Payment and Delivery System Reform in Vermont: 2017 and Beyond

Richard Slusky, Director of Reform
Green Mountain Care Board
Presentation to GMCB
February 11, 2016
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

<table>
<thead>
<tr>
<th>ACO Name</th>
<th>2016 Shared Savings Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Accountable Care (CHAC)</td>
<td>Commercial ~ 9,009 Lives</td>
</tr>
<tr>
<td></td>
<td>Medicaid ~ 21,213 Lives</td>
</tr>
<tr>
<td></td>
<td>Medicare ~ 6,446 Lives</td>
</tr>
<tr>
<td>36,668 Attributed Lives July 2015</td>
<td></td>
</tr>
<tr>
<td>OneCare Vermont (OCV)</td>
<td>Commercial ~24,108 Lives</td>
</tr>
<tr>
<td></td>
<td>Medicaid ~30,964 Lives</td>
</tr>
<tr>
<td></td>
<td>Medicare ~ 55,144 Lives</td>
</tr>
<tr>
<td>110,186 Attributed Lives July 2015</td>
<td></td>
</tr>
<tr>
<td>Vermont Collaborative Physicians/Healthfirst (VCP)</td>
<td>Commercial ~ 8,999 lives</td>
</tr>
<tr>
<td>8,999 Attributed Lives July 2015</td>
<td></td>
</tr>
</tbody>
</table>
Shared Savings Calculated Annually

- Projected Expenditures
- Actual Expenditures
- Shared Savings
- Quality Targets
- Accountable Care Organizations
- Payer
# Financial Summary Aggregated Results

- **Medicaid 2014**

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

Commercial 2014

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

*If shared savings had been earned
Financial Summary Aggregated Results

- Medicare 2014

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

^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

Volume-based reimbursement

Price focus

To:

Patient-centered system

Value-based reimbursement

Total Medical Expense
US Health Care Delivery System Evolution

Acute Care System 1.0

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

Coordinated Seamless Healthcare System 2.0

- 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

- 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
Fee For Service From Great to Toast

Stage 1
Hubris Born of Success

Stage 2
Undisciplined Pursuit of More

Stage 3
Denial of Risk and Peril

Stage 4
Grasping for Salvation

Stage 5
Capitulation to Irrelevance or Death
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Updates</th>
<th>MIPS Payment Adjustment (+/-)</th>
<th>Certain APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 and earlier</td>
<td><strong>0.5</strong></td>
<td>-</td>
<td>Medicare Payment Threshold Excluded from MIPS</td>
</tr>
<tr>
<td>2016</td>
<td>0.5</td>
<td>4%</td>
<td>Qualifying APM Participant</td>
</tr>
<tr>
<td>2017</td>
<td>0.5</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0.5</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>0</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>0</td>
<td>MIPS Payment Adjustment (+/-)</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>0</td>
<td>Excluded from MIPS</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2026 and later</td>
<td>0.75</td>
<td><strong>0.25</strong></td>
<td>APM conversion factor *</td>
</tr>
</tbody>
</table>

---

*APM = Alternative Payment Models*

## Medicare Payment Programs
### FY 2016

<table>
<thead>
<tr>
<th>Medicare Programs</th>
<th>FY 16 Payment Changes</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in Hospital Inpatient Quality Reporting (IQR) Program + Meaningful HER</td>
<td>+0.9%</td>
<td>+2.4% market basket update - 0.5%multi-factor productivity - 0.2% ACA provision - 0.8% documentation and coding recoupment (ATR Act)</td>
</tr>
</tbody>
</table>

### Compounding Penalties and Bonuses to Annual Payment Change

<table>
<thead>
<tr>
<th>Component</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Hospital IQR Participants</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Non MU EHR hospitals</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>-1.0% (maximum) Average penalty in VT (2 hospitals) - 0.02%*</td>
</tr>
<tr>
<td>Hospitals in Worst Performing Quartile of Hospital Acquired Condition Reduction Program**</td>
<td>-1.0% (maximum)</td>
</tr>
<tr>
<td>Value-Based Purchasing Program***</td>
<td>-1.25% (maximum penalty) +2.25% (maximum bonus) Average Bonus in VT (2 hospitals) 0.19% Average Penalty in VT (4 hospitals) -0.14****</td>
</tr>
</tbody>
</table>


**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.

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 Population @630,000 People
Covered Under All Payer Model

**Medicare**
- Beneficiaries @116,000
- PMPM @$7,842
- Total Cost of Care $1.1B
- Est. Attributed Lives 58K (50%)

**Medicaid**
- Beneficiaries @146,000
- PMPM @$5,818
- TCOC @ $1.0B
- Est. Attributed Lives 73K (50%)

**Commercial * (Private Mkt)**
- Enrollees @ 156,000
- PMPM @$5,400
- TCOC @ $1.01B
- Est. Attributed Lives 47K
  - 30% (Exchange Only)

**Other: Self Ins. +**
- Enrollees @ 195,000
- PMPM @$5,400
- TCOC @ $1.26B
- Est. Attributed Lives 0

---

**Total Attributed Lives**
- 180,000 Lives
- TCOC @ 1.5B

**Non Attributed Lives**
- 433,000 Lives
- TCOC $3.02B

- 20% or $.3B Based on Fee Schedules
- Enhanced FFS Payments (MACRA, etc.)
- Std. FFS Payments

---

- **Participating Providers**
  - Hospitals, Specialists
  - Primary Care, FQHC's
  - DA's, Home Health
  - Other

- **Non-Participating Providers**
  - Hospitals, Specialists
  - Primary Care, FQHC's
  - DA's, Home Health
  - Other

---

**Payments for Non-Vermont Residents**

---

**Fee For Service Payments**

---

**Capitation Payments**

---

**ACO**
- 80% or $1.2B

---

**Capitation or Enhanced Fee For Service Pay**

---

**Fee For Service Payments**
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.
ACO Collaboration Participants

Proposed High Level Goals:
- Governing Board
- Business Plan
- Local and Regional Empowerment
- Improve Access to and Payment for Primary Care
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.
Questions?
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
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.
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