

Payment and Delivery System Reform in Vermont: 2016 and Beyond

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Agenda

■ Transition Year 2016

- 1. Medicare Waiver Overview
- 2. ACO Options in 2016
- 3. ACO Collaboration
- 4. All-Payer Model Framework

■ Regulatory Role of GMCB

- 5. Responsibilities to Consider and Resources Required

■ Next Steps

Members of the ACO Payment Sub-Committee

- **Vermont's 3 ACOs**

- CHAC
- OneCare Vermont
- VCP/Healthfirst

- **Provider Leaders and Associations**

- Bi-State Primary Care Association
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Medical Society

- **Payer Organizations**

- Blue Cross Blue Shield of Vermont
- MVP Health Care
- Department of Vermont Health Access

Glossary of Acronyms

ACO – Accountable Care Organization

CAH – Critical Access Hospital

CHAC – Community Health Accountable Care

CMS – Centers for Medicare and Medicaid Services

CMMI – Center for Medicare and Medicaid Innovation

FFS – Fee-for-Service

FQHC – Federally Qualified Health Center

GMCB – Green Mountain Care Board

SSP – Shared Savings Program

MSSP – Medicare SSP

VMSSP – Vermont Medicaid SSP

XSSP – Commercial SSP

TCOC – Total Cost of Care

VCP – Vermont Collaborative Physicians

1. Medicare Waiver

Reach Agreement with CMS by Fall 2015 for Start Date 1/1/2017:

- 2016 becomes a transition year

Discussions with CMMI Involve:

- Base and Trend for All Payers
- Medicare Savings
- Potential Payment Models for 2017
 - ❖ ACO/Network Providers
 - ❖ Non-Participating Providers

2. ACO Options in 2016

Medicare SSP (MSSP)

➤ OneCare VT

- ❖ Continue participation in MSSP
- ❖ Participate in the Next Generation ACO (should they receive approval) in 2016 or 2017

➤ CHAC

- ❖ Continue participation in MSSP

Medicaid SSP (VMSSP)

➤ OneCare VT and CHAC

- ❖ 3 year program ending in 2016

Commercial SSP (XSSP)

- All three ACOs currently participating
- Current ACO XSSP standards call for downside risk in 2016
- Need to determine formula for calculating expenditure targets and savings calculations for 2016

3. ACO Collaboration

Vermont's three ACOs continue to discuss ways they can collaborate.

***Purpose:** Build upon the foundation created by our work together 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.*

Activities:

- Establishing a single entity (“the ACO”) if pre-established governance and other organizational and financial criteria are met (2017)
- Determine the composition of governance body for possible unified ACO based on the following principles:
 - ❖ Have broad geographic representation
 - ❖ Meet requirements for provider and consumer participation
 - ❖ Be of reasonable size to ensure effectiveness
 - ❖ Have balanced representation of provider types
 - ❖ Establish voting rules that ensure broad support for major policy decisions

3. ACO Collaboration

(cont'd)

Activities: (cont'd)

- Negotiating data sharing agreements (2016)
 - ❖ Sharing data and analytics
 - ❖ Pursue a single approach to data collection and analytics
- Modeling merging of attributed populations (2016)
- Collaborating to improve care management and care coordination (2016)
 - ❖ Participate in community collaboratives as the foundation to improved care
- Be transparent in all aspects of the process of health care reform
- Establish milestones and timelines to meet goals and prepare for 2017

4. Vermont All-Payer Model Framework (Currently Under Consideration by the ACOs)

This Framework is intended to be used to inform the GMCB and the State's CMS waiver negotiating team regarding this group's thinking about how an all-payer model might be implemented in Vermont. This document represents the understandings reached by this group as of its meeting of August 10, 2015, recognizing that many details are yet to be resolved.

The document continues to be a “work in progress.”

