State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

[phone] 802-241-0440
[fax] 802-241-0450

Al Gobeille*, Secretary*
Martha Maksym*, Deputy Secretary*

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To the Honorable members of the Joint Fiscal Committee,

Thank you for the opportunity to discuss the contract between the Department of Corrections (DOC) and the corporation known as Centurion. As you are aware, the Health Care Advocate (HCA) brought questions to light concerning the payment structure and reimbursement methodology during a Joint Legislative Justice Oversight Committee meeting. Questions such as these are important, and the committee, the bodies they represent, and Vermont is best served by these dialogues. It is unfair to Vermonters to offer as transparency the ability to review lengthy contracts or to attempt to understand these matters by reviewing multiple budgets. It is with this interest, that the people may understand their government, that I attempt a plain language explanation of the contracted health services provided at DOC.

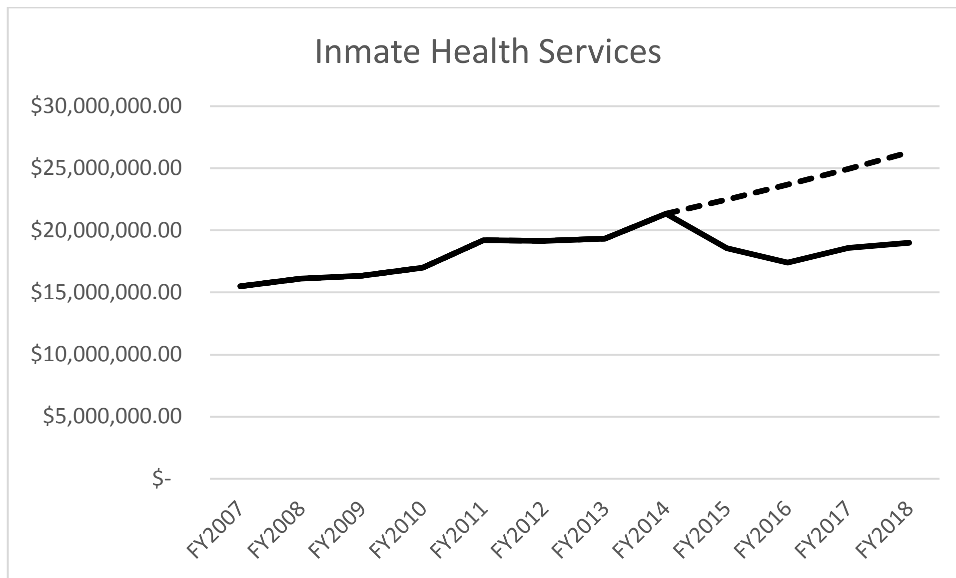
For over 50 years, health care services in the United States have been paid by a fee. For each test, prescription drug, office visit, examination or procedure, providers have submitted a claim and been paid a "usual, customary and reasonable" amount for their time and effort. This is commonly referred to as "Fee for Service" (FFS) medicine. While this method of payment provides 100% reconciliation of payment, it does not answer the questions "Was the procedure necessary?" "Is the patient better off?" or "Could the treatment have been avoided through prevention?" In addition, FFS medicine creates powerful incentives in the provider community to produce a high volume of services, often in direct opposition to the affirmative answers these questions beg for.

Value Based Payments (VBP) have arisen to address the weaknesses of the FFS model. These payment innovations attempt to combine three important components to address the questions raised above.

1. **Change in payment method.** VBP change the way providers are paid. Instead of being paid for every service, providers are paid for the estimated, combined service cost for a given population. Often referred to as capitation, these payments are typically expressed as a monthly estimate of costs referred to as a Per Member Per Month or PMPM.
2. **Quality of care.** Performance measures are created to insure quality of access, patient experience and overall care.
3. **Reconciliation.** A reconciliation process is created to allow payers and policy makers to analyze the delivery of care, and the impacts that changing incentives have on service delivery. The combination of these components gives both the payers of health care services and the providers the fiscal predictability each desire, the aligned incentives to keep people healthy, and the data to determine the efficacy of the health system.

