Update on Vermont Payment Reform Initiatives

Presentation to House Healthcare Committee

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Agenda

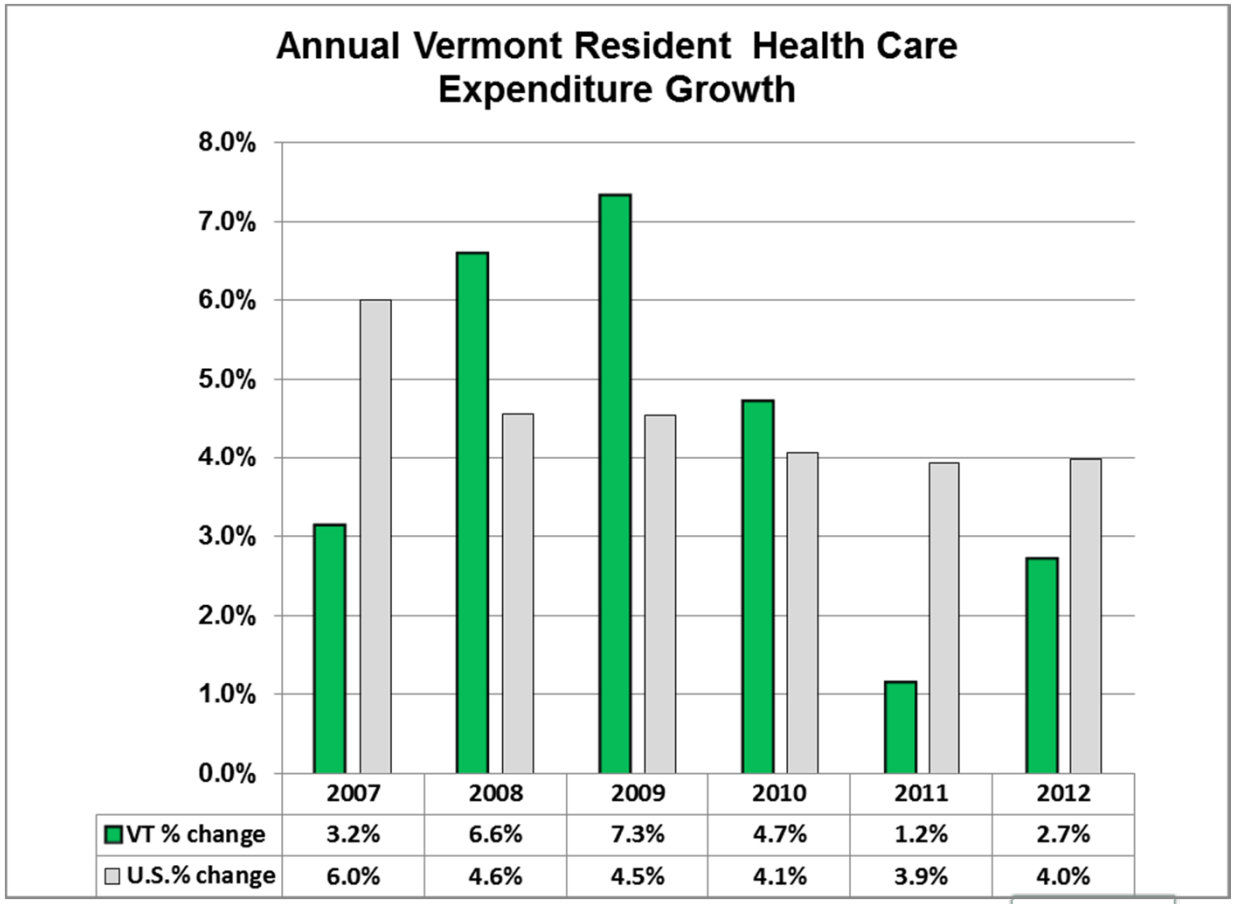
- History of Health Care Expenditures
- Role of the GMCB under Act 48
- SIM Grant Funding (VHCIP) and Payment Models
- Accountable Care Organizations (ACOs) and Shared Savings Programs
- Global Budgets
- Other Payment Reform Initiatives
- Questions

Health Care Expenditures in Vermont

What is the Rate of Growth in Vermont Compared with the U.S.?