Vermont All-Payer Model Framework

(cont'd)

Reasons to Pursue an All-Payer Model for Vermont:

- Health care delivery and payment systems are currently very fragmented, and are not designed to provide efficient and well-coordinated health care services. If Vermont is able to achieve the health care payment and delivery system reform as set forth in state legislation, the result could be a much more integrated system of care, better health outcomes, and better management of overall health care costs (including reducing health insurance premium inflation).
- Developing a single ACO that could be accountable for financial risk; having sufficient resources to provide the infrastructure for data collection, analytics, and care coordination; and having a sufficient number of attributed lives appears to be the best option to achieve a more integrated system of care.

Vermont All-Payer Model Framework

(cont'd)

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

- Better access to care
- More time for patients with doctor 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 health care team and patients

Vermont All-Payer Model Framework

(cont'd)

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

- Support for high value health care
- Greater flexibility
- Provider driven model
- Local empowerment
- Focus on prevention and population health
- Freedom of choice
- Reducing cost shift growth

Vermont All-Payer Model Framework

(cont'd)

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 patient 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.
- Manage financial risk.

Vermont All-Payer Model Framework

(cont'd)

Payment Model Principles: Prior to discussing the manner in which contracted providers should be paid by the ACO, the Subcommittee identified the following consensus set of principles to govern the provider payment methodologies.

- Be holistic in orientation
- Be equitable
- Reward desired outcomes
- Encourage improved care delivery and health investment
- Ensure consistent payer rules and performance incentives and measures
- Promote wellness and healthy lifestyle choices by patients

Vermont All-Payer Model Framework

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Provider Payment Models: Introduction

The Subcommittee envisions that, through a phased-in process, the ACO will make broad use of value-based payment methods for the vast majority of services for which it is responsible. Initially, however, the Subcommittee agrees that such methods should focus on payments to hospitals (including employed physicians), FQHCs, and independent primary care and specialty practices.

The language that follows describes the consensus elements of those payment models, tentatively settled upon as of August 10, 2015, recognizing that many details are yet to be resolved.

Vermont All-Payer Model Framework

(cont'd)

Provider Payment Model – Participating Primary Care Providers:

- The Subcommittee recommends that primary care practices participating in the ACO should:
 - ❖ Be offered the option of primary care capitation or enhanced fee-for-service payments.
 - ❖ Be eligible for performance based incentive payments.
 - ❖ Be paid by all Vermont licensed insurers based on payment methods approved by the GMCB.

- The Subcommittee recommends Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) participating in the ACO should:
 - ❖ Be reimbursed in accordance with federal rules related to FQHC and RHC payments.
 - ❖ Be eligible for CMS Medicare, Medicaid, and commercial alternative reimbursement programs
 - ❖ Be eligible for performance based incentive payments.

Vermont All-Payer Model Framework

(cont'd)

Non-Participating Primary Care Providers:

➤ The Subcommittee recommends non-participating primary care providers receive standard payments regulated by the GMCB to ensure compliance with agreed upon statewide expenditure targets.

Vermont All-Payer Model Framework

(cont'd)

Primary Care Practice Patient Attribution:

- Attribution is important for payment and for establishing/recognizing relationships between patients and primary care providers
- Patients should be prospectively attributed using voluntary patient selection as a preferred method, and claims-based attribution as a secondary method.
- Goals of attribution:
 - ❖ Attribute as many patients as possible.
 - ❖ Avoid attribution to multiple providers.
 - ❖ Administrative simplicity and feasibility.
 - ❖ Prospective rather than retrospective attribution.

Vermont All-Payer Model Framework

(cont'd)

Specialist Physicians & Other Non-Hospital Providers:

- The subcommittee's goal is to recommend a fair and equitable method of payment that ties specialist physician and other providers into the ACO's population health approach. The subcommittee has organized a work group to address this topic.

Vermont All-Payer Model Framework

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Hospitals – Participating Hospitals:

- For hospitals participating in the ACO, fixed revenue budgets are recommended to be the payment model for inpatient and outpatient services, and for professional services provided by hospital-employed physicians and allied health professionals.

