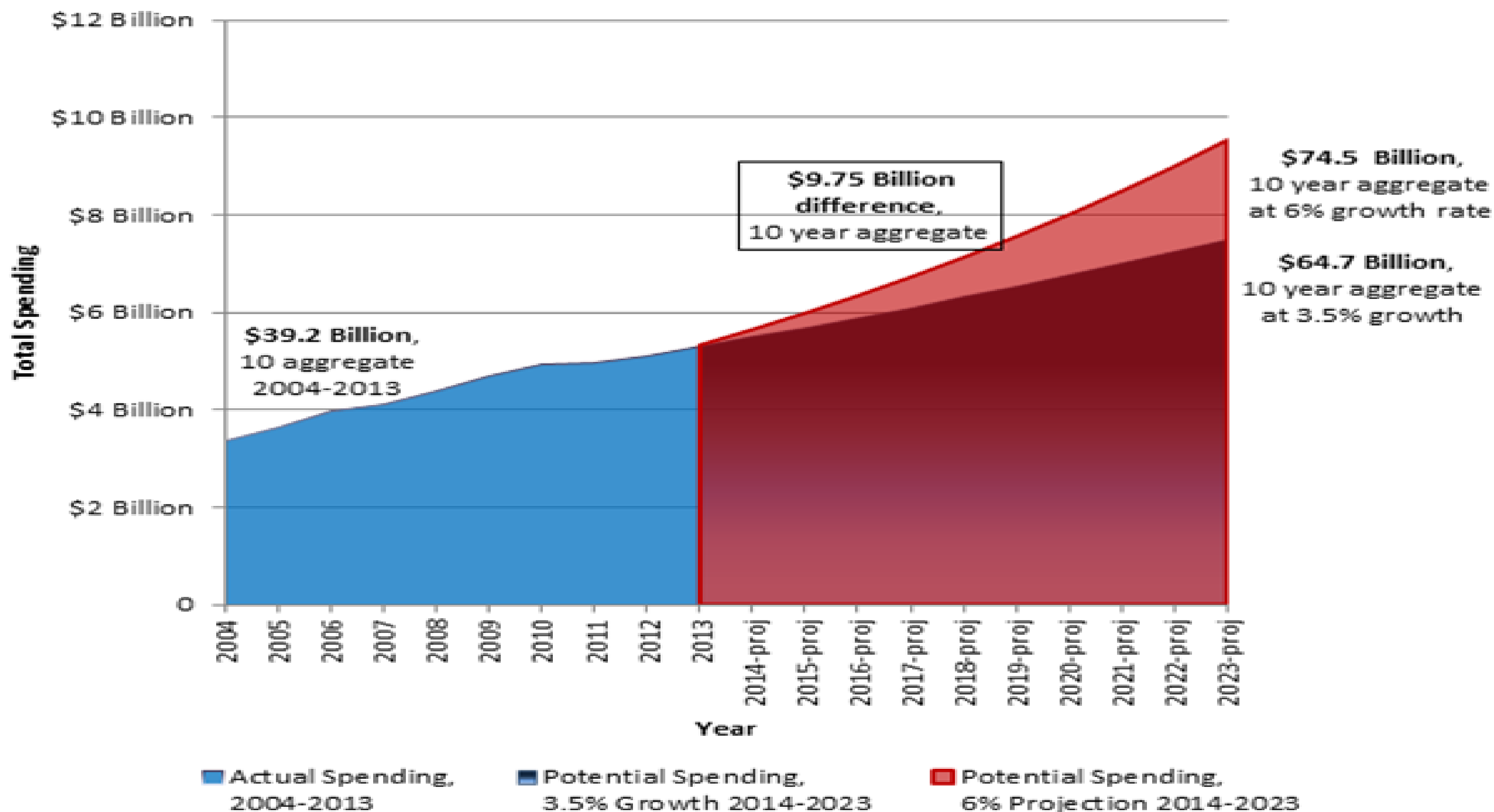
Agenda

- What are the problems we are facing?

