Payment and Delivery System Reform in Vermont: 2017 and Beyond

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Green Mountain Care Board

Presentation to GMCB

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Agenda

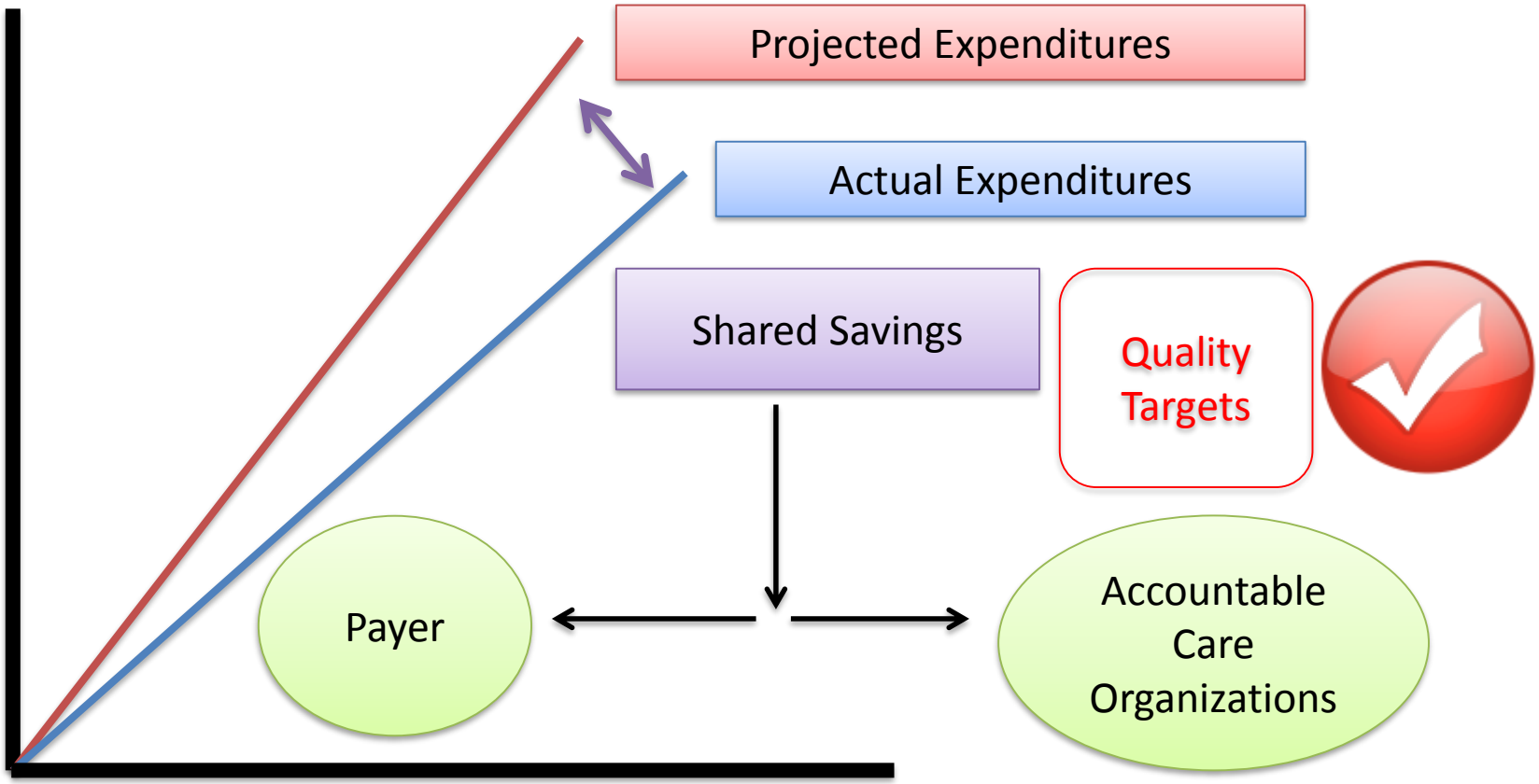
1. Brief Review of the Shared Savings Program (SSP) *(Slides 1-8)*
2. Beyond the SSP to the All-Payer Model in 2017 *(Slides 9-17)*
3. ACO Collaboration *(Slides 18-22)*
4. ACO "Framework" *(For Reference Only, Slides 24-35)*