Option 1 – Double Channel Model

- The ACO would make payments to hospitals on a fixed payment basis using the methodology established by the ACO for all ACO-attributed patients.
- For non-ACO-attributed patients, the hospital would receive fee-for-service payments from the responsible payers. Adjustments to the rates employed for fee-for-service payments would be authorized by the GMCB on a periodic basis, if necessary, to ensure that the budget was not exceeded for this portion of the population.

Vermont All-Payer Model Framework

(cont'd)

Hospitals – Participating Hospitals: (cont'd)

Option 2 -- Single Channel Model

- Hospital budgets would be based upon total historical revenue for all payers, including costs incurred for the treatment of Vermont and non-Vermont residents, and non-claims-based payments;
- Payments to the hospitals would be made by the individual payers based upon instructions from the ACO (upon approval by the GMCB). The aggregate of all payments would constitute the hospital's revenue budget for the performance year.
- The GMCB would review and approve hospital budgets on an annual basis under an enhanced budget review process.
- The ACO would be accountable for hospital costs incurred for patients attributed to the ACO.

Vermont All-Payer Model Framework

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Hospital Payments – Non-Participating Hospitals:

- Non-participating hospitals would be subject to an annual enhanced budget review process set by the GMCB, with specific rules regarding net patient revenue, rate increases, and compliance.

Vermont All-Payer Model Framework

(cont'd)

Payer Risk Model

- The Subcommittee agreed that the proposed CMS Next Gen ACO payment model could 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.

5. 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.

Regulatory Role of the Green Mountain Care Board

(cont'd)

Issues the Board will need to address in 2015 and 2016

- **Delineation of GMCB Regulatory Roles related to ACO(s), Hospitals, Payers and Other Providers**
 - ACO Budget and Operations Review Process
 - Hospital Budget Review Process
 - ❖ Hospitals inside the ACO/Network
 - ❖ Hospitals outside the ACO/Network
 - ❖ Critical Access Hospitals
 - Provider Payments (PCP and other providers)
 - ❖ Participating in the ACO/Network
 - ❖ Non-Participating Providers
 - ❖ FQHCs
 - Payers
 - ❖ Commercial: Annual Rate Review and Payment Variation
 - ❖ Medicaid (DVHA): GMCB regulatory authority, if any, over Medicaid payments

Regulatory Role of the Green Mountain Care Board

(cont'd)

Issues the GMCB will need to address in 2015 and 2016 (cont'd)

■ Other Regulatory Issues

- Will the ACO(s) be subject to State insurance regulations and licensing
- If there is one ACO, does this raise market competition issues (Anti-Trust/FTC/DOJ etc.)
- Who will enforce patient protection regulations (e.g., Rule 9-03)
 - ❖ Appeals
 - ❖ Fraud and Abuse (Medicaid retains its own F&A oversight?)
 - ❖ Patient Safety
 - ❖ Patient Access
- Other

Regulatory Role of the Green Mountain Care Board

(cont'd)

Issues the GMCB will need to address in 2015 and 2016 (cont'd)

■ Resources the GMCB will need to implement this authority

- Current positions
- Positions approved by the legislature in 2015 for SFY 2016
- Additional positions needed, if any, for SFY 2017
- Consultants/Lawyers
- Space/Software/Bandwidth, etc.
- Other

Next Steps

Time is short and much needs to be done if we decide to travel down this path:

ACOs:

- Reach agreement on collaboration by September 1, 2015
- Begin working on activities and milestones in 2016
- Develop a work plan that prepares for implementation of a statewide integrated delivery system and all-payer model in 2017

GMCB:

- Complete negotiations with CMMI and decide whether or not to execute a waiver agreement for an all-payer model in 2017 by December 2015
- Consider the scope of the regulatory role the Board wants to assume in 2017, and develop a work plan and timelines necessary to assume that role
- Based on the above, prepare a legislative agenda and any legislative language for consideration by November/December 2015

Questions?