- What is the Role of the Green Mountain Care Board?
    - Hospital Budgets
    - Rate Review
    - Certificate of Need
    - Act 54 Deliverables

-Question/Comments

The Problem: Health Care Costs Growing Faster Than Overall Inflation



VERMONT
GREEN MOUNTAIN CARE BOARD

What is the Role of the Green Mountain Care Board?

Regulation

-Health insurer rates and rules (including for the Exchange)

-Hospital budgets

-Major capital expenditures (Certificate of Need)

Innovation

-Payment reform

-Health care delivery reform

-Data and analytics

-Payer policy

Evaluation

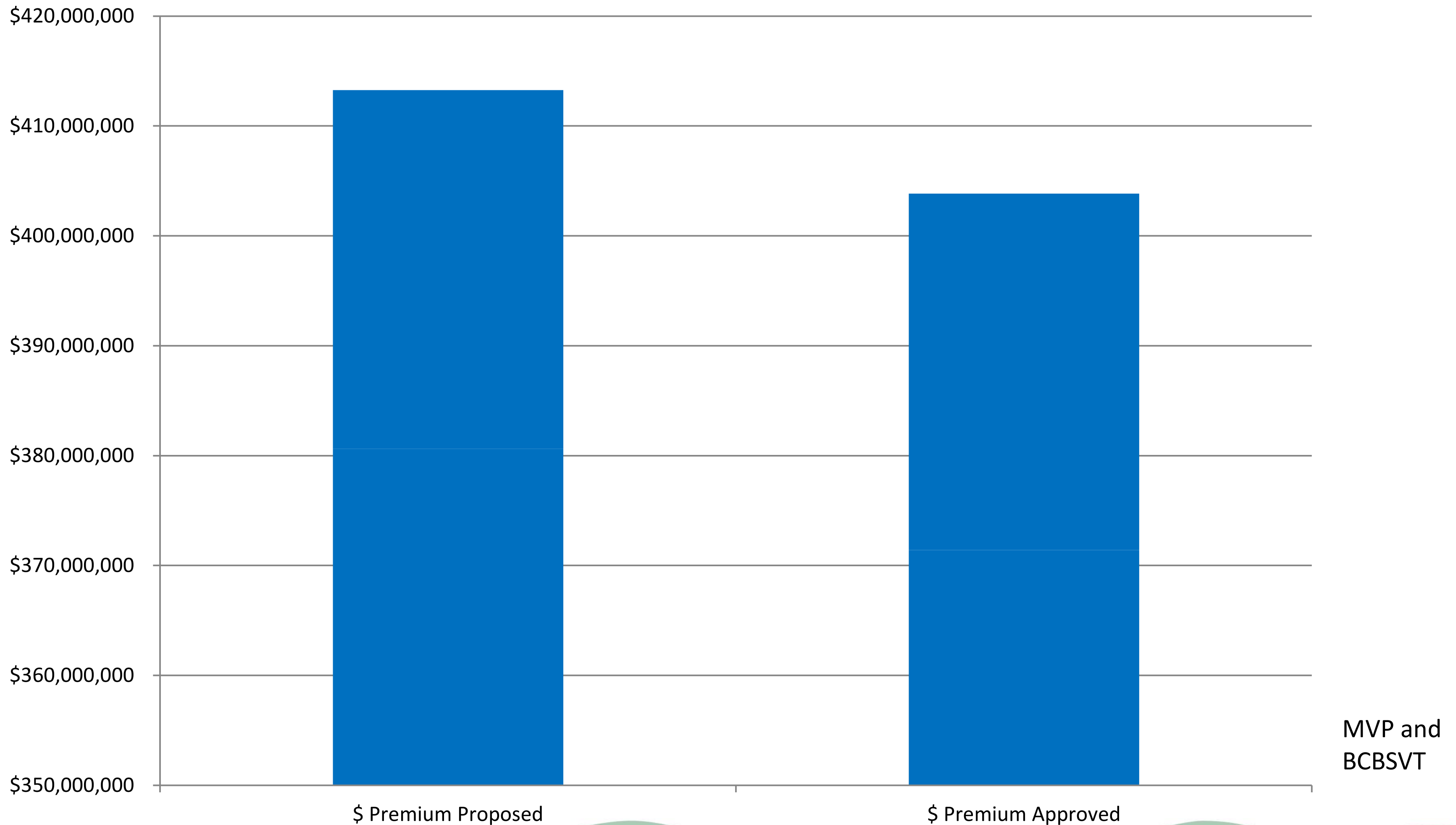
-Payment Reform Pilots

-State Innovation Grant (VHCIP)

2016 Exchange Health Insurance Premiums

Proposed versus Approved Total Dollars Based on Expected Enrollment

Total Savings of $9.4 Million



VERMONT
GREEN MOUNTAIN CARE BOARD

Hospital Budget Review Net Patient Revenue FY14-FY16

Year	Target	Allowance for Credible Reform Proposals	Total	Approved Budget	Actual
FY-14	3.0%	1.0%	4.0%	2.7%	1.5%
FY-15	3.0%	0.8%	3.8%	3.1%	N/A
FY-16	3.0%	0.6%	3.6%	3.5%	N/A

Certificate Of Need

<u>Applications currently under active review:</u>

- **Copley Hospital: Construction of new surgery center**
- **Northwestern Medical Center: Construction of new medical/surgical unit and ICU, and renovation of registration for non-emergent services (scheduled for hearing 10/22)**
- **Northwestern Medical Center: Construction of medical office building (scheduled for hearing 10/22)**
- **Green Mountain Surgery Center: Construction of new ambulatory surgery center**
- **Southwestern Vermont Health Care: Purchase of replacement linear accelerator**

Act 54 Deliverables

Bill/§	Subject	Purpose	Due
Act 54 Sec 21	Consumer Information and Price Transparency	Directs GMCB to evaluate potential models for allowing consumers to compare information about health care cost and quality across VT	10/1/15