Vermont ACO Shared Savings Programs — Brief Update

Vermont's ACOs and Shared Savings Programs

ACO Name	2016 Shared Savings Programs	
Community Health Accountable Care (CHAC) 36,668 Attributed Lives July 2015	Commercial Medicaid Medicare	~ 9,009 Lives ~21,213 Lives ~ 6,446 Lives
OneCare Vermont (OCV) 110,186 Attributed Lives July 2015	Commercial Medicaid Medicare	~24,108 Lives ~30,964 Lives ~ 55,144 Lives
Vermont Collaborative Physicians/ Health*first* (VCP) 8,999 Attributed Lives July 2015	Commercial	~ 8,999 lives

Shared Savings Calculated Annually



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Financial Summary Aggregated Results

- Medicaid 2014

	Medicaid		
	CHAC	OneCare	VCP
Total Lives	26,587	37,929	N/A
Expected Aggregated Total	$ 67,803,470.45	$ 81,686,552.31	N/A
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$ 59,956,030.18	$ 74,931,984.20	N/A
Shared Savings Aggregated Total	$ 7,847,440.27	$ 6,754,568.12	N/A
Total Savings Earned	$ 7,847,440.27	$ 6,754,568.12	N/A
Potential ACO Share of Earned Savings	$ 3,923,720.13	$ 3,377,284.06	N/A
Quality Score	46%	63%	N/A
%of Savings Earned	85%	100%	N/A
Achieved Savings	$ 3,335,162.11	$ 3,377,284.06	N/A

Financial Summary Aggregated Results

➢ Commercial 2014

	Commercial		
	CHAC	OneCare	VCP
Total Lives	9,353	22,260	8,526
Expected Aggregated Total	$31,829,851	$76,413,313	$23,581,249
Target Aggregated Total	$30,817,275	$74,489,076	$22,796,150
Actual Aggregated Total	$34,377,496	$81,899,734	$25,292,905
Shared Savings Aggregated Total	($2,547,645)	($5,486,421)	($1,711,656)
Total Savings Earned	$0	$0	$0
Potential ACO Share of Earned Savings	$0	$0	$0
Quality Score	56%	67%	89%
%of Savings Earned	75%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

Financial Summary Aggregated Results

➢ Medicare 2014

	Medicare		
	CHAC	OneCare	VCP
Total Lives	5,948	55,058	7,639
Expected Aggregated Total	$47,069,176	$466,249,733	$56,724,584
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$45,957,103	$470,417,853	$59,486,632
Shared Savings Aggregated Total	$1,112,073^	($4,168,120)	($2,762,048)
Total Savings Earned	$0	$0	$0
Potential ACO Share of Earned Savings	$0	$0	$0
Quality Score	Pay for Reporting	89.15%	92.10%
%of Savings Earned	N/A	N/A	N/A
Achieved Savings	$ -	$ -	$ -

^CHAC did not meet the MSR in the MSSP in order to earn savings

Beyond the Shared Savings Programs:

All-Payer Model 2017

Our Challenge is to Move

From:

Physician-centered system

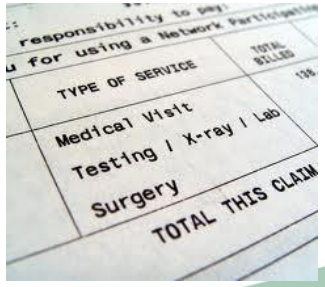
To:

Patient-centered system

Volume-based reimbursement

Value-based reimbursement

Price focus



Total Medical Expense

US Health Care Delivery System Evolution

Acute Care System 1.0

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

Coordinated Seamless Healthcare System 2.0

Outcome Accountable Care

- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

Community Integrated Healthcare

- Healthy population centered
- Population health focused strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

Halfon N. et al, Health Affairs November 2014

Two Kinds of Change

Technical

Problem is well-defined

Solution is known, can be found

Implementation is clear

Adaptive

Challenge is complex

To solve requires transforming long-standing habits and deeply held assumptions and values