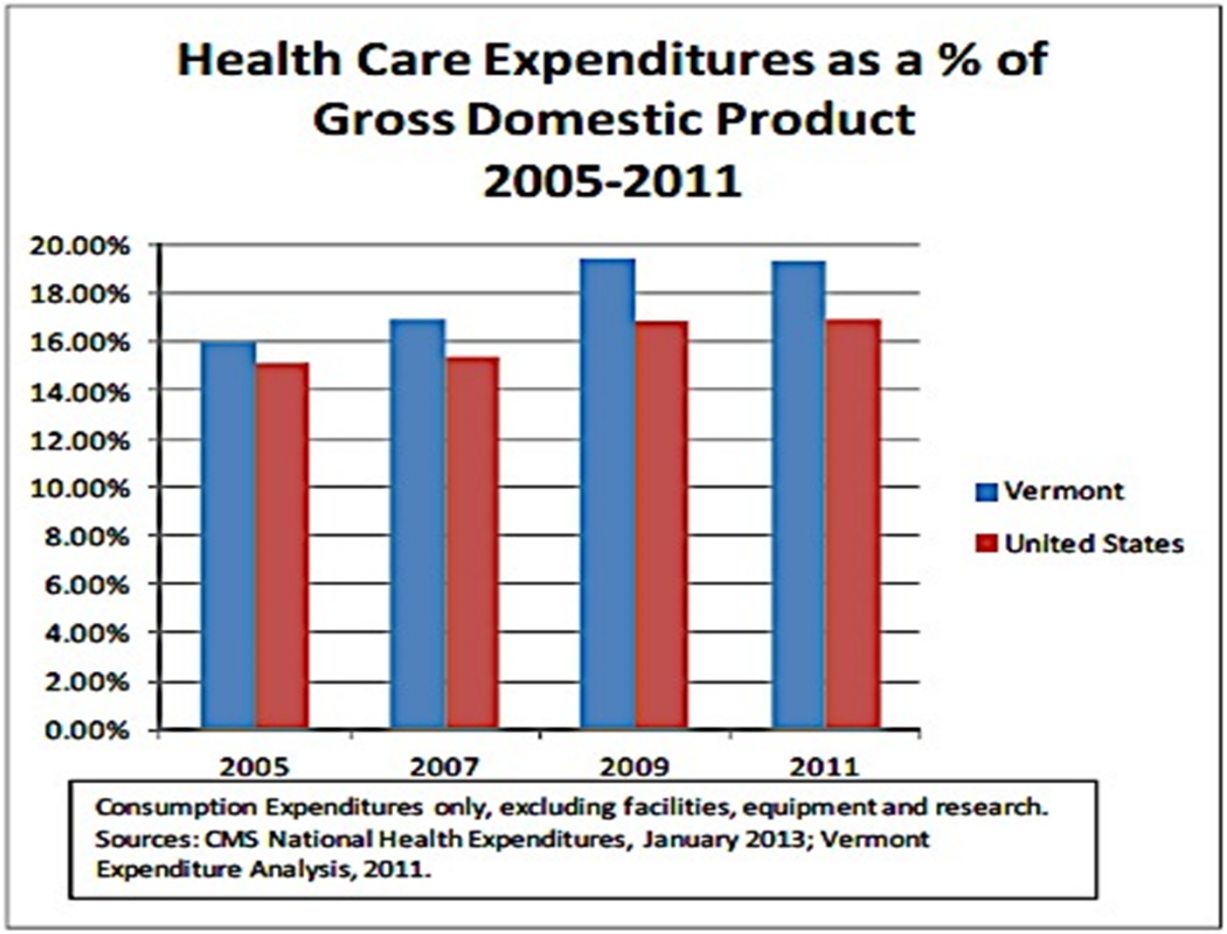
Expenditures for health care services received by Vermonters grew an average of 4.5% per year (2007-2012) while the U.S. grew an average of 4.2% per year.

Note: U.S. - Health Consumption Expenditures with projected 2012



	2007	2008	2009	2010	2011	2012
VT % change	3.2%	6.6%	7.3%	4.7%	1.2%	2.7%
U.S.% change	6.0%	4.6%	4.5%	4.1%	3.9%	4.0%

Vermont has a very high Proportion of Health Cost as % of GSP



Taken from a Study on Payment Variability conducted by the Vermont Association of Hospitals and Health Systems

Role of the Green Mountain Care Board Under Act 48

Act 48 GMCB Payment and Delivery System Reform Charge:

- 18 V.S.A. § 9377(a): "In order to . . . ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section."