Act 54 Sec 47	Repurpose excess hospital funds	Directs GMCB to identify "stranded dollars" in FY 2016 hospital budget review process and report to the General Assembly	10/15/15
Act 54 Sec 15	Large Group Market; Impact Analysis for 2018 Transition	Directs GMCB to analyze projected impact on rates in the large group market if large employers buy Exchange plans beginning in 2018	1/15/16
Act 54 Sec 28	DA Budgets analysis	Directs GMCB to analyze budget and Medicaid rates in one or more Designated Agencies , similar to hospital budget review	1/31/16
Act 54 Sec 23	Provider parity implementation plan	Insurers to submit to GMCB. GMCB to provide update on progress in annual report	7/1/16
Act 54 Sec 7	Vermont Information Technology Leaders (VITL)	Requires GMCB to annually review and approve VITL's budget and its core activities associated with public funding Requires GMCB to consult with VITL when reviewing the statewide Health Information Technology Plan	Ongoing

Questions

What is an All-Payer Model, and What Does it Mean for Vermont?

Ena Backus, Deputy Executive Director
Pat Jones, Health Care Project Director

Presentation to GMCB Advisory Committee
October 7th, 2015

VERMONT
GREEN MOUNTAIN CARE BOARD

Overview

- What is an All-Payer Model, and what does it mean for Vermont?
- All-Payer Model Agreement
- Transformative Model
- Quality Measurement in an All Payer Model

What is An All-Payer Model, and What Does it Mean for Vermont?

What is an All-Payer Model?

- An All-Payer Model is a payment and service delivery model that is consistent across payers in the health care system:
    - Commercial
    - Medicaid
    - Medicare

- Vermont wants to test alternatives to fee-for-service (FFS) reimbursement across all payers

What does an All-Payer Model Mean for Vermont?