Involves feelings of loss, sacrifice (sometimes betrayal to values)

Solutions requires learning and a new way of thinking, new relationships

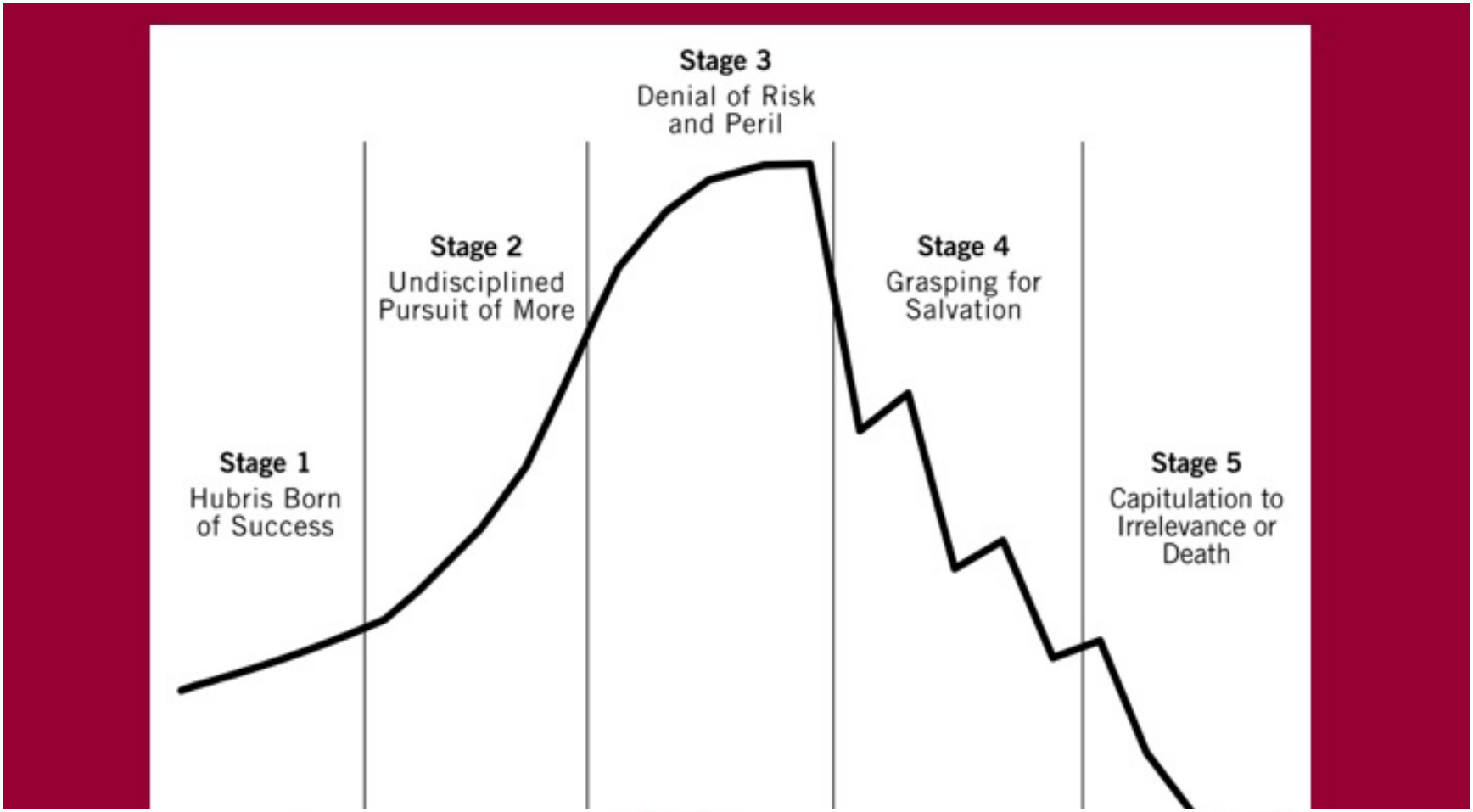
From Jack Silversin, Amicus

Achieving The Triple Aim

From experiments in the United States and from examples of other countries, it is now possible to describe *feasible, evidence-based care system designs that achieve gains on all three aims at once: care, health, and cost.* ***The remaining barriers are not technical; they are political. The superiority of the possible end state is no longer scientifically debatable. The pain of the transition state—the disruption of institutions, forms, habits, beliefs, and income streams in the status quo—is what denies us, so far, the enormous gains on components of the Triple Aim that integrated care could offer.***

