Primary Care and Value-Based Reform Operational Issues

Green Mountain Care Board Meeting

January 17, 2018

OneCareVermont

Primary Care: Reform-Based Operational Reality

Pieces of the Puzzle:

1. Overall Reform Vision and Goals
   - Addressing desire for high value and a more coordinated, measurable system of care
2. Proactive Population Health Management (PHM)
   - Proactivity every time and new processes/roles adds work and expense
3. Documentation – Current and Evolving Needs
   - Not going away for many reasons and encounter "claims" likely to always be required
   - Need to address how to handle new types of delivery models and encounters
4. Measuring Quality
   - Also not going away and can make measurement as "passive" as possible, but arguments will always abound over metrics and burdens to accurately score
5. Innovation Program Impacts
   - Implementing specific program for innovation may have mixed impact - may help immediately, may help after efforts to implement, or may add work but which generates value for patients
6. Need for Financial Resources to Support Reform Processes and Reward Results
   - Added resources for requirements must be part of the mix – possibly the major approach if want to achieve all of the above
7. Support in Addressing True Low-Value Administrative Burden
   - Just making a dent will be progress

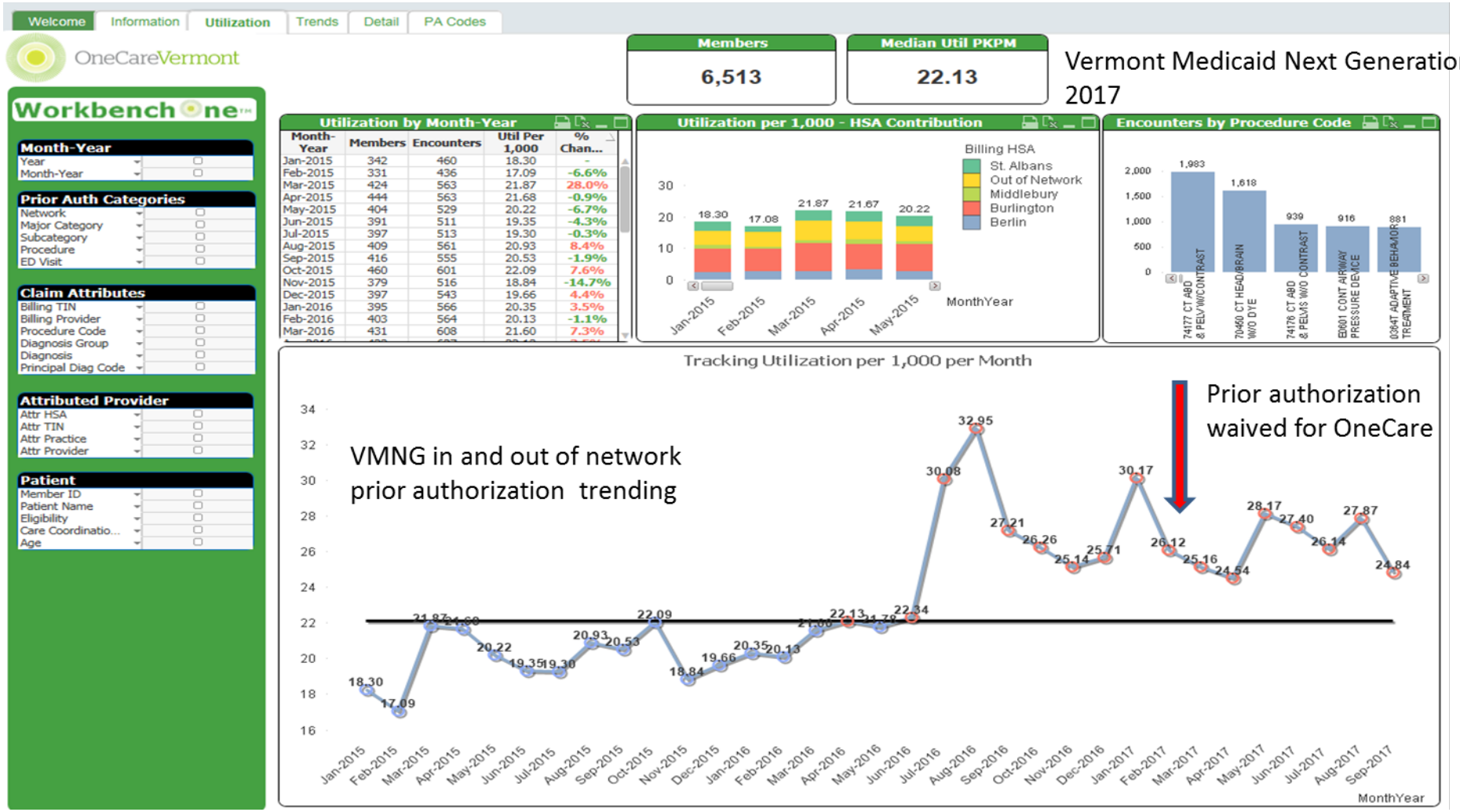
OneCare Primary Care Vision

1. **Design Proactive and Aligned Value-Based Programs and Population Health Models with Input from Participants**
   - Primary Care Practice (PCP)-centered approach
   - Data driven integrating sources from claims and clinical information from network EHRs and the VITL HIE
   - Drive toward true PHM – plan for every patient from prevention and wellness to no complex patients "falling through the cracks" who need increased support and coordination
   - Promote care models and processes to avoid waste, treat in lower cost settings, and/or prevent more expensive care later