Moving away from FFS across all payers allows Vermont to:

1. Incent value rather than volume
2. Construct a highly integrated system
3. Control the rate of growth in total health care expenditures
4. Align measures of health care quality and efficiency across health care system
5. Create more equitable provider payments and mitigate cost shift on commercial payers

What does an All-Payer Model Mean for Vermont?

- The federal government will move towards value-based payment that may not be tailored to Vermont's experience

2016:

- 30% of all traditional Medicare payments tied to quality or value through alternative payment models
- 85% of all traditional Medicare payments tied to quality or value through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs

2018:

- 50% of payments tied to alternative payment models
- 90% of traditional Medicare payments tied to quality or value

All-Payer Model Agreement

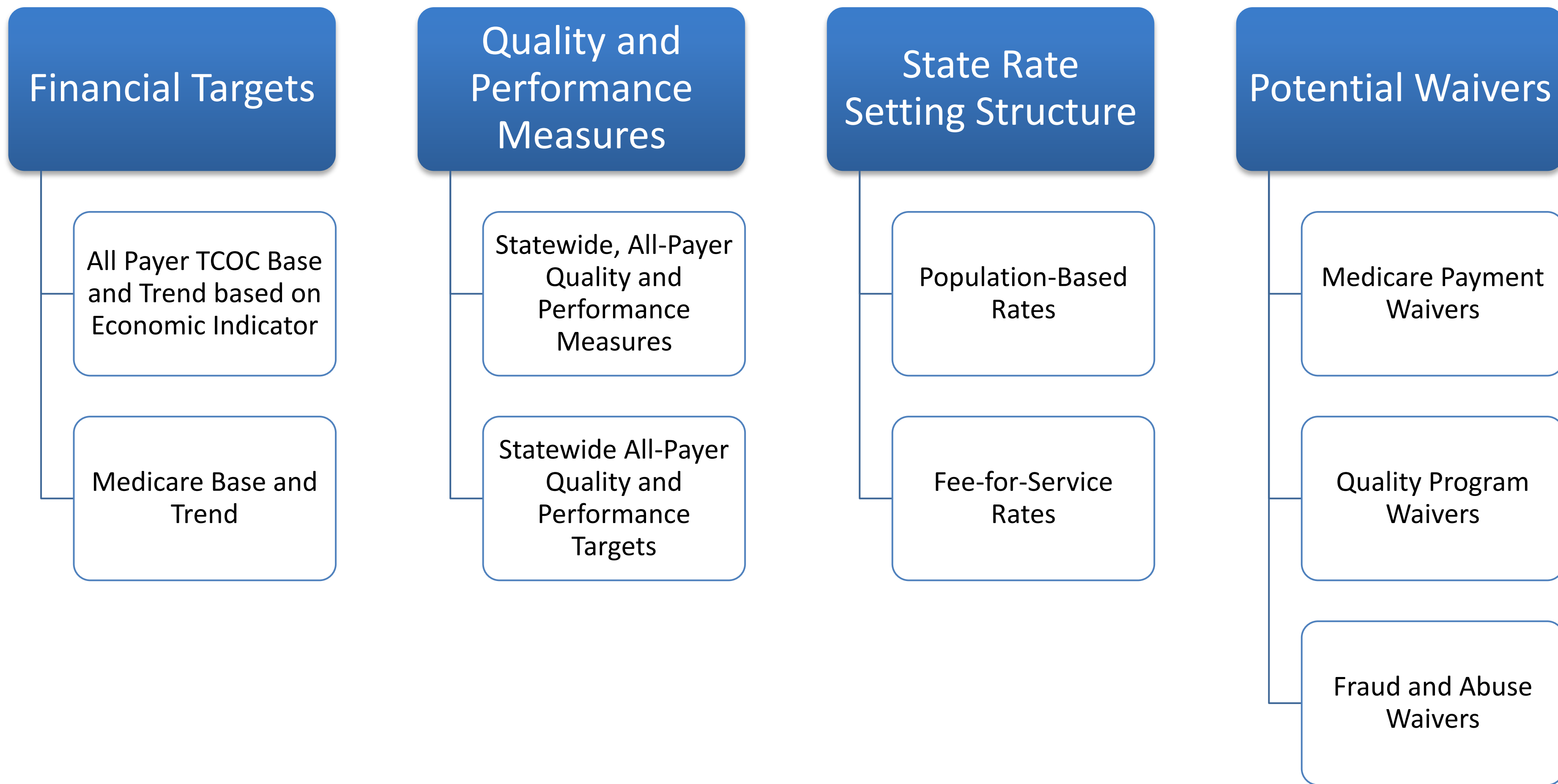
All-Payer Model Agreement

- The Center for Medicare and Medicaid Innovation (CMMI) and the Center for Medicare and Medicaid Services (CMS) must grant waivers for Medicare to participate in Vermont's All-Payer Model

- Such waivers are contingent upon an agreement between the State of Vermont and CMMI/CMS in which Vermont substitutes for CMMI/CMS in determining how Medicare pays providers (FFS vs. alternatives)

VERMONT
GREEN MOUNTAIN CARE BOARD

All-Payer Model Agreement: Vermont and CMMI/CMS

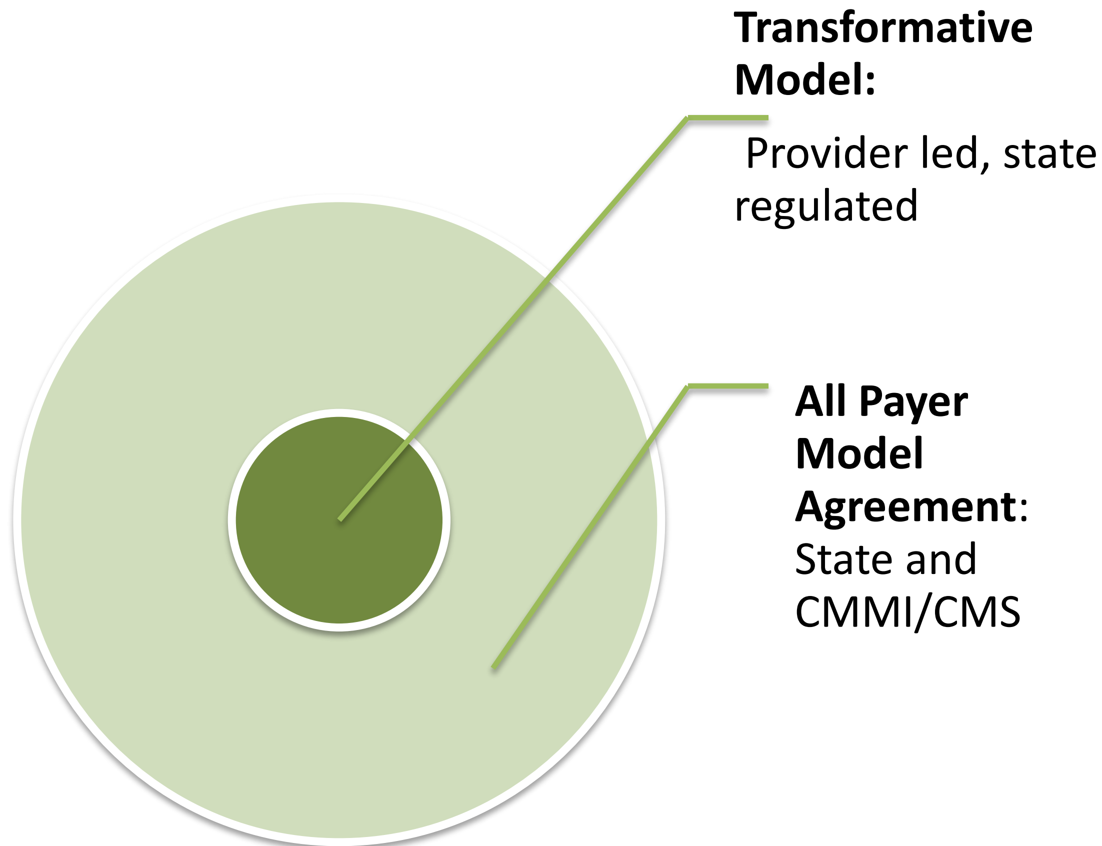


VERMONT
GREEN MOUNTAIN CARE BOARD

Transformative Model

Transformative Model

Vermont must implement a transformative payment and delivery system model that enables the State to meet its obligation to CMMI/CMS with respect to all payer TCOC trend, Medicare target, and quality and performance measures