Berwick, Nolan, and Worthington, Health Affairs, 2008

Fee For Service From Great to Toast



Good-Bye SGR
Hello MACRA and MIPS
(Example of the FFS Future World)

SGR --- Sustainable Growth Rate

MACRA --- Medicare Access and CHIP Reauthorization Act of 2015

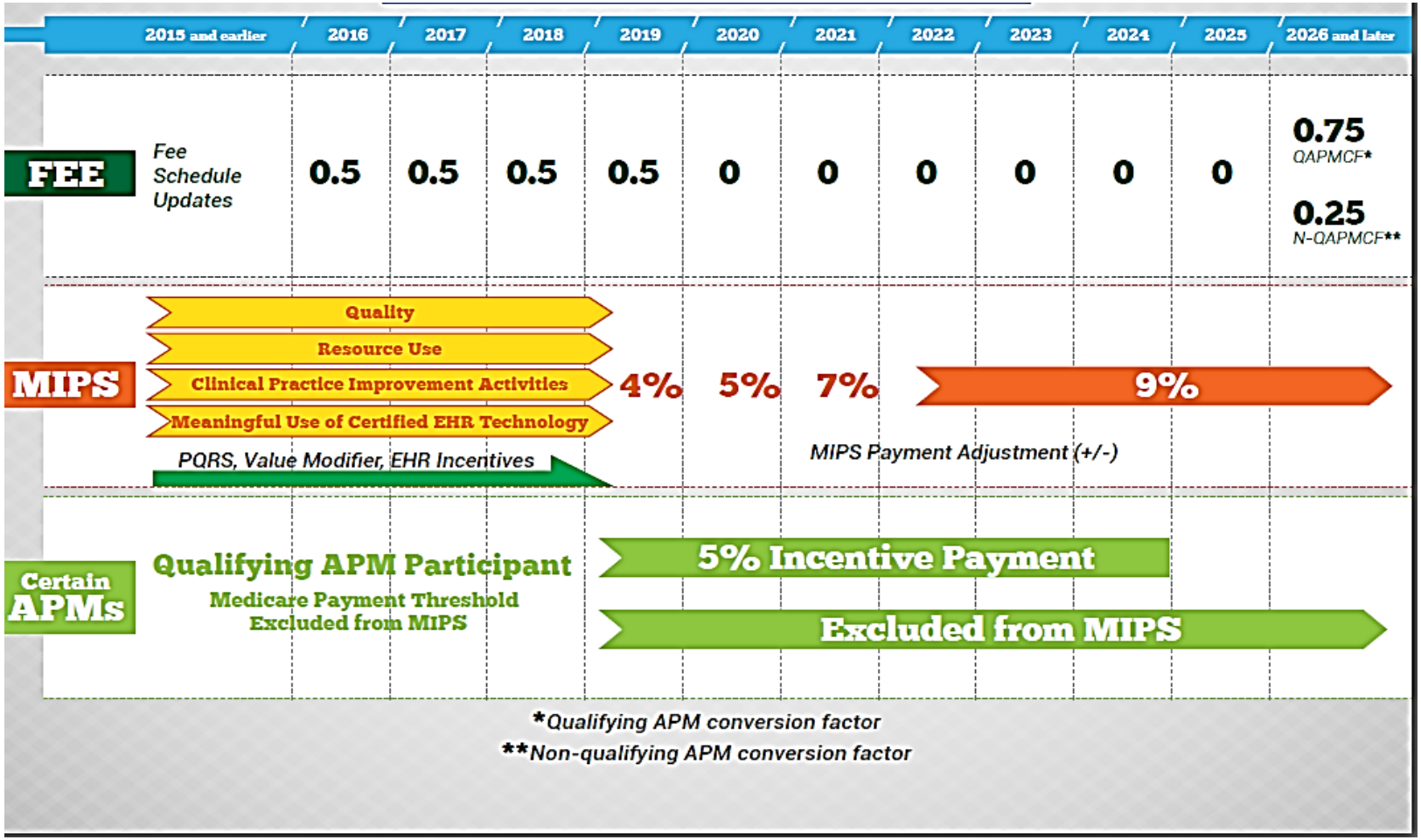
MPFS --- Medicare Physician Fee Schedule (2016 - 2026+)