- 18 V.S.A. § 9377(b): "The board shall be responsible for payment and delivery system reform, including the pilot projects established in this section."

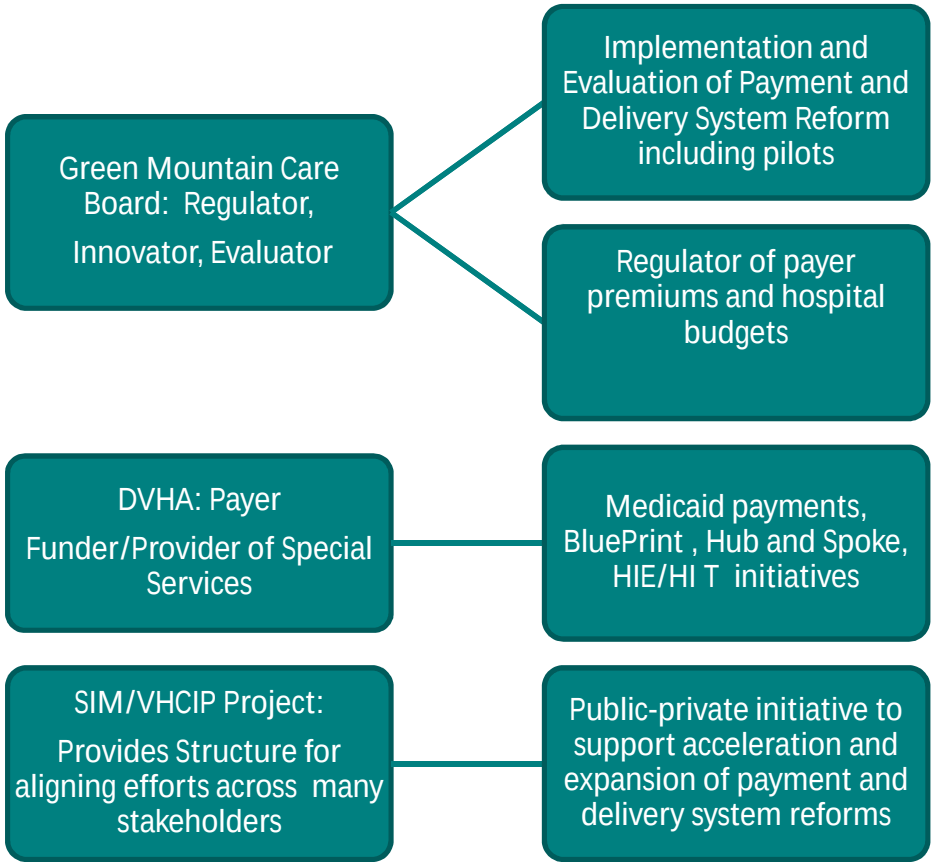
Act 48 GMCB Payment and Delivery System Reform Charge (continued)

- 18 V.S.A. § 9375(b)(1): GMCB shall "[o]versee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont."