   - Measure and improve reasonable sets of quality metrics
   - Align all models across payers as much as possible
2. **Work to Provide Added/Redesigned Financial Resources to Adequately Support the Programs and Models**
   - OneCare PCP "Standard" Reform Model – All types of PCP
   - CPR Pilot for Independent Practices
   - Continuity of former Medicare Blueprint payments and programs
   - Community-based provider participation in complex care coordination payment models to work with the PCP
   - Value-based incentive fund to reward high quality with 70% going to PCP
3. **Work to Reduce/Avoid Low Value-Added Work for PCPs**
   - Within the ACO program and models including being as flexible as possible in how to implement PHM activities
   - Those made possible (or more possible) by being in a risk-bearing ACO
   - Others which may be feasible to address with the scale and influence of a large ACO

Examples to Date on Limiting or Reducing Practice Burdens

- Eliminating prior authorization of services in VMNG program
- Aligning quality measures (QM) across payer programs. For example, 2017 VMNG negotiations resulted in:
  - Reduction in the number of QM
  - Increase in the number of QM tied to claims, resulting in less interruption for practices
  - Alignment with Vermont APM measures
- ACO participation eliminates additional Medicare Incentive Payment System (MIPS) reporting requirements
- OneCare clinical governance selecting limited clinical priority areas to with focused QI activities, measurements and tools
- OneCare and Blueprint leadership working in close alignment to identify priorities and deploy shared resources
- Implementing current and future benefit waivers to improve access, efficiency, effectiveness, and timeliness of care system for patients
- Best possible support for quality measure collection – Education, entry tools, OneCare abstractors, and increased automated tracking/collection of measures and gaps during performance year
- Support in assessing ongoing need for NCQA certification