PQRS --- Physician Quality Reporting System (2016 - 2018)

MIPS --- Merit Based Incentive Payment System (2019 – 2026+)

APM --- Alternative Payment Models (2019 - 2026+)

Timeline for Medicare Payment Adjustments



APM = Alternative Payment Models

Slide adapted from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

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Medicare Payment Programs FY 2016

Medicare Programs	FY 16 Payment Changes	Formula
Participation in Hospital Inpatient Quality Reporting (IQR) Program + Meaningful HER	+0.9%	+2.4% market basket update - 0.5%multi-factor productivity - 0.2% ACA provision - 0.8% documentation and coding recoupment (ATR Act)
Compounding Penalties and Bonuses to Annual Payment Change		
Non Hospital IQR Participants	- 0.6%	
Non MU EHR hospitals	- 1.2%	
Readmissions	- 1.0% (maximum) Average penalty in VT (2 hospitals) - 0.02%*	
Hospitals in Worst Performing Quartile of Hospital Acquired Condition Reduction Program**	- 1.0% (maximum)	
Value-Based Purchasing Program***	-1.25% (maximum penalty) +2.25% (maximum bonus) Average Bonus in VT (2 hospitals) 0.19% Average Penalty in VT (4 hospitals) -0.14****	

*FY 2014 actual data from Vermont. Source: "By State: Hospital Quality Bonuses and Penalties." *Kaiser Health News.* November 14, 2013. See http://khn.org/news/value-based-purchasing-medicare-hospitals-chart/.

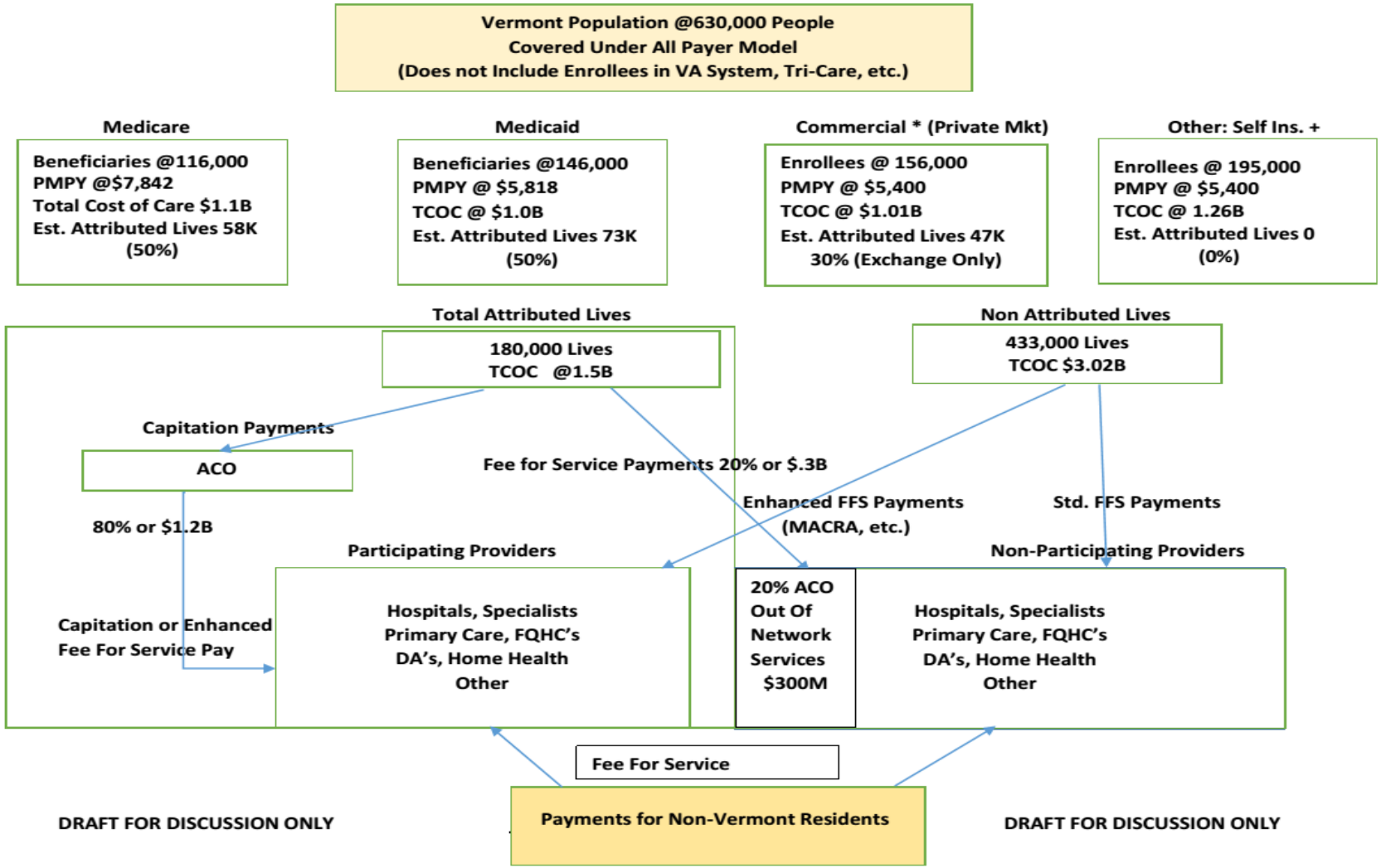
**No Vermont hospitals were in the worst performing quartile in FY 15.