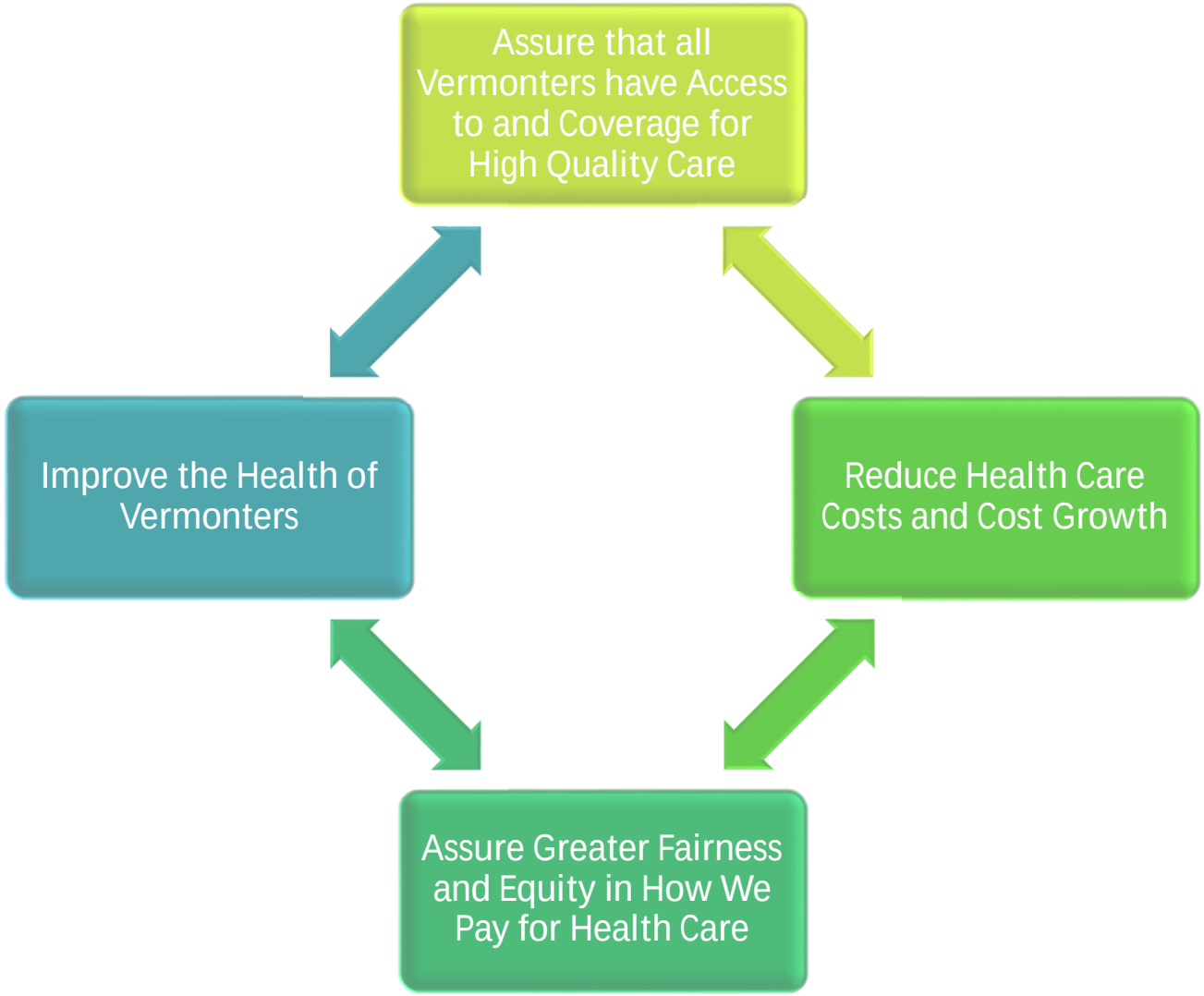
Green Mountain Care Board Role in Payment and Delivery System Reform

- Oversee implementation, testing and evaluation of payment reform models
- Review and approve hospital budgets, payer premiums, and certificate of need applications

Roles in Payment and Delivery System Reform



Vermont's Health Reform Goals



SIM/VHCIP Grant Funding and Payment Models

SIM/VHCIP Grant Purpose

- The State Innovation Model (SIM) grant was awarded to Vermont by the federal Centers for Medicare and Medicaid Innovation (CMMI). The grant provides approximately $45 million in funding and other resources over three years to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017.

Goals of the SIM/VHCIP Grant

- Encourage partnerships between Vermont government agencies and the private sector to improve and coordinate health and human services
- Increase organizational coordination and financial alignment between Blueprint advanced primary care practices and specialty care;
- Provide resources to support the implementation and evaluation of the impact of value-based payment models;
  - Shared Savings/Accountable Care Organizations
  - Episodes of Care/Bundled Payments
  - Pay-for-Performance (P4P)