VERMONT
GREEN MOUNTAIN CARE BOARD

Transformative Model: Leveraging ACOs

- Regulated by the Green Mountain Care Board (GMCB)
- Current all-payer Shared Savings Programs (SSP) are the starting point
- Next Generation ACO "capitation" model is a platform for moving away from fee-for-service across all payers
  - Projected annual expenditures for all payers are combined into a PBPM payment with money withheld to cover anticipated care provided by non-ACO providers/suppliers
  - GMCB reviews and approves PBPM payment
  - FFS claims will continue to be paid as normal for care provided to beneficiaries from providers and suppliers not participating in an ACO

Transformative Model: Enhanced Primary Care

For primary care providers participating in an integrated ACO:

- Payments that more accurately reflect the value of primary care
- Increased payments to PCPs either through enhanced fee-for-service payments or capitation payments
- Reduced administrative burden

Leverage the VT Blueprint for Health's interdisciplinary care teams to:

- Coordinate care for patients
- Provide education to prevent escalation of chronic illness
- Connect patients to community supports

Transformative Statewide Model

Unregulated
FFS Still Exists

$$$

NEXTGEN For All Payers

Medicare
Medicaid
Commercial
Self-Insured?

ACO Revenue, quality and performance measures regulated by State

ACO

Aligned incentives, across payers, to achieve integration

Statewide enhanced primary care platform

$$$

Hospitals
Physicians
Health Centers
Other Providers

Quality Measurement in an All-Payer Model

VERMONT
GREEN MOUNTAIN CARE BOARD

Vermont Has Already Developed Quality Measure Sets

Example: ACO Shared Savings Program (SSP)

- Measure set developed by multi-stakeholder work group, including payers, consumer advocates, provider organizations, ACOs
- Goal was to identify standardized measures to help:
  - Evaluate the performance of Vermont's ACOs
  - Link quality to shared savings payments
  - Guide improvements in health care delivery
- Initially identified more than 200 potential measures; narrowed the list after extensive discussion and compromise

2015 ACO SSP Payment Measures: Claims Data

Commercial & Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite

Medicaid-Only

- Developmental Screening in the First Three Years of Life

2015 ACO SSP Payment Measures: Clinical Data

Commercial & Medicaid

- Diabetes Care: HbA1c Poor Control (>9.0%)*
- Controlling High Blood Pressure*

Medicare Shared Savings Program measure

Quality Measurement in an All Payer Model

- CMMI requires states to have quality goals if they want to obtain waivers of selected federal requirements
- Maryland quality measures include:
  - Reductions in 30-day All-Cause Readmissions
  - Reductions in Potentially Preventable Complications/Hospital Acquired Conditions
  - Reporting of Patient Experience, Inpatient and Outpatient Process of Care Measures, Provider Participation in Health Care Reform, Utilization of ED and Inpatient Care, Population Health Measures
- Vermont does well in some of these measures, so our APM measures may vary from Maryland's

Principles for APM Quality Measures

- Unified priorities are critical for success:
  - Align with existing measure sets, such as Hospital Report Card and ACO Shared Savings measures
  - Align with existing quality improvement initiatives
- Select a few key population level measures:
  - Measures should be representative
  - Number of measures should not be overwhelming and should be tied to existing quality improvement efforts
- Targets should support improvement and be achievable

Questions/Discussion

VERMONT
GREEN MOUNTAIN CARE BOARD