***CMS Hospital Value Based Purchasing Program is funded through a 1.75% reduction from participating hospitals' base operating DRG Payments for FY 2016. These funds are distributed based on performance scores.

****FY 2014 actual data from Vermont. Source: "By State: Hospital Quality Bonuses and Penalties." *Kaiser Health News.* November 14, 2013. See http://khn.org/news/value-based-purchasing-medicare-hospitals-chart/.

Payer Risk Model

- The proposed CMS Next Gen ACO payment model should be the framework for Vermont's All-Payer Model, and that payment should incorporate some type of fixed payment risk from all payers starting in 2017.



All numbers used in this chart are estimates and should not be relied upon for calculations of costs or attributed lives. This is intended for discussion purposes only.

ACO Memorandum of Understanding

ACO Memorandum of Understanding

Purpose:

Build upon the foundation created by the collaborative work that has been achieved to date, and take additional steps to build trust, develop shared knowledge about the populations served, and collaborate on activities that are essential to managing an integrated system of care

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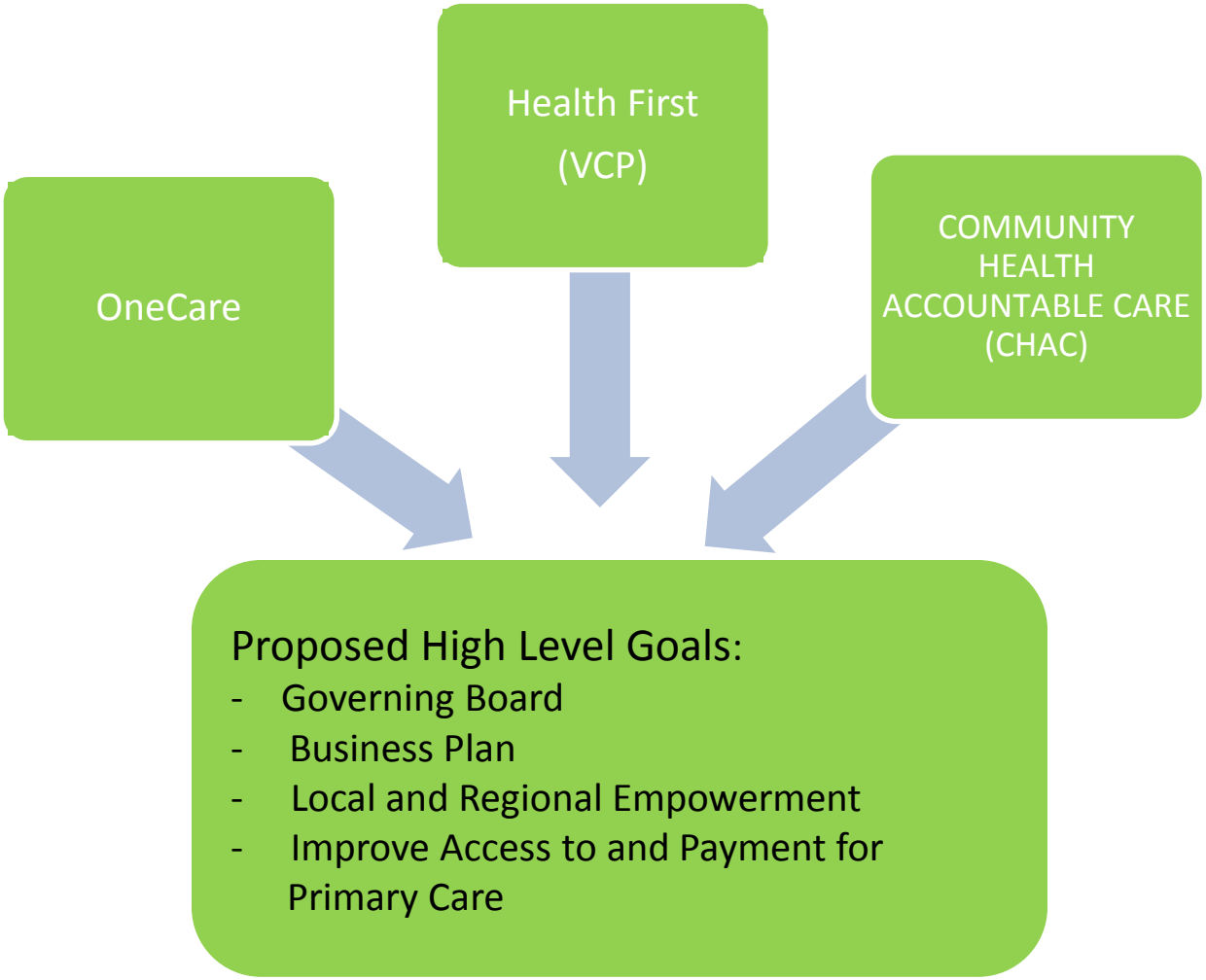
ACO Collaboration Participants



Criteria for a Single ACO

- Capable of Assuming Financial Risk (Capitation Payments)
- Representative Governance Board with Consumer Participation
- State-Wide Integrated Network of Providers
- Ability to Contract with Participating Providers
- Ability to Pay Participating Providers Value Based Payments
- Minimum Number of Lives for Each Participating Payer
- Oversee Management of Data Flow and Analytics for the System

Regulatory Role of the Green Mountain Care Board (GMCB)

The GMCB will need to demonstrate to CMMI that it has the authority, willingness and capacity to assume the necessary regulatory and rate setting role required in the context of a Medicare Waiver Agreement that would lead to the creation of a fully integrated statewide all-payer model.