The DOC's plan for correctional health care contracting is a forward-looking effort to move the Department away from FFS, integrate mental and physical health services, improve outcomes, and provide fiscal predictability to the State budgeting process. From Fiscal Year 2007 through Fiscal Year 2014, there was an increase in the inmate health services

contracting cost from $15.5M to $21.3M, which was an average increase of 5.37% annually. Had DOC continued to operate in FFS-based contracts, the cost for providing correctional health care likely would have continued as represented in the dotted line below.



Contract with Centurion

The contract, at a high level, calls for over $20 million dollars in health care spending to be paid to Centurion to meet health system performance goals and measures that are designed to provide high quality health care to the inmate population. With an emphasis on quality of care, the value-based contract establishes a PMPM with a shadow claim reconciliation process. This process compares the total dollars paid in a PMPM to the amount that would have been paid under a FFS agreement.

In the current contract year (Year 4), the capitated amount of $1,181.02 is paid monthly for an estimated average daily population of 1,450 inmates. While there are shared risk limitations on off-site services and pharmaceuticals and limited facility payments, the bulk of the contract is based upon a value-based payment model. Once these financial calculations are made and the contract is signed, the risk moves off the State coffers and onto the contractor to deliver services and manage expenditures, all while meeting performance standards. Examples of performance-based metrics include:

- % of patients with active insurance upon discharge from DOC custody.
- % of patients that are designated as SFI that are seen at least every 30 days.
- % of patients who received the initial healthcare receiving screening within 4 hours of admission.
- % of sick call requests which were seen within the required timeframes.

The data called into question by the HCA, was the reconciliation of some, but not all, components of the PMPM during Year 3 of the contract with Centurion. During calendar year 2017 (Year 3), the capitated payment made for pharmaceuticals and off-site medical services was $4,822,446. The contractor had total shadow claim expenditures of $2,619,129. Per the terms of the contract, the remaining $2,214,317 was utilized for other cost centers within the contract. Our reconciliation of capitated payments to the vendor, minus expenses incurred, yields $445,554 in profit. The contractor, at risk in the contract, retains the profit. This $445,554 is in addition to the corporate overhead (this covers administrative costs and margin) that was built into this contract, which was competitively bid. Centurion was the successful bidder amongst three vendors that responded to the RFP.

In testimony, the DOC team correctly outlined the changes to the vendor contract made earlier this year. While the contract has improved over time, I believe the discussion was not as fruitful as a more considered presentation may have been. Changes to the contract that increase or create risk corridors are not claw-backs or some attempt to retrieve lost money. Risk corridors are usual and customary in provider contracts and reflect upper and lower limits for each partners risk tolerance. In the new contract, the State limits the vendor's lower limit to allow the State to share in some of the impacts of aligned incentives. Again, this is usual and customary in this arena and is not a form of retribution or recognition of some nefarious activity.

Summary

Performance of delivered services versus the PMPM is often expressed as money paid vs. services delivered. While this is a good analysis for future rate setting and examinations of care delivery, it is not representative of services paid for as compared to expenditures of the contractor. Charts labeled as such are inaccurate. The HCA's letter to the Joint Legislative Justice Oversight Committee dated September 20, 2018 shows this comparison and assumes this is a comparison of actual spending. There are no unaccounted for dollars under this contract.

Once the contractor takes the risk of caring for a given population, through a VBP capitated rate, the savings achieved, within the limits of the contract, are the health system's reward for producing high quality care. The State's rewards are improved health for our inmates and not suffering the budget gyrations brought on through FFS utilization spikes. As we change incentives, in the community or through the DOC vendor, it is important to realize that comparing what might have occurred under the old FFS system is illogical, as two incentive systems cannot exist at the same point in time.

As we move to new healthcare payment models, it is discussions like these that demonstrate the DOC's capacity to develop statewide value-based contracting arrangements which will continue to build our knowledge base and provide Vermonters with an ever-increasing understanding of the evolving landscape of health reform.

Sincerely,

Al Gobeille
Secretary, Agency of Human Services