Reducing Burden Example: Prior Authorizations



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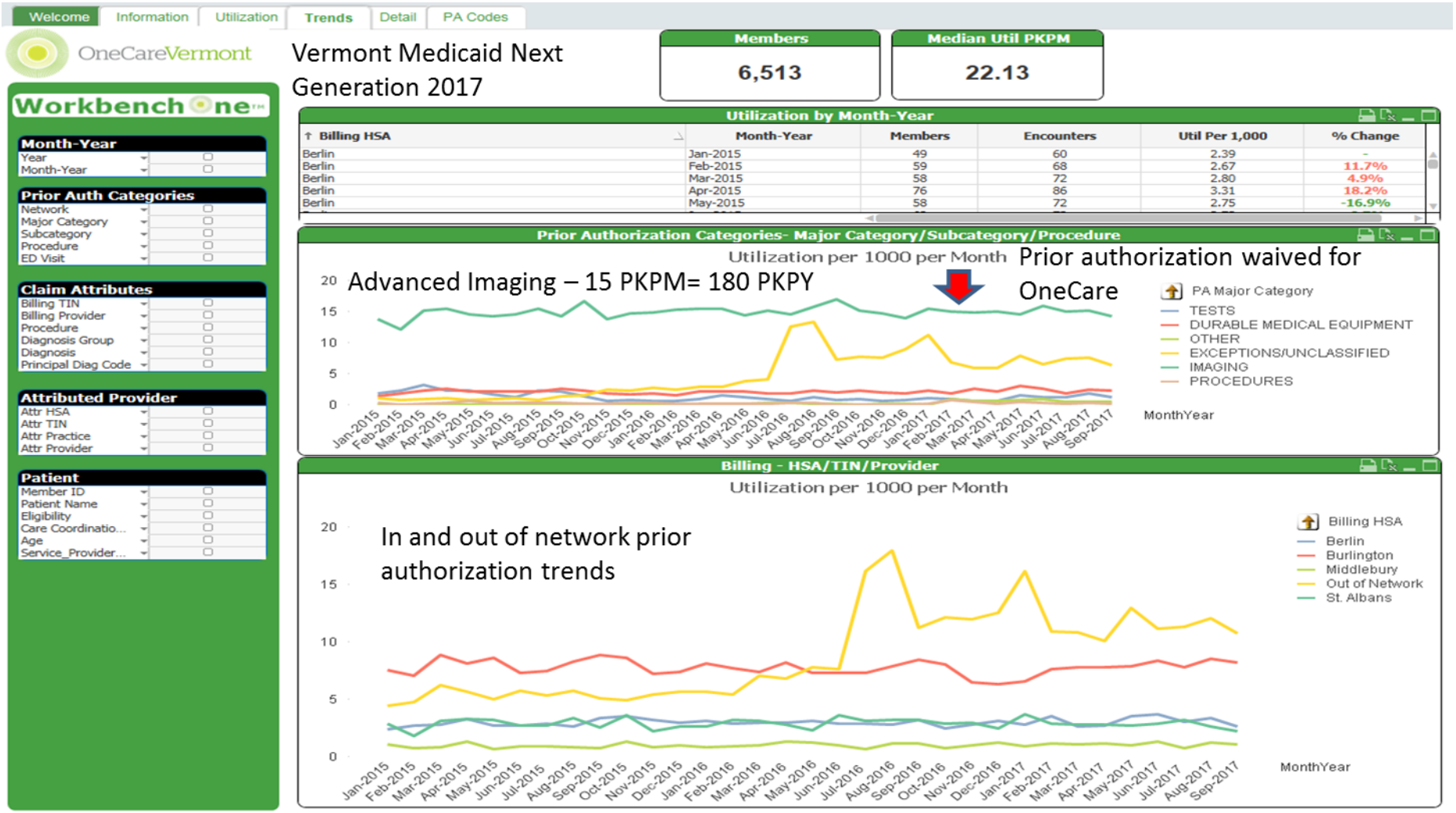


Appendix 1: Documentation

Documentation - Why Do We Document Clinical Care?

- Facilitate excellent clinical care – history, physical findings, differential diagnoses considered, diagnostic study rationale, treatment plan, cross coverage
- Billing/Payment/Insurance Authorizations
- Quality measurement
- Medico-legal considerations
- Licensure professional standards
- Patient engagement – “open notes” understandable to patients
- Population risk adjustment and global budget actuarial target setting

Documentation – How to Handle Non-Face-To-Face Encounters

- Growing importance in a population health system – patient engagement, patient convenience, improved access, efficiencies
- EMR patient portal (email) communications
- Telemedicine (video) visits
- Phone encounters
- Billable and non-billable services – blurred importance in a global budget capitated paradigm
- New clinician compensation models – receiving “credit” for work performed (time at work, RVUs, panel outcomes)

Documentation – Care Coordination

- Complex patient care coordination involves multiple community support entities
- Promoting multidisciplinary and inter-agency communication
- Multiple EMRs
- Care Navigator software – a web-based common system for organizing care teams and documenting shared care plans – a virtuous cycle of improved communication and outcomes
- Team-based Care Plan – high value if implemented but must be acceptable to all care team members