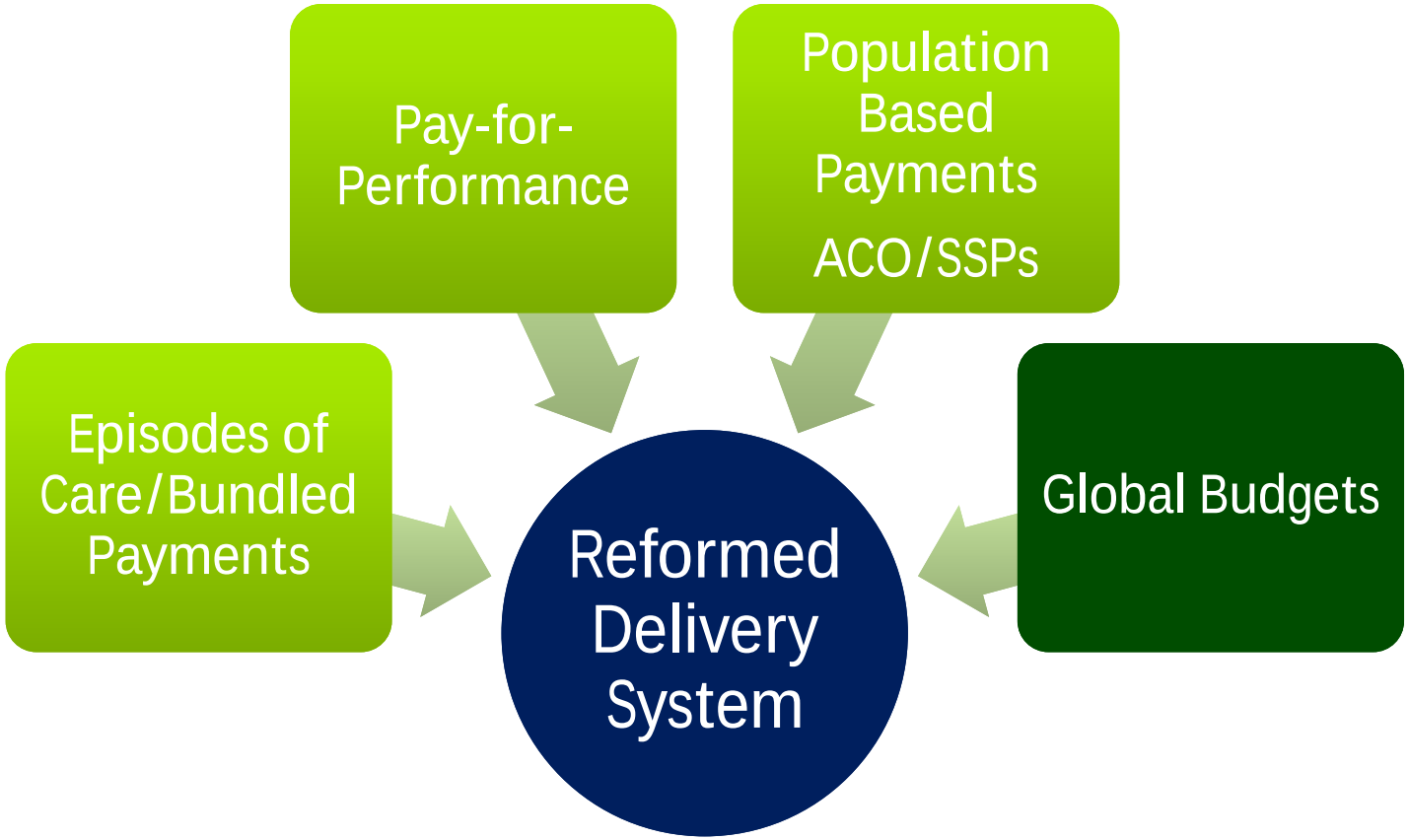
Goals of the SIM/VHCIP Grant (continued)

- Provide Funding for:
  - Expansion of electronic health records (EHRs) to primary care, mental health and long term service providers;
  - Accelerated development of interfaces between EHRs and the state's Health Information Exchange;
  - Improved data transmission, integration and use across providers, including ACOs;
  - Coordinated and possibly expanded measurement of consumer experience;

Goals of the SIM/VHCIP Grant (continued)

- Provide Funding for:
  - Improved capacity to measure and address provider workforce needs;
  - Improved data analytics and predictive modeling to support monitoring system costs and quality; and
  - Development of stronger links between the Blueprint for Health (advanced primary care) and specialty care, including mental health and substance abuse programs.