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Questions?

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For Reference Only Not Part of Presentation

Vermont All-Payer Model Framework Document

Vermont All-Payer Model Framework

This Framework is intended to be used to inform the GMCB and the State's CMS waiver negotiating team regarding the Subcommittee's thinking about how an all-payer model might be implemented in Vermont.

Vermont All-Payer Model Framework

This is what an all-payer model could mean for Vermonters:

- Better access to care
- Continued Freedom of Choice
- More time for people with their providers and care team
- Improved care
- More affordable care
- Greater focus on prevention and early intervention
- Expanded efforts to keep people healthy
- More flexibility in health care services
- Improved communications among individuals and their health care team

Vermont All-Payer Model Framework

This is what an all-payer model could mean for providers and payers:

- Support for high value health care
- Greater flexibility in providing needed services and supports
- Provider-driven model
- Predictable payments
- Local empowerment
- Focus on prevention and population health

Vermont All-Payer Model Framework

Core Functions of the ACO:

- Develop a plan for near-term and long-term pathways to better clinical and population health outcomes.
- Set targets, measure performance and create provider incentives for cost, clinical outcomes and individual experience.
- Work closely with the Blueprint and other local organizations to assist community collaborative partnerships and coordinated approaches to care management.
- Improve population health status using population health strategies.
- Provide data management support and analytics.
- Process payments to providers and manage financial risk.