Appendix 2: Value Base Reform and Quality Measurement

Value Based Reform

General Goals of Heath Reform

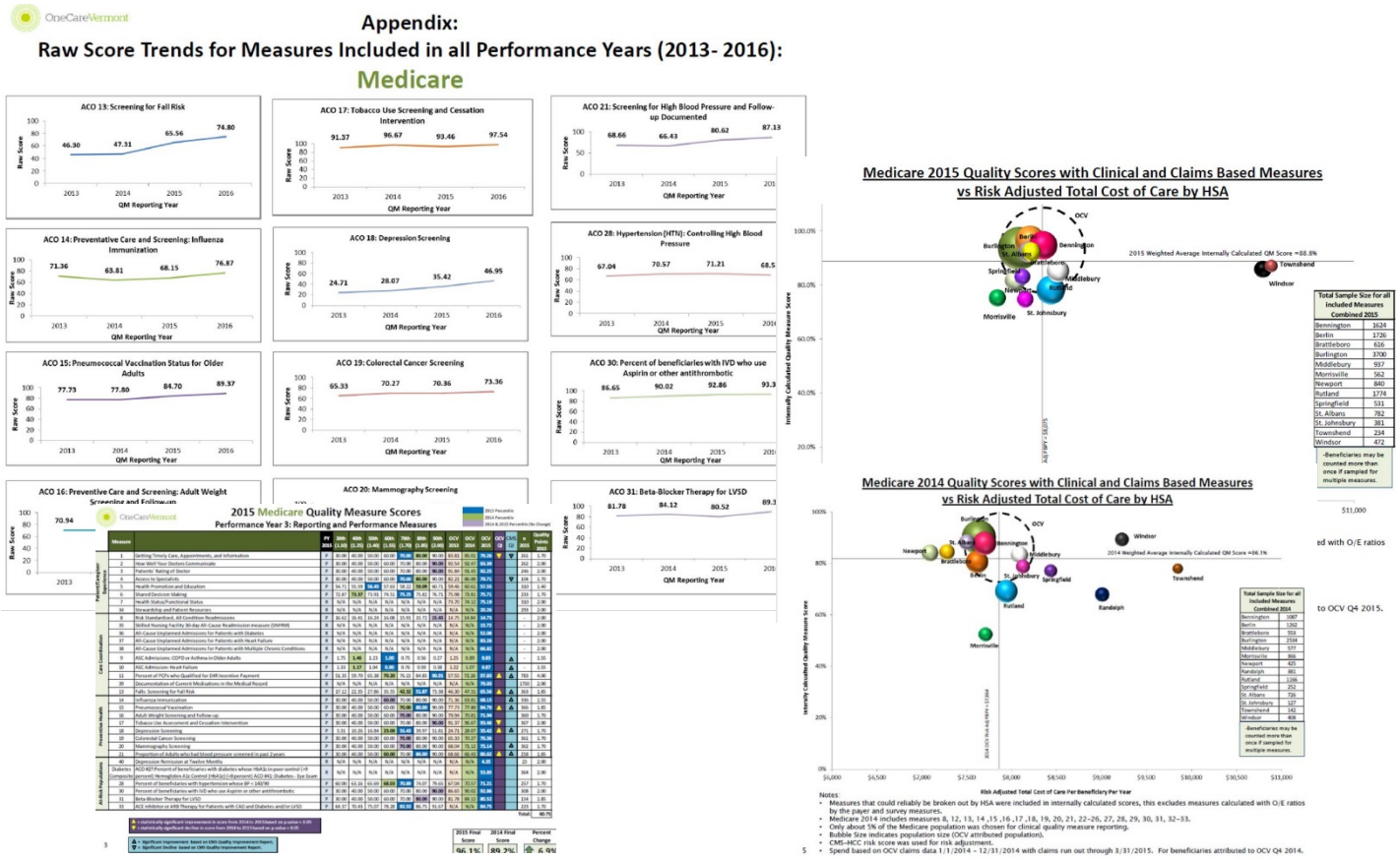
- Drive Better Value
  - Payers/consumers both say they get mixed (or even low) value from U.S. system
  - Value is high quality/satisfaction and low cost/utilization
  - Need for “measurability”
- Move Away from FFS as Sole Payment Mechanism
  - Stop digging the hole of unaffordability by moving away from FFS payments (especially for hospitals)
  - Reward health care providers for delivering better health not higher volume
- Coordinate a Fragmented System
  - Leads to variable outcomes, lack of satisfaction, significant waste, and limits to value-based achievement
  - Need for more integrated networks, systems, processes especially once “low hanging fruit” is gone
- Address Socio-Economic Barriers to Health Care Value and Health Status
  - Government, regulatory and public health improvement needs come into play

Quality Improvement Strategies to Achieve the Triple Aim

- Upshot: Can make life better for patients/families but add new care delivery models and processes to be designed/implemented
- **Timely and Accurate Data**
  - Identify gaps in care
  - Drive decision-making
- **Support Local Communities to Improve**
  - Aligned clinical priority areas
  - Representation on clinical governance committees
  - Blueprint/OCV aligned staffing & resources
- **Resources, Training, and Tools**
  - A3 QI reporting processes
  - All Field Team staff trainings
- **Dissemination of Results**
  - Network Success Stories
  - OneCare Grand Rounds, Topic Symposia, Conferences
  - Facilitated sharing on clinical committees