Payment and Models to be Tested Under the SIM/VHCIP and RWJF Grants



Grant Funding from Robert Wood Johnson Foundation and CMMI (SIM/VHCIP) to support all four models

Payment Reform Initiatives (SIM/VHCIP)

- Episodes of Care/Bundled Payment Initiatives
  - Discussions underway in SIM/VHCIP Payment Models Work Group

- Pay for Performance (P4P) Initiatives
  - Discussions scheduled to begin in Spring of 2014 and will initially focus on Medicaid

Accountable Care Organizations and Shared Savings Programs

Accountable Care Organizations

- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population

- These providers work together to coordinate care for their patients and have established mechanisms for shared governance

- ACO participation in a Shared Savings Program is voluntary

Shared Savings Programs

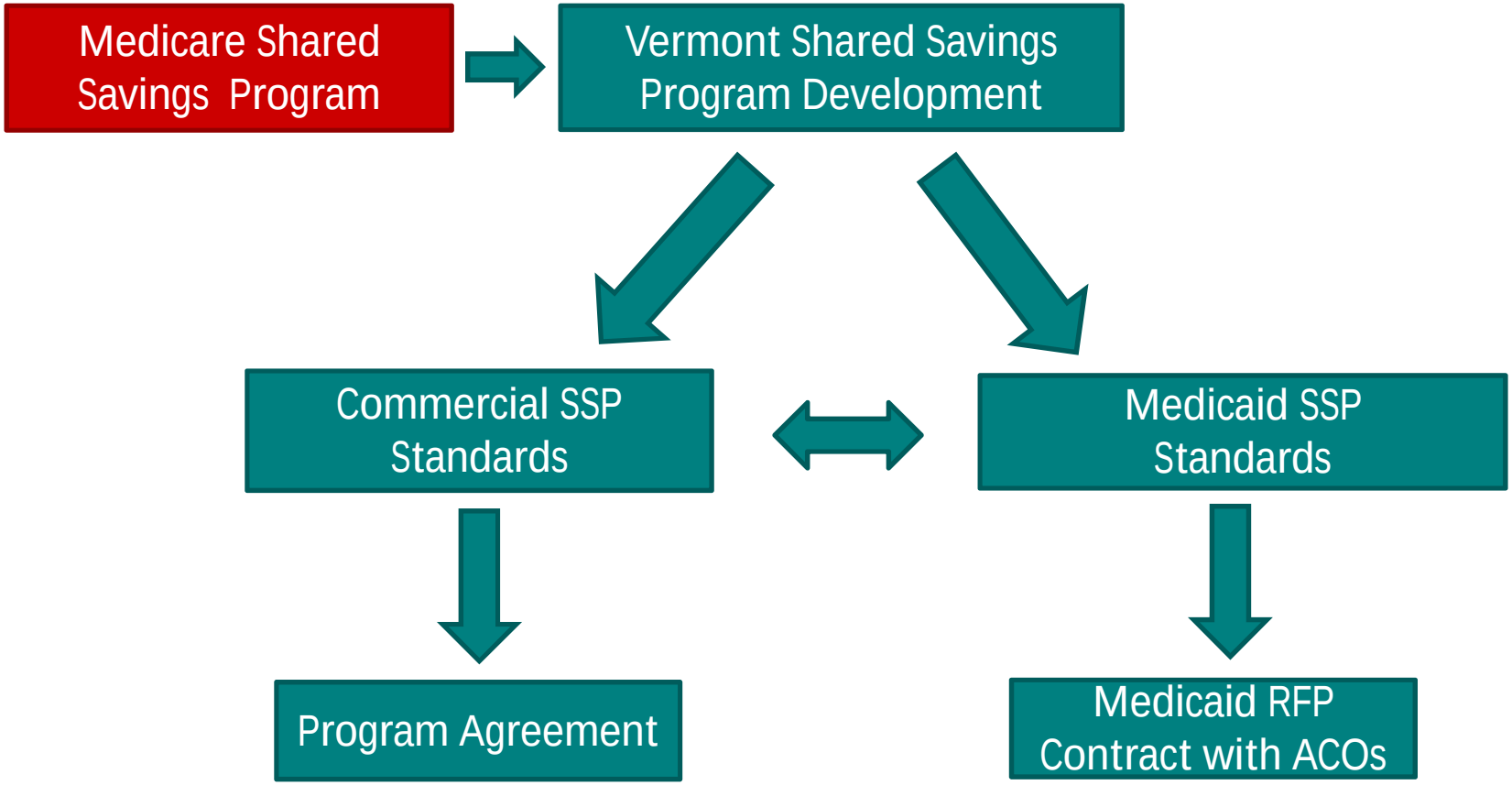
Shared Savings Programs are payment reform initiatives developed by health care payers. Shared Savings Programs are offered to health care providers who agree to participate with the payers to:

- Promote accountability for the care of a defined population
- Coordinate care
- Encourage investment in infrastructure and care processes
- Share a percentage of savings realized as a result of their efforts

Shared Savings Programs in Vermont

- Shared Savings Program standards in Vermont are a result of voluntary programs designed by payers, providers and stakeholders, and facilitated by the State.
- Develop ACO/SSP standards to that include:
  - Attribution of Patients
  - Establishment of Expenditure Targets
  - Distribution of Savings
  - Impact of Performance Measures on Savings Distribution
  - Governance

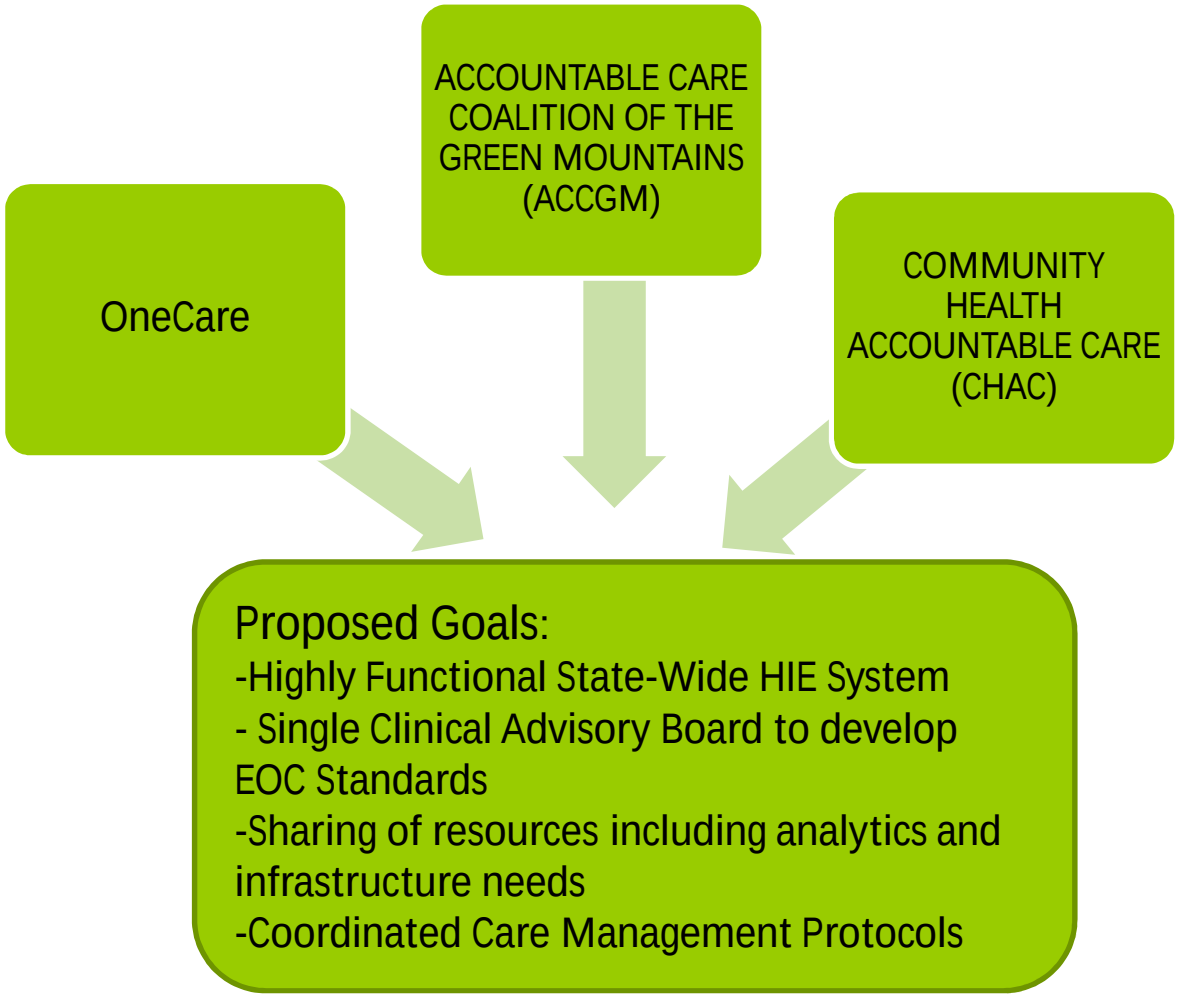
Development of VT Shared Savings Program