Vermont All-Payer Model Framework

Payer Risk Model:

- The Subcommittee agreed that the proposed CMS Next Gen ACO payment model should be the framework for Vermont's all-payer model, and that payment should incorporate some type of fixed payment risk from all payers starting in 2017.

Vermont All-Payer Model Framework

- **Provider Payment Models:**
  - Participating Providers
    - Capitation to primary care providers for attributed lives; enhanced fee for service payments for non-attributed lives
    - Continue Medicare and Medicaid encounter payments to FQHCs
    - Capitation payments to hospitals for attributed lives; fee for service payments for non-attributed lives
    - Continue Medicare payments to Critical Access Hospitals under current rules
    - Enhanced fee schedule or bundled payments for specialists
  - Non-Participating Providers
    - Standard fee for service payments based on payer specific rules
    - GMCB hospital budget review process

Vermont All-Payer Model Framework

Primary Care Practice Patient Attribution:

- Attribution is important for payment and for establishing/ recognizing relationships between individuals/families and primary care providers
- Individuals/Families should be prospectively attributed using voluntary selection as a preferred method, and claims-based attribution as a secondary method
- Goals of attribution:
  - Attribute as many people as possible
  - Avoid attribution to multiple providers
  - Create a system that is easy to administer
  - Employ Prospective rather than retrospective attribution

Home Health

(Added to the Framework at the request of Home Health Agencies)

The Subcommittee recognizes the value of home health in achieving the triple aim of health reform - improve quality, improve patient experience and reduce costs. The Subcommittee acknowledges that Home Care is a full service community-based operation with its existing skilled multi-disciplinary staff managing highly complex patients with multiple chronic conditions in the patient's home; utilizing a case management model to assess and coordinate an individualized plan of care; using existing relationships with community partners to connect its patients with necessary services and supports, utilization of telehealth equipment to maintain consistent contact with patients, and a stable infrastructure that can support all administrative functions.

Partnering with home health services is essential for reducing hospitalizations and re-hospitalizations, providing medication management, early symptom recognition and management, chronic disease management, minimizing risk of falls, patient education re: disease self-care, reducing Emergency Department use, supporting patients and families in end of life care and overall care coordination – all while patients remain in a lower cost setting, their own home.

Home Health

(Added to the Framework at the request of Home Health Agencies)

- The Subcommittee recognizes that Home Health offers a variety of services which will require different payment methodologies. The following is our recommendation:
- Acute skilled care (including Palliative Care) – Prospective Payment System consistent with current Medicare methodology
- Hospice – tiered daily rates based on level of care consistent with current Medicare methodology
- Long-term Care Choices for Care – bundled payment rate based on levels of care such as Moderate, High or Highest Needs
- Case Management – per member per month rate based on the level of care and case coordination needed.
- Payments for Home Health services should be established utilizing the Medicare Cost report for a base year and adjusted annually with an overall trend factor applied to historical costs that take into consideration inflation and a demographic adjuster such as wage index.
- Home Health would give future consideration to a Value Based Purchasing Program.

Mental Health and Substance Abuse

(Added to the Framework at the request of Vermont Care Partners)

The ACO network recognizes the value of Designated and Specialized Service Agencies (DA/SSA) providing mental health, substance use disorder and developmental disability services in integrated community based care that results in controlled health care costs and improved population based outcomes. The social determinants of health address behaviors, as well as socioeconomic factors that have an important impact on health and well-being which can prevent or improve the outcomes of most chronic medical conditions.

The State of Vermont and Vermont Care Partners will design a value based payment methodology for designated and specialized services agencies providing mental health, developmental disability and/or substance use disorder services and will invest in provider readiness for this change. The new payment methodology will align with the all-payer model arrangement and pathways for inclusion in the APM and in the ACO network will be designed within the first year of APM implementation.

Questions