Quality Measurement, Analysis, & Reporting

Upshot: Can make life better for patients/families but add new care delivery models and processes to be designed/implemented but significant “system” fatigue



EMR Adaptations to Facilitate Quality Measurement/Reporting

- Improving simplicity of data collection – clinical care documentation and quality measure elements closely linked
- Moving from process to outcome measurements
- Increased opportunity for patient entered data
- More durable measures in ACO programs can lead to specific entry and measurement functionality
- Possible stronger, interoperable links to other data sources and systems

Appendix 3: Innovation Impacts

Innovation Impact Example: Flexible Care Models under Reform

- Increased telephone/email interaction
- Telemedicine visits for direct real-time patient care
- "Virtual Visits" which store and forward encounters via electronic health record patient portals
- Use continuum of care community providers as "arms and legs"
  - Home Health agency
  - SASH
  - Designated Agencies
  - Agency on Aging
- Pharmacist patient support and consultative services
- PCMH embedded mental health services
- More Medication Assisted Treatment (MAT) in PCMH
- RN performed Annual Wellness Visits

Innovation Impact Example: Medicare Next Generation Waivers

- Expanded patient benefits:
  - Access to skilled nursing facilities without a 3-day inpatient stay requirement
  - Access to two home health visits following hospital discharge
  - Access to telehealth services not currently allowed by CMS
  - Still accrues against ACO “risk” target but facilitates compliant service delivery and revenue flow
- Future topics under consideration through Vermont APM:
  - Additional innovation possible under Vermont Medicare ACO Program starting in 2019
  - Medicare support for MAT
  - “Virtual PACE program” – funding of adult day care for patients in complex care coordination
  - Home IV antibiotics
- Expansion to other payers

Appendix 4: Added PCP Financial Resources in support of Reform

Added Resources: 2018 OneCare Primary Care "Standard" Model

Attributed Population

Full Attributed Panel

High Risk

NOTE: PCP and OCV Collaborate with Full Continuum of Care on Population Health

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OCV Complex Care Coordination $15-$25 PMPM

OCV Basic PHM Payment $3.25 PMPM

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Care Navigator (Population Health Management System)

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Value-Based Quality Incentive (Annual Eligibility for Attributed Lives)

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Supporting Data and Systems at No Charge

Workbench One (Performance Data and Analysis)

NOTE: Base Revenue Model Remains as Usual FFS; Primary Care is Under No Financial Risk

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OCV Provides Blueprint Continuity for Medicare Practice Payments and CHT Support Funds (plus SASH program)

Blueprint Payments/Programs Continue

BlueCross BlueShield of Vermont

VERMONT AGENCY OF HUMAN SERVICES

Independent PCP Comprehensive Payment Reform (CPR) Pilot

- **Budget model includes supplemental investment to develop a multi-payer blended capitation model for primary care services**
  - Voluntary program offered to *independent PCP practices* with at least 500 attributed lives across all programs
  - Would further enhance financial resources and simplify the “standard” model on previous page
  - Would be designed to measure and achieve parity on an attributed panel, risk-adjusted PMPM basis
  - Designed to test sustainable model for independent practices <or> pilot offering to all primary care in future years
- **Operational model is monthly PMPM prospective payment to cover primary care services delivered to the attributed population by the practice**
  - Enables innovation and more flexible care models
  - Provides predictable and adequate financial resources for the practice
- **Exact model in collaborative development with participating practices**

CPR Pilot: Added Resources plus Simplification

Major Concept 1: Service Breakdown

	Adults (>18 YOA)	Kids (<19 YOA)
Core Primary Care Services	Multi-Payer Standard "Base Rate" which is adjusted for Population Risk for Practice Pane,	Age/Sex Standard Capitation Bands applied to Practice Pediatric Population Profile
Additional Services Delivered	Fixed PMPM based on historic pattern and adjusted for major shifts	Fixed PMPM based on historic pattern and adjusted for major shifts

Major Concept 2: Economic Resources

- Value of Waived FFS +
- OCV 2016-2018 Inflation +
- Value of Standard OCV Add-Ons +
- CPR supplemental Add-On

CPR Pilot Proposed Model

- New practice payment "aggregate" PMPM standard for CPR multi-payer attributed panel
- Adjust for BCBSVT expected FFS payments still to be received to generate net OCV monthly cash PMPM payments

Common Point: CPR Pilot Involves plan payment only economics;
Patient OOP same as if system remained FFS and not affected by OCV programs including CPR