ACO Programs and Participants

- ACOs in Vermont
  - OneCare
    - Participating in the CMS/SSP as of January 1, 2013
    - intending to participate in the Commercial and Medicaid SSPs being developed in Vermont as of January 1, 2014
  - Community Health Accountable Care (CHAC)
    - Five of Vermont's Federally Qualified Health Centers (FQHCs) participating in the CMS/SSP as of January 1, 2014
    - Eight FQHCs are intending to participate in the Commercial and Medicaid SSPs being developed in Vermont as of January 1, 2014.
  - Accountable Care Coalition of the Green Mountains
    - Participating in the CMS/SSP as of July 1, 2012
    - Intending to participate in the Commercial SSP being developed in Vermont as of January 1, 2014

ACO Collaboration Meetings



Global Budgets

Global Budgets

- What is a Global Budget:
  - Can be Hospital/Physician Based
  - Can be Population Based
  - Hospitals are very interested
  - Two are actively modeling what a Global Budget would look like
    - Southwestern Vermont Medical Center
      - Engaged an outside consultant from MD to help them develop a straw model that they will present to GMCB Payment Reform team and consultant Bob Murray
    - Rutland Regional Medical Center
      - Consultants Bob Murray and Jack Cook are modeling for Commercial and Medicaid

Global Budgets: Maryland Example

- Global Budgets can be structured to include all Payers (including Medicare and Medicaid) under CMMI's authority to waive current Medicare payment policies and allow a state to experiment with an all-payer payment program in which Medicare would participate
- Maryland has had an All-Payer System under a Medicare Waiver for over thirty years. They are currently negotiating a new waiver that would develop rate methods and payment arrangements for all hospitals that are "population-based" (i.e., Global Budgets for a hospital or a hospital and related providers caring for a population of patients in a given region
- Under Maryland's Demonstration with CMMI, the state will limit the growth in all-payer per capita hospital costs to less than the growth in Maryland's Gross State Product (3.58% per resident)

Other Payment Reform Initiatives

Current Payment Reform Pilots (GMCB)

- Vermont Oncology Project
  - Goal: To improve care for patients diagnosed with Cancer in St. Johnsbury region
  - Participating Providers: Northeastern Vermont Regional Hospital, Northern Counties Health Care, Norris Cotton Cancer Center (DH)
  - Participating Payers: BCBSVT, MVP Health Care, Cigna and Medicaid
  - Enhanced care coordination supported by payments to PCPs and Specialists
  - Approved by GMCB in June 2012; patient enrollment and payments began in October 2012
  - Scope: Nearly 50 patients and families served to date; potential for ~270 patients with $5 million/year in expenditures in St. Johnsbury and ~9,800 patients with $172 million/year in expenditures statewide
  - Preliminary Results: Improved communication between providers, increased palliative care referrals, additional collaboration initiatives proposed by providers, plans to further integrate nurses

Current Payment Reform Pilots (GMCB)

- Emergency Department Pilot
  - Goal: Reduce avoidable ED visits by employing care coordinator and nurse practitioner to work with patients and refer them to PCP practices after ED visit
  - Participating Provider: Northwestern Medical Center (St. Albans has highest per capita use of ED services in VT)
  - Potential Payers: Discussions underway with BCBSVT and Medicaid to develop shared savings or other model
  - NMC has hired care coordinator and nurse practitioner, submitted pilot application, and been given approval by GMCB with some contingencies

Current Payment Reform Pilots (GMCB)

- Congestive Heart Failure (CHF) Bundled Payment Initiative
  - Goal: To improve care for patients with CHF inpatient admissions by creating integrated care delivery system
  - Participating Providers: Rutland Regional Medical Center, Community Health Centers of the Rutland Region (FQHC), Rutland Area VNA, Nursing Homes, Pulmonologists, Cardiologists
  - Participating Payer: Medicare (approved January 2013)
  - Potential Scope: ~120 patients diagnosed with CHF with expenditures of ~$1.9 million/year
  - Preliminary Results: CHF all-cause 30-day readmission rates are now averaging 12-13 percent for these patients, well below their historical rates of 24-25 percent

Questions?